HELP UNDER CONSTRUCTION:

CURRENT CONCEPTS OF MASCULINITY AND ITS IMPACT ON MEN'S HELP-

SEEKING

By Dave Vass

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APPROVED BY

Maria Stella, Ph.D., R.C.C., Thesis Supervisor, Counsellor Education Faculty

Chris Kinman, Ph.D. (Candidate), Faculty Reader, Counsellor Education Faculty

Division of Arts and Sciences

**Abstract**

This thesis thoroughly explores the dynamic between current conceptions of masculinity

and resulting help-seeking practices in men, so as to promote a better understanding of the

factors and context influencing men's behaviors when experiencing symptoms of distress. By

utilizing a qualitative, social constructionist research approach, room for variability among men

and in one man's experience opens the area of inquiry to not only if, but *how* men are seeking

help, and at what times is this happening? This seems critical to attend to presently, as men have

been deemed to be in a state of crisis with regards to their mental and physical health, with ties to

traditional masculine ideals as been the catalyst for oppressive practices presented from

discourses inspired by the #MeToo movement and unfair wage compensation for women, yet

only a small fraction of those affected have sought formal-help and we need to know why. What

was uncovered was that it appears that society is going through a transition period, where men

are negotiating the 'old roles' and constructing help-seeking as a masculine act of courage. These

men are also choosing alternative and/or indirect means of help-seeking, via online researching

and forum groups, peer-group mediation, and adaptive self-help strategies such as self-

monitoring and reframing problems, that have tended to either go unnoticed or dismissed by

health-care professionals. This information can prove to be quite useful for counsellors in not

only providing more viable support services for this population, but also in addressing our own

biases formed as a result of our own socialization experiences, and how this can influence how

we relate to males, as well as shape our beliefs around what may be considered as 'valid' help-

seeking behaviors. Areas of further research are also explored.

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## Dedication

This thesis is dedicated to my grandmother, 'Gannie'-Lee, who has always encouraged my passion for writing, as well as reminded me of the power of relationships to inspire positive change.

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**Chapter 1: Introduction**

The purpose of this thesis is to see how male's socialization and gender role formation—via internalized concepts of masculinity—not only effects if and how men go about seeking help, but also how others interpret their help-seeking behaviors. In doing so, I hope to provide relevant information from a range of different sources that will broaden our understanding of the processes involved, leading to better informed clinicians and mental health practitioners, policy makers, and citizens. It is with this understanding that we can better recognize and support males experiencing mental health challenges in ways that are congruent with their modus operandi.

I anticipate that there will be a number of attributes associated with traditional masculinity that deter males from seeking help. Among these would be that: 1) it is not acceptable for males to be vulnerable, espousing stoicism and rationality over emotional expression; 2) men should be independent, competitive, and success-driven; and 3) men shouldn't be preoccupied about their bodies, ignoring health concerns and engaging in risk-taking behavior.

I also anticipate that society is going through a transition time where these traditional gender roles are being questioned and negotiated, leading to hybrid forms of help-seeking that may not be recognized by formal health-care providers. My guiding assumption is that there are present gaps in knowledge and/or mixed responses towards when and how men are seeking help, which could be narrowing the visibility and viability of a range of support for men experiencing symptoms of distress.

In this chapter, I will first present the context of the problem: identifying the health crisis that men seem to be facing, as well as factors that may be contributing towards this predicament,

signifying the importance of help-seeking behaviors--not only for men experiencing distress but for those indirectly affected. I will follow this up with a description of the methodology used for the purposes of this study. Key terms and phrases will be explained, with the chapter ending with an outline of the structure of the thesis.

## Background

### Males in Danger

Much progress has been made in the medical and mental-health communities, leading to better informed citizens with greater access to resources promoting well-being. Men and women are generally living decades longer than their previous counterparts even just a century ago. Yet what is still not understood is the growing age discrepancy between the genders that has emerged, where US men, on average, are dying nearly 7 years younger than women while also surpassing women in death rates for all 13 leading causes of death--"...left unquestioned, men's shorter life span is presumed to be 'natural' and inevitable. (Courtenay & Keeling, 2000, p.244).

Arguments for this rather sizable difference is the result of men's health behavior, which could more accurately be represented by their propensity towards unhealthy behavior. Among these would be higher rates of violence, unsafe sex, drug-use, smoking and drinking, coupled with less preventive action (Farrimond, 2012). Men have also been found to have a much higher suicide rate than women, which has been linked to a general unwillingness to express or talk about emotions (de Boisem & Hearn, 2017).

Associated with emotion-talk is help seeking, which is viewed as an important health behavior for men because it is one of the least contested sex differences found in the psychological literature, with an explicit connection made by researchers that avoiding help seeking has detrimental health effects for men (Hoy, 2012). With the increased attention on

men's health in the last few decades as a result of the developments in sociological theories of

gender--and masculinities in particular--there has been a rising interest in if and why men are

unwilling to seek medical help (O'brien, Hunt, & Hart, 2005).

**Systemic Dangers**

Harding and Fox (2015) have described men's mental health help-seeking behavior as

"problematic, failing, and in some countries in a state of crisis (p.451), with O'brien, Hunt, and

Hart (2005) supporting this notion by stating that the "apparent reluctance to consult a doctor has

been identified as an important obstacle to improving men's health" (p.503). While Obrien et al's

study is coming more from a biomedical disease-prevention model perspective, the underlying

common theme and area of concern is that the 'under-usage' of the health-care system is been

constructed as clearly a social problem (2005).

Men's current predicament towards behaviors that include limited emotional expression

and help-seeking tendencies is ultimately a systemic problem, as medical researchers,

psychologists, and other health professionals have all contributed to cultural portrayals of men as

strong and healthy while women are depicted as the 'sicker' gender, which has led to the

indivisibility of men's poor health status (Courtenay & Keeling, 2000). Indeed, as Courtenay and

Keeling (2000) suggest in their study on 'Men, gender, and health: toward an interdisciplinary

approach', "problems that endanger men's health conspire to undermine discussion of it."

(p.243).

**Danger to Themselves?**

Contemporary times seems to have brought about a change of ideals related to the

perception and role of men in postindustrial Western societies, where the traditional construction

of masculinity has become confusing and dysfunctional (Moller-Leimkuhler, 2002). Men who

align themselves strongly to hegemonic masculine norms find themselves caught teetering in a construction of their own demise as they face a 'double jeopardy', characterized by higher psychological distress and less willingness to seek help. The result of this is that many men suffer in silence. (Berger, Addis, Green, Mackowiak, & Goldberg, 2013).

Even though men are reported to having lower levels of mental health disorders than women, a prevailing rationale for these numbers is an under-diagnoses in men due to a reluctance in seeking assistance as opposed to the absence of the disorder. The denial of illness and preference for 'self-management' approaches in addressing mental and physical distress are what likely cause poor health outcomes for men in the long-run (Harding & Fox, 2015).

Men are also considered to be using fewer coping strategies than women, having a tendency to enact unhelpful strategies when attempting to cope with distress and depression (Fogarty et al, 2015). Chuick, Greenfeld, Greenberg, Shepard, Cochran, and Haley (2009) support this in their findings in which participants described a process they called a 'big build', whereby negative emotions such as sadness, emptiness, and anger intensified in men through suppressive means of coping. The suppressive coping methods led to expressions of depression not generally classified in present clinical settings, such as impulsive risk-taking, withdrawal, and escalating substance-abuse (Chuick et al, 2009). Studies on gender bias in diagnosis of depression have determined that when measurement criteria include gender-fair items, depression can be found much more readily in men (Chuick et al, 2009).

Aside from the perceived or real barriers that prevent men from accessing the health care system, men also face additional setbacks in the consulting room that come along with the 'constricting role expectations' or 'psychological difficulties' attributed with their gender (O'brien, Hunt, & Hart, 2005).

**Collateral Danger**

Commentary that has suggested that men are victims of their own behavior have used this to argue that men are either ignorant about or disinterested in their health (Smith, Braunack-Mayer, Wittert, & Warin, 2008), as well as an unwillingness to take responsibility for their well-being (O'brien, Hunt, Hart, 2005).

This concept of selective differed responsibility in men is nothing new. Women have typically been considered as the stewards of health matters for the family, encouraging awareness of health issues, assisting men in interpreting symptoms, and being key agents in persuading men to seek help (O'brien, Hunt, & Hart, 2005). While it is considered normal within the family unit to have both shared and unique roles, as well as working off of each other's strengths, the complete reliance on a partner for personal matters as critical as health can have severe complications for the male's own development, as well as adding stressors on the relationship in an unbalanced caregiver situation. Any children will ultimately be affected as well, as the diminished capacity to recognize and attend to mental health issues for the father will negatively impact all areas of his life.

**Potential Dangers in 'Knowing'**

What is perhaps less looked at is how do we, as individuals and a society at large, find ourselves relating to someone who we perceive to be unwilling to take responsibility in matters as important as health when taking into account the assumption that not doing so has a deleterious effect on others?

Another area of address related to this is our collective concepts of masculinity, which has been under significant scrutiny by the media as of late, with references to the dominant form of masculinity as being toxic and dehumanizing. Courtenay and Keeling (2000) attest, however,

that things are not so black-and-white here; in order for there to be a toxic masculinity, there must also be a healthy masculinity. Even though they themselves are not exactly sure as to what 'that' is, they do describe certain aspects of traditional masculinity which are associated with positive health outcomes. Among them would be examples of acting independently and being assertive and decisive, which has been found to be helpful in enabling men to cope with chronic illness and cancer (Courtenay & Keeling, 2000).

Much research has been made in the hopes of uncovering some strategies that will reduce the social pressure men feel to hide vulnerability and avoid seeking help (Courtenay & Keeling, 2000). Wilkins, Payne, Granville and Branney (2008) warn to proceed in this pursuit on gender differences as problematic with caution, as a UK based report regarding gendered access to the health-care system described the evidence base as 'surprisingly poor' (as cited in Farrimond, 2012).

## Past Contributions

It can be helpful now to take a closer look at some of the previous history of work examining the topics of gender formation and health-oriented attitudes in western societies. It is the hope of the author that by having this brief overview of information we may have a better appreciation of the context surrounding current concepts of masculinity and its impact on men's help-seeking behavior.

### Women Leading the Way

Feminist scholars were pioneers in addressing gender and health, to the extent that Courtney and Keeling (2000) suggest that 'gender and health' have now become essentially synonymous with 'women's health'. More recently, pro-feminist commentators and campaigners have indicated a growing understanding of men's emotional lives, with getting men to

understand their own emotions as central to addressing gender inequalities (de Boisem & Hearn, 2017).

A main tenet found in the original Women's Liberation Movement in the 1960s and 1970s was to reveal how the 'personal is political', placing the focus of women's personal lives and relations between men and women as the base of political resistance (de Boisem & Hearn, 2017). Many of the feminists around this time argued how the emotional relations between women and men were shaped and maintained through patriarchal structures. Personal experiences which might be considered 'private' were actually critical productive sites of social struggle which could lead to changing the ways in which we see and experience the world (de Boisem & Hearn, 2017).

**Women Shaping Men's Experience**

Women are not only considered to be influential in developing the gendered perspective on health, but have also been attributed to being prominent figures by some personality theorists in the development of the male identity and gendered relations via their caregiver relationship with boys.

One of these theories is object relations theory. Conceived by Melanie Klein in the 1930s', object relations theory is an offshoot of Freud's instinct theory which emphasizes early childhood and places more importance on consistent patterns of interpersonal relationships (Feist, Feist, Roberts, 2013). This theory addresses how boys' early construction of self is made as a result of the fathers' early absence through negative associations: ie. as 'not mother' and 'not-feminine' (New, 2001).

Psychodynamic approaches, such as Klein's objects relations theory and Freud's pyschoanalytical theory, can be described as theories which see human functioning as being

comprised of the interaction of drives and forces within the person, particularly unconscious, resulting from early development (Feist, Feist, Roberts, 2013). Psychodynamic approaches to masculinity focus the attention on the early years of men's lives, making claims towards the vast importance of the caregiver's interactions as shaping men's later emotional and interpersonal development (Addis & Cohane, 2005). It is assumed that these early experiences and relationships with the caregiver are critical for males in developing the capacity for relatedness and the ability to reflect on their own and others emotions necessary for adult life (Addis & Cohane, 2005).

**Men as a Product of Our Social Environment**

Another approach taken in addressing men's underreporting of mental health issues and subsequent high suicide rates focuses on the role of socialization in shaping gendered-emotion narratives (de Boisem & Hearn, 2017). Social learning paradigms are likely the most prevalent psychological methods in studying gender. And while there are a variety of different social learning frameworks, they all stem from the notion that gendered behaviors, beliefs, and attitudes are learned from social environments via operant conditioning--ie. "...reinforcement, punishment, modeling, and the acquisition of gendered schemas or belief systems (Addis & Cohane, 2005, p.637).

Sociologically informed perspectives attribute some of the 'costs of masculinity' as being directly related to emotions in the sense of men's learned inability to talk about experiences of vulnerability, mortality, pain, grief and loss. It is through these cultural gendered constructs which they ascribe as being central to men's underreporting of depression and other issues concerning mental health (de Boisem & Hearn, 2017).

**Men as a Co-Creation with Their Social Environment**

What sets sociological 'Second Wave' psychology perspectives apart is the advancement of the idea that, rather than an inherent inability to develop emotions, it is men's inability to understand, express, or communicate them that creates a sense of struggle and ensuing suffering (de Boisem & Hearn, 2017). Therefore we find ourselves becoming witnesses to men's emotional expression as examples of gender performances, where actual emotions evolve and transmute into displays consistent with the ideals of social privilege (de Boisem & Hearn, 2017).

A growing body of literature has focused on the study of barriers to men's use of medical supports when faced with signs and symptoms of illness, including 'why' and 'how' men's help seeking appears to be problematic on a broad level (Wenger, 2011). Research tends to concentrate on the influence of masculinity norms to provide insights into why some men either delay or avoid engaging particular health services (Wenger, 2011). What second wave sociological researchers have gravitated towards is a perceived critical gap which typically discounts attention to a diversity of male experiences (Wenger, 2011). Among them is attention to *how* men navigate help seeking over time, which gets lost with a narrowed conceptualization of help-seeking from certain previous explorations.

**Method**

The methodology used in this thesis is a Social Constructionist (SC) approach, which is a conceptual framework that, "...emphasizes the cultural and historical aspects of phenomena widely thought to be exclusively natural." (Conrad & Barker, p.S67). The meanings of the phenomena are not inherent in the phenomena themselves but are created through interaction in a social context (Conrad & Barker, p.S67). Coming from this approach will be helpful in uncovering the dominant discourse of what is considered practices of being 'masculine' and how this might be affecting men's help-seeking behaviors.

SC is used in the field of research through an investigation as a collaborative process between the researchers and participants, with the intentions of constructing new ways of knowledge (Losantos, Montoya, Exeni, Santa Cruz, & Loots, 2016). For the purposes of this paper, I, the researcher, will take a number of statements from relevant academic studies and newspaper articles collected in the literature review to be representative of the participants. From there, analysis of the findings will be made as a way of identifying patterns of help-seeking behavior within the context of masculine roles and ideals. Discussion of the results will ensue.

**Key Terms**

Before going further, it would be useful to identify some of the key terms related to the topics of this paper to better orient the reader to the material being discussed. These are just a few of the broad concepts involved. Others will be addressed later in the literature review section.

*Help-Seeking:*

Despite its growing popularity in the research and intervention focus, help-seeking, as a complex construct, has yet to have a clearly agreed upon definition (Rickwood & Thomas, 2012). In practical terms, the Oxford dictionary has defined it as an "attempt to find (seek) assistance to improve a situation or problem (help)" (as cited in Rickwood & Thomas, 2012, p.174). From a health standpoint, the term originates from the medical sociology literature studying illness behavior, which relates to, "...the way people monitor their bodies, define and interpret their symptoms, take preventive or remedial action, or utilize the health care system" (Rickwood & Thomas, 2012, p.174).

What becomes critical here is that help-seeking can only be enacted by a recognized need. This means that the process can only proceed after an individual defines a situation as

problematic and sees intervention as necessary (Wenger, 2011). Help-seeking can also be viewed

here as a means of attempting to maximize wellness or to mitigate, or eliminate distress (Saint

Arnault, 2009).

People utilize help-seeking in a number of contexts, via the formal route--ie.

professional help-seeking, including: psychotherapy, medication, or a mixture of both

(ie.psychiatry)--and/or by informal means: seeking support from family or friends (Berger et al,

2013, p.434). Help-seeking can also be conceptualized in two main ways: 1) the rational, or

dominant, choice--which primarily explores *who* seeks help, and 2) the dynamic approach--

which explores *when* and *how* one seeks help (Wenger, 2011). The latter option can be seen as to

create more complexity. As Farrimond (2012) explains, "the question...is not: 'do men visit the

doctor?', but 'in what ways do men visit the doctors (or not), for which illnesses and through

which pathways?'" (p.210).

### *Signs of Distress and Symptoms*

Signs of distress, for the purposes of this paper, include both physical and psychological

dimensions. Hoy (2012) incorporate the term psychological distress in their study, as it was

found to encompass a broad spectrum that captured negative affective states, such as anxiety and

depression, while not necessarily implying a disease state. Saint Arnault (2009) suggests that

physical sensations or emotions can be labeled 'symptoms' when "... they are interpreted as a

sign of an abnormal state, a disturbance, a pathology, or an illness" (p.263). Wenger (2011)

points to the contextual significance of these decisions, as he reflects on how one's given,

"...situation, presentation, socialization, experience, and knowledge" (p.492) forms the basis of

interpretations for signs and symptoms.

### *Culture*

Culture is recognized here as a system-level, multidimensional construct that details the social processes of values and beliefs, rules concerning social behavior, and social practice (Saint Arnault, 2009). Saint Arnault (2009) asserts that all aspects of health and illness are shaped by culture, "...including the perception of it, the explanations for it, and the behavioral options to promote health or relieve suffering. (p.260). Along these lines, 'idioms of distress' is the term medical anthropologists have used to describe the culturally specific experience of psychosocial and physical suffering (Saint Arnault, 2009).

Cultural ideology is what qualifies as the beliefs and values held by a people about what is considered as good, right, and normal (Saint Arnault, 2009). This represents itself in the medical and mental-health field as the available symbols, meanings, and values associated with the ideology of a culture concerning what is important, and what behaviors are right and correct (Saint Arnault, 2009).

The political/economic dimension of culture comprises how those in positions of power define proper social conduct, as well as towards the means of regulation for public behavior (Saint Arnault, 2009). The practice dimension of culture is a combination of both power and ideals, which can be found in traditional behaviors, spatial organization, and interpersonal behaviors (Saint Arnault, 2009). Practice is essentially the embodiment of 'tradition', and while people may have access to several cultural models that guide their perception, thinking, emotions, and behavior, unconscious and conscious processes are operating which reinforce and maintain similar coherent cognitive maps within small groups, families, and reference groups (Saint Arnault, 2009).

## Significance of the Study

The study of help-seeking is essential, as indicated by Rickwood and Thomas (2012), because the majority of people experiencing mental health problems are not accessing professional services, and we need to know why. Studies have indicated that 26% of adults will have had a mental health disorder in their lifetime, however only a small percentage of that population, ranging from 11-30%, will have gone to seek psychological treatment for their issues in a given year (Vogel et al, 2011). It seems that for some men, seeking help is even associated with a loss of personal identity, being sought out through desperation as a last resort (Fogarty, Proudfoot, Whittle, Player, Christensen, 2015).

Mental health help-seeking has been seen as an important outlet for men in resolving issues that have had an impact on their personal and work-related relationships (Harding & Fox, 2015). Terry Real, an internationally recognized family therapist, speaker, and author, has been ardent in expressing how traditional gender roles are hurting both sexes, but particularly toxic for men, referencing a recent World Health Organization (WHO) statement, "...implicating traditional masculine values as inimical to good health." (Real, Sept/Oct 2017, p.2).

There have been many gender studies situated around work which have recognized the oppression of men as workers, and how their attempts to make work meaningful often entails ideas and practices that are oppressive to women (New, 2001). What sociologists of gender have not given much thought towards is the possibility that men are oppressed on the same level as women with respect to gender relations (New, 2001). Now, this viewpoint could be taken alongside a more recent anti-feminist backlash--who deny that women are being oppressed, seeing women (especially feminists) as the oppressors of men (New, 2001)--but that is not the intention of the author for the purposes of this paper. More so, these inferences are being made

consistent with New's (2001) assertion that, "the very practices which construct men's capacity

to oppress women and interest in doing so, work by systematically harming men" (p.730).

Men's issues are gaining more visibility in the popular media, with newspaper and

magazine articles covering topics such as the the decreasing number of men in the workforce, or

the decreasing percentage of males graduating from high school and college (Addis & Cohane,

2005). We can also see the social construction of gender being played at the macro levels of

social organization. Competitiveness, physical prowess, and insensitivity to pain are ideals

forwarded by advertising and media coverage in professional sports that play off of the

construction of particular meanings of masculinity (Addis & Cohane, 2005).

Research around men's ambivalence in seeking help for mental and physical health is

nothing new. The first study done on this topic was by Fischer and Turner (1970) over 40 years

ago, and yet men's help-seeking behaviors have remained the same (Harding & Fox, 2015).

What also seems consistent is the prevalence of practitioners noting the inevitable challenges that

come about when working with men, with therapists wondering,

> *"How can I be effective with men when it seems many are reluctant to be in therapy,*
>
> *uncomfortable with the process of disclosure, and quick to avoid emotional*
>
> *exploration?" (Mahalik, Good, & Englar-Carlson, 2003, p.123)*

Such being the case, the growing number of men experiencing psychological concerns

but not seeking therapy represents a mandate for counselors to better understand the help-seeking

process. It is with this increased understanding that more relatable and viable interventions be

made that encourage men's help-seeking behavior (Vogel et al, 2011). The media can also be a

means of reframing the negative norm of help-seeking by emphasizing mental health promotion

(Harding & Fox, 2015).

Taking on these topics and examining their distinctions from a social constructionist perspective can be enlightening, with Conrad and Barker (2010) attesting that doing so can, "...bring into sharp relief the cultural landscape that ordinarily eludes us (p.S69). As anthropologist Ralph Linton (1936) put it, "The last thing fish would notice is water" (as cited in Conrad & Barker, 2010, p.S69). By providing space for variability among men and within one man's experience, research can resist essentializing assumptions that correlate masculinity with attributions of deficiency (Wenger, 2011).

## Structure of the Thesis

The next chapter of the thesis will be a review of the literature focusing on the processes involved in identity development and gender role formation for men, and how these elements influence help-seeking behavior. I believe that it is critical when addressing a problem to expand the lens to the environment and history surrounding the problem so as to ascertain, from a systemic approach, the multiple factors that could be contributing to this development. This would include attending to male's socialization process and internalized masculine ideals as being a byproduct of their interaction with others; their consequent degrees of identification with the traditional/hegemonic masculinity; and how this may be negatively impacting men in developing characteristics and practices associated with help-seeking. I also felt it was important to explore literature that reveals how men are navigating help-seeking in ways that are congruent with their conditioned value-system. Chapter three will cover the research methodology being used, which is qualitative and based on a social constructionist approach. Chapter four will discuss the results of the research, and Chapter five will offer further reflection and possible resources for counsellors when working with men in the ensuing discussion.

# Chapter 2: Literature Review

This section of the thesis entails the necessary researching component of previous studies concerning the topics of this paper. The information provided from this investigation has been grouped together into categories (from #1-5), with subcategories being given to each.

The organization of the material uncovered, for the purposes of this literature review, became one of first gathering a popular theoretical framework for how gender formation is enacted for males, and its corresponding concepts of masculinity that stem from that process. This is categorized as 1) Socialization Process and Masculine Ideals, and includes: social learning theory, forced autonomy and independence-seeking, emotional repression and stoicism, and finally, estrangement from body.

The following inquiry centralized on what constituted as an overarching, or dominant, conception of 'traditional masculinity' and its impact on men's identity and behavior. This is categorized as, 2) Traditional Masculinity and its Effect On Men, and includes: traditional/hegemonic masculinity, gender role conflict, men being oppressed, and fear of vulnerability.

Having gained more knowledge around some of the main concepts of gender-formation and identity, attention gets directed towards how masculinity can be construed as a site for reproduction through interpersonal interaction, as well as the resulting impact this has on males' interpretation of symptoms relating to help-seeking behavior. This is categorized as, 3) The Construction of Masculinity and Resulting Practices in Help-Seeking, and includes: masculinity as a construction, presentations of manliness, needing validation/policing masculinity, stigmatizing labels, and legitimizing symptoms.

Once this information is collected, a more concentrated effort is placed on help-seeking behaviors for males identifying with traditional masculine ideals, such as its barriers, enablers, important roles, and exception-cases. This is categorized as, 4) Barriers, Enablers, Important Roles, and Exceptions in Help-Seeking, and includes: (Barriers) public/self stigma, limited knowledge of counselling, (Enablers) reciprocation, social group normativity, (Important Roles) role of significant others, role of physicians, role of self/self-awareness, (Exceptions) disease, aging/disability, minority background, and ultra-masculine jobs.

The final portion of research constituted bringing to light a number of ways in which men have gravitated towards help-seeking behaviors in the past. This is categorized as, 5) Known Preferences for Men in Help-Seeking, and includes: typical preferences for help-seeking, typical preferences for counselling, and alternative means of help-seeking.

**1) Socialization Process and Masculine Ideals**

**Social Learning Theory**

In order to comprehend the nature of something, it is helpful to examine the conditions from which its development may have been influenced by. Which is exactly what social learning theory attends to. Shepard (2004) describes the theory as proposing that boys learn through modeling, observing, and imitating behaviors from their peers and their fathers, which becomes later internalized as one of their core sense of self. These representations of prescribed behavior could be what Addis and Cohane (2005) label as roles, which is a sociological construct assigned by social learning approaches that form particular social positions.

Pertinent physical or emotional sensations, as well as related aspects of the social environment, are encouraged in individuals in early infancy as a result of the processes of enculturation (Saint Arnault, 2009). In essence, Saint Arnault (2009) asserts that, "The cultural

model 'tells' the person to attend to certain aspects of his or her experience, what to ignore, what

things mean, and what should be done about them (p.263).

A familiar product of this early development conditioning can be characterized by

Pollack's 'Boy Code', which included, 1) The Sturdy Oak -- be stoic, don't show weakness; 2)

Give'em Hell -- maintain a false sense of extreme daring and bravado, 3) The Big Wheel --

achieve status and dominance; and 4) No Sissy Stuff -- don't express tender feelings such as

dependence, warmth and empathy (Shepard, 2004). The idea behind this is that boys learn to

conform to a male code of behavior through continued reprimand, embarrassment, and

humiliation when their behavior errs from masculine role norms (Shepard, 2004).

de Boisem and Hearn (2017) attest that research linking gendered emotional differences

to socialization has been important, as it has challenged the weak evidence that assigned the

observed emotional differences between men and women as determined by an evolutionary

process governed by biology. Cross-national comparative studies demonstrated that gender

affects emotional displays, and can differ from country to country, and at different points in time

(de Boisem & Hearn, 2017). This is significant, as it, "...suggests that displays of emotionality

and unemotionality are conditioned by cultural factors which can be contested (de Boisem,

Hearn, 2017, p.782).

An interesting take on the gendered approach to behavior and identity development is the

idea of the 'great divide', which esteemed family therapist Olga Silverstein (author of *The*

*Courage to Raise Good Men*) refers to in her concept of 'the halving process'. The idea behind

this process is that it is as if we were to amass all the qualities of one whole human being, draw a

line down the middle, and then declare that all the traits on the right side of the line are

considered masculine, while all those on the left are feminine (Real, Sept/Oct 2007). Suddenly,

everyone is expected to know where each trait belongs to--ie. being logical and competent is found on the right, while being nurturing, dependent, and emotional can be found on the left (Real, Sept/Oct 2017).

The goals from a social learning approach are to find interventions that help boys and men to shield and alleviate the harmful effects accumulated by masculine role socialization.

**Forced Autonomy and Independence-Seeking**

Masculinity is an ideology that has taken on the status of gender identity. Mejia (2005) describes this process as examples of trauma, where men are being forced to internalize the ideology until they experience it as an intrinsic part of their sense of self.

What could be a contributing factor towards this process is a suggestion made by theorist Nancy Chodrow (1978) that mothers (or the infant's primary caregiver) are being pressured, both by social forces and unconsciously, to push their sons out of a state of relational bonding prematurely (as cited in Shepard, 2004). On some level, these caregivers received the message that it is not good parenting to allow their sons to remain in the same state of emotional attachment and dependency as girls, thereby initiating the journey towards becoming autonomous males (Shepard, 2004). It is this concept of lost closeness for boys that researchers in male development have argued as being felt as a traumatic experience of abandonment (Shepard, 2004).

Independence is concomitantly forwarded, with boys being told that "big boys don't cry" and that he shouldn't be "a mama's boy". If not said directly, these messages get expressed through subtle ways in how boys are treated, and thereby incorporated into how boys come to think of themselves (Mejia, 2005). Boys receive encouragement when successfully

demonstrating their independence by hearing statements such as, "What a big boy you are",

invoking pride in the child (Shepard, 2004).

Over time, this early conditioning leads boys to become so proficient that they can

learn how to disavow their most basic psychological need--to depend on another person for love,

support, and nurturance (Shepard, 2004). This becomes problematic when the desire for hyper-

independence disrupts men's abilities in seeking assistance from others for fear of 'attaching',

which includes partners, health-care professionals, or when severely ill or injured (Mahalik,

Good, & Englar-Carlson, 2003). This is especially concerning as research has found that men's

conformity to self-reliance norms has been related to greater levels of psychological distress

(including greater depression, anxiety, irritability, intrusive thoughts, and social discomfort)

(Mahalik et al, 2003).

Another attributed effect of the mother-child separation process is that the boy

psychologically deals with the loss by asserting his 'difference'--ie. his maleness--with

comparing himself to other boys (Shepard, 2004). As time progresses, these early socialization

experiences evolve to become internalized as a generalized fear of femininity. Considering that

qualities associated with femininity are a part of being human, boys are taught to fear their own

inner experiences (Shepard, 2004). How this presents itself is with the boy developing an internal

critical voice which condemns him whenever he feels weak and dependent (Shepard, 2004). de

Boisem and Hearn (2017) also contribute towards this by stating that personal experiences of

'emotional distance' with fathers and male siblings can also be seen to directly impact the

development of critical, academic work on men and masculinities (de Boisem & Hearn, 2017).

**Emotional Repression and Stoicism**

Attached to the "boys don't cry" mentality is the idea of emotional repression, where boys learn rather quickly from the explicit and implicit messaging that others will not respond positively to their advances for help (Vogel et al, 2011). What becomes interesting is that earlier research (Pollack, 1998) had found that boys, at birth and several months afterwards, were seen to be in fact actually more emotionally expressive than female babies. Yet by age 5 or 6 years of age, boys become decidedly less likely than girls in expressing hurt or distress to their teachers or parents (as cited in Mejia, 2005). This would support theories that suggest the interrelationship between emotions and the discourses brought about by social structures, intimating the growing need to improve men's emotional competency towards fostering greater gender equality (de Boisem & Hearn, 2017).

Peace (2012) has argued the challenges that come about with a one-pointed focus by suggesting that men simply repress emotions as opposed to exploring the ways in which men interpret and understand them, and how these links connect to social structure (as cited in de Boisem & Hearn, 2017). Among the things to be addressed would be how adherence to 'ideals' of masculinity are impacting men's ability to express emotions because they imply irrationality, dependence, and weakness (de Boisem & Hearn, 2017).

In Western societies, boys are systematically barred in their access to affectionate physical contact, with contact with other boys being considered sexualized or forbidden (New, 2001). They are also discouraged from expression of grief, and to ignore physical and emotional pain (New, 2001). These suppression-inducing practices has led to what Levant (1998) termed as 'alexythymia', which is considered to be a problem whereby people are unable to identify and describe emotions--consequently, this can show up frequently as a result of masculine

socialization (as cited in Mahalik et al, 2003). And while there has not been a consistent sex-based pattern found for alexithymia, connections have been made towards men's restricted emotionality and greater levels of alexithymia, as well as to increased paranoia and psychoticism, higher levels of depression and fears of intimacy, and greater hostile-submissive personality styles (Mahalik et al, 2003).

**Estrangement from Body**

As Peace (2012) sumizes, emotions are what connects the psyche and subjectivity of the individual to the wider social order; it is through our emotions, created in relation with others, that gives meaning and understanding to our actions (as cited in de Boisem, Hearn, 2017). Given these circumstances around emotional alienation, it seems evident that men need to be better 'attuned' to their bodies in order to effectively express and communicate their 'inner' lives (de Boisem, Hearn, 2017).

O'brien, Hunt, & Hart (2005) had found evidence to support this, with male participants blaming their hesitation to consult a physician being based on a lack of knowledge about the workings of their body. Discussions in the group led to the idea that the scrutiny of one's body was encouraged by a 'feminine' culture, and that as a result women were more adept at recognizing the subtle signs of change in their bodies that ordinarily eluded men (O'brien, Hunt, & Hart, 2005). One of the participants believed that men were in fact actively deterred from taking an interest in their bodies for fear of appearing feminine to his peers, and that the rights of passage into manhood did not require the same amount of vigilance around body awareness compared to women (O'brien et al, 2005).

**2) Traditional Masculinity and its Effect on Men**

   **Traditional/Hegemonic Masculinity**

   The concept of gendered power-constructs has been around for awhile now, with

renowned psychologist Alfred Adler, in his theory of Individual Psychology, coining the term

'masculine protest' as the, "...will to power or a domination of others." (Feist, Fest, & Roberts,

2013, p.74). Imbued in this characterization was his belief that it was cultural and social

practices, *not* anatomy, that influenced many men and women to magnify the importance of

being manly (Feist et al, 2013).

   Mejia (2005) describes a leading assumption supporting the social definition of

masculinity as being that, "...Men are synonymous with masculinity, and masculinity is

somehow an intrinsic property of maleness (p.31). 'Hegemonic masculinity' is a term used to

define the dominant, or traditional, form of masculinity which is considered acceptable within a

patriarchal culture--ie. what it means to be a 'real' man (Farrimond, 2012). And while there may

be different conceptions of what is considered 'traditionally masculine', depending on the social

and cultural contexts, it is argued that all men living within the United States (and thereby North

America) must fall in-line with the dominant culture's notion of masculinity (Vogel et al, 2011).

   Within this model, men are supposed to be naturally strong, resistant to disease, visibly

unaffected by pain and physical distress, and unconcerned with minor symptoms (Hoy, 2012).

Other ideals and practices encoded in this archetype is that men be competitive, aggressive,

emotionally contained, self-reliant, and heterosexual, and acting as the material providers for the

family (Farrimond, 2012). Those who do not fall under or embody the ideals of hegemonic

masculinity, such as those in the 'marginalized' or stigmatized groups (ie. ethnic minorities,

working-class, or homosexuals) are discriminated against, including women (Farrimond, 2012).

Connell (1995) and Seidler (2007) suggest that these white, heterosexual, middle-class, able-bodied men (WHAMs') assert their privileges through adherence to forms of rationality based on a the continued control of emotions, linking this emotional control to a Cartesian separation between mind--which is responsible for 'rational' action-- and body--which is responsible for 'irrational' action (as cited in de Boisem, Hearn, 2017).

Oliffe, Kelly, Bottorff, Johnson and Wong (2017) bring awareness to a subset of masculinities which include both complicit and subordinate manifestations. Complicit masculinity sustains hegemony by reinforcing traditional Western social practices that place men as family providers, stoic and independent, while subordinate forms of masculinity entail practices associated with femininities: ie. domesticity, weakness, and lack of agency (Oliffe et al, 2017).

**Gender Role Conflict**

There are psychological costs to the socialization process, with O'Neil, Good, & Holmes (1995) developing the concept of gender-role conflict which can come about due to restrictive traditional masculine ideologies and norms (as cited in Addis & Cohane, 2005).

Confusion arises from contradictory messages men receive as early as childhood and later as adults on what qualifies as positive masculine behaviors (Shepard, 2004). On one hand, culture still encourages the traditional definitions of male gender role (ie.being the sole breadwinner, on achievement, on having power over others, stoicism, etc), yet they are also being faced with increasing pressures to commit to relationships, to express vulnerable feelings and desire deeper levels of intimacy, to nurture children, and to prohibit aggressive and violent impulses (Shepard, 2004).

This places traditional masculine norms imposed by the dominant western culture in direct conflict with ideologies necessary for help-seeking behavior (Vogel et al, 2011). Mahalik et al (2003) were able to demonstrate, through their Conformity to Masculine Inventory (CMNI), a significant negative relation between high scores on the inventory and attitudes towards psychological help-seeking (as cited in Farrimond, 2012).

How these contradictory messages concerning help-seeking behavior have shown up in men's lives can be found in Smith, Wittert, and Warin's (2007) study, where a participant had suggested that his wife initially attributed his delayed help seeking as stubbornness, but then simultaneously defended his behaviors by declaring that he likes to act independently. New (2001) picks up on a disturbing discrepancy where males are told that their gender requires them to be responsible, while also being told that men are bad and dangerously irresponsible, and somehow this is admirable. Their irresponsible behavior is generally being allowed or colluded with, but may also find themselves being punished, oftentimes severely, depending on the circumstance (New, 2001).

**Being Oppressed**

Related to punishment is the condition of shame, which is what enables society to traumatically push the agenda of the ideology of masculinity (Mejia, 2005), and oppressing men as a result. This may seem like a bold, or perhaps exaggerated, statement. But if we were to take from New's (2001) concept of 'systematically mistreatment' that, "...implies that as a result of institutionalized social practices, Xs' human needs are not met, they are made to suffer, or their flourishing is not permitted, relative to other groups and to available knowledge and resources" (p.731), then we may be able to make a connection towards male's socialization process as having a dampening effect on men's ability to flourish.

This systematic mistreatment that New (2001) describes goes beyond the concept of material inequalities, and includes the deprivation of 'recognition' and other means of inclusion necessary for groups and communities to thrive. Attending to those who doubt or contend the notion of male's experience of oppression, New (2001) makes a comment that could also be applicable in men's case, stating,

> *It is wrong to undermine a person with the claim that she does not know what she wants or feels, or that what she wants or feels is inappropriate; and you cannot know what is wanted or felt and cannot discover oppression unless you listen to people (p.730).*

Mejia (2005) believes that the most traumatizing and dangerous idea burdening boys and men is the 'literal gender straitjacket' which bars boys from expressing feelings or impulses that are conceived to be 'feminine'. This restriction is enacted by the cultural structures of masculinity that harness the development of these potentials in men, frequently leading to defensive emotional strategies, a diminished capacity for empathy, and discomfort with intimacy (New, 2001).

To complicate matters further, boys and men are conditioned to avoid shame at all costs and to wear a mask of coolness, acting as if everything is alright and under control--even if it's not (Mejia, 2005). Developments such as this could be seen as examples of mistreatment, however because this constriction prepares men to stifle their emotions in the workplace, it is more often regarded as an aspect of men's privilege (New, 2001). In the end, long-term shaming only results in powerful emotional injury in the shamed, as well as the potential in cultivating rage and violence as defensive behaviors (Mejia, 2005).

**Fear of Vulnerability**

Shepard (2004) asserts that men pay a price for lost opportunities of being vulnerable; of saying "I love you" when desiring connection, or giving themselves permission to shed tears when their souls are wounded. Courtenay and Keeling (2000) would agree, suggesting that it is rare for men in most cultures to seek out and claim the identity and territory of the 'at-risk, not-so powerful' man which has been revealed by most men's health journals. It seems that men are consistently finding themselves at a cross-roads between yearning for intimate connections with others while being bound by the constricting rules of masculine behavior (Shepard, 2004).

Early boyhood and adolescent socialization experiences regarding appropriate male behavior instill an unconscious belief for boys and men that intimacy is a fundamental liability, and is dangerous (Shepard, 2004). Instances in which boys were cruelly teased if they showed 'weakness' by crying has resulted in viewing help-seeking behaviors as undesirable and to be avoided (Vogel et al, 2011).

These pressures lead boys feeling like they need to disconnect from their vulnerable, connection-needing, tender parts in order to survive; what they are effectively doing is disconnecting from themselves (Shepard, 2004). By reactively asserting their difference, the masculine is held as superior to the feminine--ie. not being a girl, woman, or sissy--generating subsequent judgments around vulnerability as a sign of weakness and source of embarrassment (Real, Sept/Oct 2017).

Boys generally learn to suppress the degree to which they allow themselves to care for and connect with others, leading later in life to sex that is nonrelational and experienced primarily as lust without any intimacy or emotional attachment (Mahalik et al, 2003). Due to their acquired fear of anything feminine or homosexual, as a result of their traditional masculine

conditioning, many men will find any intimate connection with other men as something to be avoided and held with disdain toward others (Mahalik et al, 2003).

3) The Construction of Masculinity and Resulting Practices in Help-Seeking

**Masculinity as a Construction**

Emergent in recent literature is the questioning of the once uncontested belief of masculinity as being a fixed, universal identity into something that is much less tangible. An example of this can be found in Kimmel's (1994) paper, in which he states:

*Manhood is not the manifestation of an inner essence; it is socially constructed. Manhood does not bubble up to consciousness from our biological makeup; it is created in culture. Manhood means different things at different times to different people. We come to know what it means to be a man in our culture by setting our definitions in opposition to a set of 'others'—racial minorities, sexual minorities, and above all, women (p.120).*

This quote attends to what O'brien et al (2005) describe masculinity as being a constantly changing collection of meanings that men construct--through their relationships with themselves, with each other, and with the world--that is neither static nor timeless, but is historical. Gender through the lens of social constructionist theories is not seen as a trait, but as a process that happens through interactions with the outside world; it is not a thing that one has (ie.gender role), but rather, it is a set of activities one does (Hoy, 2012).

Similar to sex role theory, the masculinities paradigm finds itself with one foot in structure and the other in agency, with the idea that masculinities both construct male selves and are constructed by them (New, 2001). It is through this process that Kimmel and Messner (1998) have suggested, "We may be born males or females, but we become men and women in a

cultural context" (p.xvi) (as cited in Addis & Cohane, 2005). As a result of a prescribed code of behaviors and attitudes, boys' and men's psychological functioning changes in the most fundamental ways of being with other people. It is for this reason that researchers insist that 'being male' is connoted by social constructs in our culture and society (Mejia, 2005).

Mejia (2005) describes how shared 'realities' become truths as they are passed down from generation to generation in families, cultures, and societies, giving gender meanings and set gendered behaviors as fitting into a particular historical time frame. Our contemporary understandings of masculinity has evolved in its construction over thousands of generations, capitalizing on minor differences between human males and females. These differences can only be recognized if one places all men as a group and all women as a group (Mejia, 2005). An example of this mass-scale categorization is related to how men have been described as having a higher tendency towards aggressive action, based, in part, on a biological characteristic that males tend to have a larger muscle mass than women (Mejia, 2005).

Regarding masculinity as a construction can be illuminating, as it rejects simplifying notions of gender and masculinity that tend to focus on the dangers of hegemonic masculinity (Hoy, 2012). Instead, a general assumption that Addis & Cohane (2005) recognize in social constructionist frameworks is, "...that there is not a singular masculinity but rather multiple competing masculinities that are continuously being constructed and contested." (p.640).

**Presentations of 'Manliness' - 'Manning Up' by Numbing Out /Strong and Silent**

Masculinity, as an ideology, has always had its primary function as being to challenge particular aspects of human biology and to suppress them. This is expressed in individuals by training them to ignore their instincts to run in fear or to cry in grief and pain (Mejia, 2005). It is no wonder then that a stereotype has emerged around men and illness where 'men in general' are

not visiting the doctor, with a participant from Farrimond's (2012) study describing this phenomenon as taking on an image of the 'Neanderthal Man' or as a 'hangover from cave-men times'.

Closely tied-in to the strong-and-silent masculine gender role script are the idealized notions around being a 'tough guy' (Mahalik et al, 2003). Courtneay (2000) had made direct connections between denial of weakness and rejecting help as central practices of masculinity and help-seeking behavior, arguing that the 'most powerful men among men' are those who show complete disregard towards their health and safety. Men are essentially constructing their gender through their dismissal of their health care needs. As Courtenay (2000) states, "W*hen a man brags, 'I haven't been to a doctor in years', he is simultaneously describing a health practice and situating himself in a masculine arena"* (p.1389).

These presentations of masculinity situate themselves in unhealthy practices, with their underlying ideological function being that by taking risks and dismissing their health, men are legitimizing themselves as the 'stronger' sex (Courtenay, 2000). While there were some participants in O'brien et al's (2005) study who expressed a willingness to see a doctor under the condition that something was 'really wrong', the majority of participants aligned with avoidant help-seeking behavior and toughening out 'minor' symptoms.

Reasons behind this ambivalent attitude were that they didn't want to waste the doctor's time or to be viewed as making a 'fuss about nothing', holding the perception that paying attention to 'minor' symptoms was a show of weakness (O'brien et al, 2005). This trivialization of symptoms seems most apparent in younger men, where a credo towards pain management is that men 'should be able to push things further' before taking action (O'brien et al, 2005).

This ethos of enduring pain goes beyond the physical, with some men feeling similar pressures to practice masculinity through exhibiting their ability to handle emotional difficulties without complaint (O'brien et al, 2005). This stoicism in the face of possible turmoil could be helpful to consider with regards to addressing conceptions around relationships and commitment. Driscoll (July-Sept 2005) addresses a common belief that women are perceived to be more committed when it comes to relationships, as they will talk to others when a relationship fails and be able to show how upset they are about it, whereas men usually suffer in silence, and go unnoticed.

**Policing Masculinity -- Needing Validation**

With regards to what is visible or not for men comes down to what Wenger (2011) believes as a nuanced management of acts, depending on the situation, all for the purposes of making their gender accountable to others present. A man might abide by a number of gender norms, challenge them, or by-pass them, but he does so knowing that others are judging his actions on whether they are fitting for a man (Wenger, 2011).

When a man is facing a problem, concerns surface around how other men might be talking about it, fearing being exposed as 'weak', with the underlying notion that these men have the power to define and police his masculinity (O'brien et al, 2005). Mounting anxiety rises around the anticipated judgments of these appointed arbiters, fearing that exposure to one's vulnerable side would result in being made fun of or ostracised by the group (Hoy, 2012).

Because of these pressures, some men may feel that they need something 'concrete' or 'easy to see and to point to' before they pursue consulting a health professional (O'brien et al, 2005), which creates massive complications when it comes to discussing mental and emotional pain. This tends to be where the wife or girlfriend's role as caregiver-initiator steps in, by

suggesting that they go seek professional help for their symptoms. It is as if these men need somebody else to confirm that there is something wrong and that it would be prudent to go see a doctor for (O'brien et al, 2005).

With these preconceived notions of 'normal' male help-seeking behavior, Seymour-Smith and colleagues (2002) have suggested that, "what health care professionals might see as most problematic for male patients is not 'behaving like a typical man' [ie.constructing themselves as reluctant to consult] but behaving 'like a woman'" (p.264).

**Stigmatizing Labels**

Men's willingness to seek help may also be influenced by other contextual factors, such as the use of mental health labels (Berger et al, 2013). As Saint Arnault (2009) attends to, as soon as wellness signs or distress symptoms are experienced and labeled, people take into account the meanings of their observation based on what the cultural model 'tells' them the origins of their signs or symptoms. People also reflect on the implications of what this means about them as a person, based on the values of the culture and how this affects their position in the group (Saint Arnault, 2009).

Labels such as 'anxiety' and 'depression' are commonly used by mental health professionals, resulting in the inhibition of some men from seeking help for fear of receiving a stigmatized diagnosis (Berger et al, 2013). Anxiety may be experienced by men as threatening, as it confronts the masculine image of invulnerability and strength (Berger et al, 2013), whereas taking antidepressants can have the negative connotation of failure to uphold one's independence and ability to cope with stress by needing support (O'brien et al, 2005; Addis & Cohane, 2005).

When compared with each other, anxiety was found to have a higher acceptance level, with higher forms of reluctance to self-report symptoms of depression when the symptoms are

credited to causes beyond one's control (ie. biological factors and external life events) (Berger et al, 2013). O'brien et al (2005) believe that the most vulnerable men in their study were those who diminish their suffering by describing it as 'stress' as opposed to taking on the 'unmanly' diagnosis of depression. It seemed that they were very aware of the unwelcome scrutiny bestowed upon their male identities if they were to concede by taking on the title (O'brien et al, 2005). Hoy (2012) also talks about men's fear of being called 'crazy', with heavy feelings of embarrassment that would come from their families and communities if they were to be given the diagnosis of depression.

These amassing concerns has led to cases where men were experiencing serious, long-term challenges with mental health which they strove to conceal, aiding to the relative invisibility of men's mental health problems (O'brien et al, 2005). Chuick et al (2009) mention how these adverse health problems become cyclical, in an escalating pattern, as men continue in attempting to hide their symptoms of depression.

A number of studies found that men view the experiences of distress and depression as 'facts of life', being natural reactions to life's stressors, which can be quite confronting when suddenly being told their experiences are signs of illness (Hoy, 2012). Other men accounted their absenteeism from professional support as a result of not knowing what 'depression' was, being unable to identify their experiences as opposed to coming from a position of resistance (Hoy, 2012).

**Legitimizing Symptoms**

Men who were more forthcoming in talking about their problems did so by presenting their experiences in more acceptably masculine terms. A frequent occurrence was using 'stress' to refer to their depression, with references to visiting their doctor for 'work related stress'

(O'brien et al, 2005). Stress has been described as a 'mental/macho thing' that men implicitly

subscribe to, yet will not readily admit (O'brien et al, 2005). That being said, some men still

regard the inability to cope alone with stress as being a sign of weakness, and therefore a direct

challenge to one's masculinity (O'brien et al, 2005).

Another correlation that has been made in previous research is the author's attention

towards men's somatic complaints and anger/aggression. It is believed that high numbers of men

presenting with somatic complaints may be a reason why their depression is more likely to be

overlooked by health professionals (Hoy, 2012). It could be that the gravitation towards these

atypical symptoms is an [unconscious] act of resistance towards the traditional symptoms that

are considered to be unmanly or noncompatible to their internalized idea of how a man should

deal with a depressed mood (Chuick et al, 2009)

## 4) Barriers, Enablers, Important Roles, and Exceptions in Help-Seeking

### Barriers to Help Seeking

Attitudes towards help-seeking have been noted to be less positive when men are

endorsing 'dominant masculine norms' (Harding & Fox, 2015), and it can be helpful at this time

to address a number of the more general factors that may act as barriers to this process. Included

in this would be a pervading sense of public/self stigma that is associated around help-seeking

behavior (for men in particular), as well as men exhibiting a limited knowledge of counselling in

general.

### *Public/Self Stigma*

Something that Vogel et al (2011) have identified in their study as an attitudinal barrier

to help seeking for counselling services is stigma. How this initially takes shape is through public

stigma, characterized as "the negative views society holds toward those who seek professional help" (p.369), which eventually becomes internalized as self-stigma (Vogel et al, 2011).

This internalization of negative views, engendered by society, leads to the belief that one is 'inferior' or 'weak' for requiring mental health support (Vogel et al, 2011). Vogel et al (2011) assert that self-stigma should be considered a critical predictor of help seeking for men living in American society, as the dominant gender role expectations for men consist of being able to problem-solve on one's own, being independent, and in control of one's emotions. Therefore, therapy may be regarded as a threat to a man's sense of masculinity (Vogel et al, 2011).

What is important to consider is that, due to the social and cultural contexts that base its origins, stigma has varying roles on the help-seeking process across cultural groups. For many, the greatest impact negatively influencing men not to seek outside assistance can be coming from those closest to them as a direct result of in-group beliefs and values that stigmatize the counselling experience (Harding & Fox, 2015).

This seems to be the case especially for minority individuals, with them holding a less positive light on mental health services than European Americans (Vogel et al, 2011). Individuals from cultural groups that promote more collective orientations may also face greater self-stigma, as their values of interdependence, social harmony, and saving face for one's family can serve as increasing pressures and friction around seeking help. The risk of bringing shame becomes magnified to not only themselves but towards the whole family (Vogel et al, 2011), as the experience of mental illness in an individual can imply a lack of a supportive network from his family, as well as an inability to adequately perform social roles, or improper relations with family or ancestors (Saint Arnault, 2009).

Another factor regarding barriers to help seeking is the notion that biological rationales for mental health disorders may increase levels of stigma (Berger et al, 2013). It has been recommended that future research be invested in examining if the stigma model changes depending on the presenting issue(s)--ie. Are men experiencing higher stigma for some emotional issues, such as anxiety or depression, as opposed to other issues, such as career indecision (Vogel et al, 2011). An example of this might be in O'brien et al's (2005) study, where they found participants with heart disease being able to change their perspective on consulting, attributing this development to a common perception that heart disease is considered a 'man's' disease. The authors had wondered if this change would have happened if these men had less 'macho' illnesses, such as depression (O'brien et al, 2005).

### *Limited Knowledge of Counselling*

There seems to be a general gap in understanding for men when it comes to what goes on in the therapy room, acting as a barrier for professional help-seeking. Harding and Fox (2015) found their male participants reluctant to make counselling appointments, believing that their treatment options would include Freudian couches and personality altering drugs. Even when there was some knowledge towards psychological subjects, some men were still concerned about going into 'the unknown' when it came to what a therapy looked like and how therapy would proceed (Harding & Fox, 2015).

This uncertainty around what exactly goes on in sessions and the role of the therapist could contribute as to why many men hold counsellors in such low regard and delaying in seeking assistance (Harding & Fox, 2015).

**Enablers to Help-Seeking**

What is only beginning to receive more attention by scholars in health and gender studies are factors that promote help-seeking behaviors in men. This section will provide a brief outline of some of the general elements identified as enabling factors, including reciprocation and social group normativity.

*Reciprocation*

Mansfield, Addis, and Mahalik (2003) have reported that a potential enabler for men towards help-seeking is if the men believe they have the opportunity to reciprocate. This stems from the idea that 'paying it forward' and being of assistance to others can essentially repay the debt incurred from their original request.

This could be why men's groups have become so popular, as they offer ample prospects of reciprocation that adhere to societal expectations of masculinity, thereby maintaining one's status as being 'strong and competent' (Harding & Fox, 2015). An example of this would be the Men's Shed movement, which is described as, "providing a sense of belonging, reciprocity, and mateship between men", which lead to a "vital link to health professionals and improved social, physical, and mental outcomes" (Harding & Fox, 2015, p.452).

*Social Group Normativity*

The perception of social group normativity is considered to be important for men in determining their mental health help-seeking decisions (Harding & Fox, 2015). This attitude reveals how interwoven men's health behaviors can be, where a man will act, or not act, depending on their perceptions of other men's behaviors (Harding & Fox, 2015).

Harding & Fox (2015) found that their male participants tended to disclose more of their personal experiences if it was felt to be normalized within their social group. An example of

this would be if other members of their group had similar mental health issues or counselling experiences. That being said, there still were clear boundaries around what was viewed as acceptable within their peer group (Harding & Fox, 2015).

Men would come away from these group counselling experiences with a better understanding of what they were going through, leaving behind some of the long-held misconceptions surrounding their presenting conditions. Having this new information not only positively affected their personal perspective, but also reduced the stigma and judgments they had on others problems (Harding & Fox, 2015).

**Important Roles**

A major contextual factor that contributes toward barriers and enablers in men's help-seeking process is who is suggesting they seek treatment (Berger et al, 2013). This includes the roles of significant others, of physicians, as well as self/self awareness. The following section will be a brief summation concerning the influence and factors associated with these roles and its impact on men's help-seeking behavior.

*Role of Significant Others*

A widely accepted 'common-knowledge' is the notion of significant others as being highly influential in male's decision-process when it comes to mental health matters (Harding & Fox, 2015). Oliffe et al (2017) had identified a number of trends with regards to idealized heterosexual gender relations and health in Western culture, whereby women are considered to be positively influencing health practices of their male partners. This development is believed to occur as a result of these women performing in alignment with their feminine ideals around nurturing and concerns for other's well-being, acting as a compensatory measure for men's masculine general disregard for self-care (Oliffe et al, 2017).

It is suggested that these gendered practices could partly account as to why married men typically live longer than single men, as well as the significantly reduced life expectancy widowed men having following the loss of their partner (Oliffe et al, 2017).

Indeed, for many of the participants in Harding and Fox's (2015) study it was the active role of the significant other that was the impetus for the participants in seeking therapy. For two of the men, the fact that their significant other had already attended counselling created a sense of normalization around the help-seeking process, resulting in their decision to also pursue professional services (Harding & Fox, 2015). While all the men in the study originally had stated that going to counselling was not their choice, they later expressed gratitude for the encouragement, as they benefited from going to couples or individual therapy. Overall, the sentiment was one of relief mixed with regret, conceding that perhaps they shouldn't have been waiting as long as they had before finally agreeing to go (Harding & Fox, 2015).

As Oliffe et al (2017) attend to, the relationship towards the female partner in heterosexual couples can be so important in men's health matters that often men will idealize or romanticize the connections by stating that their partner is the only 'true confidant' they have. The implications for this being that regardless if they are seeing a therapist, it is their partner they go-to first when experiencing mental and physical distress.

### Role of Physicians

Whatever the impetus to seeking assistance may be, it appears that many men will consult with their physician before going to counselling. Having limited knowledge about access to therapists, cost, or referral requirements, the role of the general practitioner (GP) becomes pivotal for men, taking on the characteristics of gate-keeper when it comes to mental health support (Harding & Fox, 2015).

Mens' experiences with GP's have been mixed, with some finding comfort and immediate assistance while others found the initial consultation to be discouraging. Those that viewed the visit as helpful felt they benefited from being provided with references to therapies that are available which could propel them forward in a direction for further inquiry (Harding & Fox, 2015). These experiences would qualify as enabling factors for men in help-seeking behavior for mental health.

Wenger (2011) points out how GP's can also reinforce the dominant masculine ideals by placing all men together into one group, affectionately promoting a version of them as being "hapless and helpless" when it comes to addressing health matters. This position of 'knowing' by GP's has led some male patients to be frustrated, as they felt their concerns were being dismissed. Examples of this would be where physicians would prescribe medication to alleviate physical symptoms without additionally exploring the patient's psychological needs which could be contributing to the patient's presenting distress (Harding & Fox, 2015).

Another way in which physicians can act as barriers to the help-seeking process is if there is a strain in the doctor-patient relationship. This can happen when certain areas of distrust and stigmas harboured by the attending physician get projected onto certain subpopulations of men, such as when these men stand outside of the hegemonic mold. This would include single and gay men, or men who are perceived to be 'more feminine', leading to them being either invisible or regarded as trivial users--not unlike that of women (Wenger, 2011).

### Role of Self/Self-Awareness

What does not get talked about as much is the role of the self, and self-monitoring, that is an essential component in the help-seeking process for men. Smith, Braumack-Mayer, Wittert, & Warin (2008) define self-monitoring as a health-practice that proceeds help-seeking, indicating

the, "...degree of interest in, and reflective thought about, one's health (p.8). Fogarty and

coleagues (2015) describe how self-reflective practices can be used by men as adaptive coping

strategies that are enacted depending on what one is feeling and what actions are perceived to be

necessary. Self-monitoring becomes a preventative strategy for men in ensuring overall health

through noticing warning signs, such as feeling down or depressed, and then doing something

about it (Fogarty et al, 2015).

**Exceptions in Help-Seeking**

A critical area that also needs to be acknowledged in this area of study are the 'exception

times', or outlier variables, for help-seeking behavior in men that go outside the dominant

discourse of societal norms. O'brien et al (2005) describe a mechanism that instigates these

exceptions to men's aversion to consultation as a 'hierarchy of threats' to masculinity. Other men

may have never fit under the traditional category, or had experiences which led them to question

typical masculine ideologies. Included among these is disease, aging/disability, being of a

minority background, and occupying ultra-masculine jobs.

*Disease*

Men who had contracted disease, such as prostate cancer, have detailed their ongoing

experiences as feelings of isolation and 'otherness'; of being disconnected from other men as

well as the man they used to be (O'brien et al, 2005). It could be that these experiences distanced

them from the masculine culture that promoted measuring one's behavior against other men

(O'brien et al, 2005).

The focus of attention for these men became one of active self-monitoring, presiding over

their bodies as a 'watchful waiting' management strategy for their cancer (O'brien et al, 2005).

This strategy encouraged them to educate themselves about what to look out for and to be

vigilant over any noticeable changes (O'brien et al, 2005). While these men recognized that their behaviors may be atypical from stereotypical masculine norms, there was an overall consensus among survivors of life-threatening episodes that the preservation of their future health was more important than preserving their masculinity (O'brien et al, 2005).

Other exception times can be found concerning individuals affected by 'disease' of the mind. Moller and Leimkuhler (2002) discuss a study which reports positive help-seeking behavior in men by finding that men experiencing a psychiatric disorder were more likely to see a mental health specialist than women, who would rather turn to a general physician. Oliffe et al (2017), in their study on heterosexual gender relations and men's depression, found that the idealized masculine and feminine roles had been traded for these couples as a way of adapting to their living situation. The men who were experiencing depression had taken on a more subordinate form of masculinity, due to their diminished abilities to work and uphold the breadwinner responsibilities, providing them varying degrees of freedom to seek help from their partner (Oliffe et al, 2017).

### *Aging/Disability*

Aging is typically associated with the concept of lost independence, with relevant literature focusing on activities of daily living, such as: diet and healthy eating; the capacity to recover from injuries; the capacity to engage in physical activity; and dementia (Smith et al, 2007). Therefore, a definition of successful aging is the capacity to maintain independence, which encompasses a range of achievements that goes beyond simplistic normative assessments of success or failure; the biggest difference being that the reliance on others is not necessarily perceived as 'unsuccessful aging' (Smith et al, 2007).

This is significant regarding exceptions in help-seeking behavior, as it suggests a population of men who would be willing to consult with a physician or counsellor if they deemed it as a worthwhile pursuit in maintaining their activities of daily living in the long-run. An example of this would be where men are willing to go see a health professional over complications with sexual performance. While the experience of disclosure may be highly sensitive in nature, these men would much rather 'risk' their masculine status by discussing their sexual health problems than putting it in further danger by not being able to have sex (O'brien et al, 2005).

### *Minority Backgrounds*

Vogel et al (2011) touch upon another exception to help-seeking with their findings that gay men tend to seek out treatment at higher rates than heterosexual men. The authors concluded that this finding could be attributed to evidence that suggested gay men's conformity to masculine norms--such as avoidance of emotional expression to other men--showed a weaker relationship with both their self-stigma and help-seeking attitudes than heterosexual men (Vogel et al, 2011).

Another minority background that seems more amenable to certain aspects of professional help-seeking are African American men. Vogel et al (2011) mention how their communication styles tend to be more expressive compared to other men, which can lend itself to seeing disclosure of sensitive information to another person, such as a counsellor, as more acceptable behavior.

### *Ultra-Masculine Jobs*

A final outlier variable to be addressed here concerning help-seeking behavior revolves around men who position themselves in 'ultra-masculine' jobs, such as fire-fighters and sporting

athletes. O'brien et al (2005) found that, for firefighters, help-seeking was a way of preserving masculinity, as it safeguarded their place in a stereotypically masculine occupation.

Having high-profile sporting identities openly talk about their battles with mental health was another influential factor for some men's perception of social norms (Harding & Fox, 2015). The consensus among participants of Harding and Fox's (2015) study was that if these elite sportsmen were able to discuss their mental health issues in a public forum, then they could talk about them as well. Considering that western society idolizes the sporting elite as epitomizing masculine ideals, the disclosure of these individuals admitting to anxiety, depression, and dependency assisted in normalizing the help-seeking process for other men.

## 5) Known Preferences for Men in Help-Seeking

Help-seeking is a very broad concept, and it is important to appraise the various contextual factors that may play a part in men's willingness to seek help (Berger et al, 2013). This section will cover a very brief outline of preferences concerning help-seeking behavior, including: typical preferences for help-seeking, typical preferences for counselling, and alternative means of help-seeking. Much more on this will be covered in Chapter 5 on implications and recommendations of the findings.

### Typical Preferences for Help-Seeking

Berger et al (2013) examine a number of outlets in help-seeking for men to determine if there are any means which are preferred over others, and in what order. They based this comparison off of what they deemed to be the major classifications of professional help-seeking, consisting of psychotherapy, medication, or a mixture of both (ie. psychiatry), as well as informal help-seeking, which involves seeking support from family and/or friends (Berger et al, 2013).

What they discovered from feedback from their male participants was that psychotherapy was deemed to have the highest rating of acceptability over medication and other forms of help-seeking, with the friends and family category considered to be in second place (Berger et al, 2013).

The authors believed that men may be responding better to the psychotherapy option because of its emphasis on drawing from one's own independent coping skills, such as developing the ability to change one's thoughts or behaviors, which does not conflict with the traditional masculine norm of self-reliance that men ascribe to (Berger et al, 2013). Medication was found to be the least accepted form of help-seeking, as the category was associated with self-stigma and perceived aberration that comes with being given a mental health diagnosis (Berger et al, 2013).

Overall, men's response to help-seeking was found to be largely ambivalent, with even the most preferred form of help-seeking, counselling, having mixed reactions from ambivalent to weak acceptance (Berger et al, 2013).

### Typical Preferences for Counselling

When men do decide to pursue counselling, it seems that the majority of them prefer therapies that are more directive, focusing on cognitions as opposed to emotions (Berger et al, 2013). Men also seem to appreciate communications with their practitioners that are coming from a place of humour, empathy, frankness, competence, and promptness--all qualities tied into an idealized masculinity image (ie. direct and skilled) which give men the opportunity to create some distance from the emotional intensity of the interaction (Wenger, 2011).

**Alternative Means of Help Seeking**

While a number of the major identifications of help-seeking have already been noted, it can be helpful to address other, less known methods of help-seeking that men are currently using to address physical and mental distress. Smith et al (2007) explored this avenue in their search to understand how Australian men are self-monitoring their health prior to seeking help. Their goal was to uncover ways in which their participants were seeking and disseminating different types of information, from a range of sources, in order to provide them the means to make an informed decision regarding whether or not they should seek assistance (Smith et al, 2008).

Consistent with this would be Harding and Fox's (2015) findings, which uncovered a growing preference for men to use the internet as an alternative way to understand their symptoms. Especially helpful to some were online forums, where participants felt chatting online with other men with similar conditions had a normalizing effect. Having the possibility to share experiences and treatment knowledge with others attends to the reciprocity factor, while also mitigating feelings of isolation (Harding & Fox, 2015). The authors believed that was is attracting these men to internet and online forum options is its qualities of 'anonymity and easy access' of websites for people undergoing mental health distress (Harding & Fox, 2015).

**Chapter 3: Methodology**

This section of the paper will provide the structure and philosophical underpinnings of the chosen methodology, so as to inform the reader on the method of analysis and following discussion from the results. The approach taken to address current concepts of masculinity and its impact on men's help seeking is from a Social Constructionist (SC) framework. Included in this chapter will be: the rationale for using a social constructionist approach; providing a more nuanced description of what social constructionism is; its origins; as well as applications of social constructionism in research.

**Social Constructionist (SC) Approach to Masculinity and Help-Seeking**

**What is Social Constructionism?**

Social constructionism came about as an attempt to understand the nature of reality (Andrews, 2012). Linking itself to the hyperbolic doubt posed by Bacon, SC sets about to question the popular notion that "...observations are an accurate reflection of the world that is being observed." (Andrews, 2012, p.39).

SC thus becomes a conceptual framework that highlights the cultural and historical aspects of phenomena commonly believed to be exclusively natural, whereby the emphasis is placed on how the meanings of phenomena are not inherent in the phenomena themselves, but develop as a result of interaction in a social context (Conrad & Barker, 2010).

SC can be found in both clinical practice and research in psychology. When used in clinical practice, the client's narrative is understood as the outcome of social relationships and the need to be both coherent and intelligible with the expectations and demands of society (Losantos et al, 2016). As Losantos et al (2016) assert, SC "...proposes that psychological reality

is determined by the language and social consensus through which we understand the world"
(p.30).

This consensus, or collaboration, was birthed within the clinical practice of psychology as
a therapeutic stance which situates the client as an 'expert' on their life; the therapist not only
seeks to understand the client's experiences from learning about the client, but is also learning
*from* the client (Losantos et al, 2016). This does not mean that the therapist dismisses their
acquired knowledge about psychological theories. Rather, the therapist will attend to the client
from a position of curiosity, refusing to stay in a place of knowing which restricts modifying
assumptions that lead to new knowledge as the relationship progresses (Losantos et al, 2016).

**Rationale for Using SC Approach**

One of the challenges with the theorization of hegemonic masculinity in men's health is
that it is being commonly conceived with having a set of fixed values (ie. self-reliance,
aggression, dislike of homosexuality) and practices (ie. avoiding health professionals, risk
taking) which emerge through measurement scales that do not take into account historical and
cultural flexibility (Farrimond, 2012).

Robertson (2003) would agree to this, believing that the prevailing discourse among
men's health research comes down to the idea that, "men don't take health seriously and
continue to take more risks with their health than women" (p.111) (as cited in Hoy, 2012). The
underlying characterization of this behavior is seen as 'men behaving badly' for being unwilling
or unable to seek help due to internalized conceptions of masculinity (Hoy, 2012).

While sex-comparative research has been helpful in directing attention to men's help-
seeking, it negates the possibilities of diversity among men, as well as similarities between men
and women. It also lacks the ability to explain processes connected to variations--bypassing the

influence of context through treating gender as a trait--which can lead to practiced stereotypes

about men (Wenger, 2011). It fails to attend to a crucial question: "Why are some men, under

some circumstances, able and willing to seek help for some problems but not for others?"

(Wenger, 2011, p.489).

While still remaining influential, sex role theory receives criticism for assuming that a

culturally dominant ideology is the norm, for viewing gender as passively acquired, and for not

giving enough attention to power dynamics between men and women (Wenger, 2011).

Connell (1995) proposes that, instead of trying to define masculinity as an object, we

need to become aware of the processes and relationships through which women and men go

about managing gendered lives (as cited in O'brien et al, 2005). As Connell (1995) describes:

> *"'Masculinity', to the extent to which the term can be defined at all, is simultaneously a*
>
> *place in gender relations, the practices through which men and women engage that place*
>
> *in gender, and the effects of these practices in bodily experience, personality and*
>
> *culture." (p,71) (as cited in O'brien et al, 2005).*

Social constructionist frameworks have become a preferred approach to studying gender

in a number of social sciences aside from psychology. Despite the fact that social constructionist

paradigms can be commonly confused with social learning frameworks, Addis and Cohane

(2005) assert that there are some critical differences.

While both frameworks lead with the assumption that gender is socially formed as

opposed to existing naturally as innate qualities in men and women, social learning approaches

focus on the way social environments shape gendered behavior whereas social constructionist

perspectives attend to the different ways gender itself is actively being constructed--from a

variety of social levels, including the micro-interactional, or dyadic, to the cultural (Addis &

Cohane, 2005). What is significant about this is that the emphasis shifts from seeing individuals as respondents to processes of operant conditioning (ie. reinforcement and punishment) to an understanding of individuals as being active agents constructing particular meanings of masculinity in particular social contexts (Addis & Cohane, 2005).

**Origins**

Social constructionism finds its roots in a number of intellectual traditions, including sociology, social philosophy, and the sociology of knowledge (Cunliffe, 2008).

Linked to the sociology of knowledge is Berger and Luckmann's influential book, the Social Construction of Reality (1966), which is considered to be an acknowledged origin of social constructionism (as cited in Cunliffe, 2008). In it, Berger and Luckmann propose that society exists as having both an objective and a subjective reality, with a social world that is governed by a dialectical process of externalization, objectivation, and internalization--ie. "Society is a human product. Society is an objective reality. Man is a social product" (p.61) (as cited in Cunliffe, 2008).

Their argument is that the social world is constructed by humans, based in ongoing activity and routines (externalization), that is experienced as objective, as it affects our lives on a continuing basis and requires us to have to go out and learn about it (objectivation) (Cunliffe, 2008). We are socialized in the world as we interpret meanings of events and other subjectivities, and as a result we adopt the world and the identities of others as representative of our own place and identity (internalization) (Cunliffe, 2008).

The origin of social constructionism in psychology is attributed to Kenneth Gergen, who wrote a book (1973) that sought to tackle the challenging concept of understanding psychology as a product of the interaction between people and their historical, cultural, and social context

within a particular period of time. (as cited in Losantos et al, 2016). His ideas and theories have grown exponentially in depth and complexity since then.

This growth could be attributed by Galdas, Cheater, and Marshall (2005), in their review on the gender comparison literature for mental health help-seeking, as the need for within group studies to explore the differences in men and not just between the genders. Their argument was that men can not be contained to a single homogenous group that should be compared against women (Harding & Fox, 2015).

The notion of masculinities as being multiple, contested, dynamic, and socially located in both time and place is becoming more commonplace (O'brien et al, 2005), with health behaviors being viewed as performances of masculinity (Wenger, 2011). Coming from this social constructionist perspective, masculinities are regarded as flexible; continually being constructed and contested as men 'do gender' in ways that position themselves as masculine (Addis & Cohane, 2005). As Kimmel has observed, "masculinity must be proved, and no sooner proved that it is again questioned and must be proved again" (as cited in O'brien et al, 2005). In this light, gender is interactive and social and can be better understood as a verb rather than a noun (Addis & Cohane, 2005).

Wenger (2011) reflects on the recognition of the health implications of men's efforts to align their acts to the prioritized way of being a man. And with this comes a growing awareness of help seeking behavior as being influenced by shifting constructions of masculinities, as men construct meanings of masculinities with others and in relation to femininity norms (Wenger, 2011).

**Applications of SC for Research**

Social constructionism, when applied to the field of research, is regarded as an inquiry, via a collaborative process between researchers and participants, for the purposes of constructing new ways of knowledge (Losantos et el, 2016). Research form a SC framework generally utilizes qualitative methods within a nonpositivist epistemology; the reason being that, due to the belief that social reality is in a constant state of construction and reconstruction, objective measurements become less of a concern (Addis & Cohane, 2005).

Semistructured, in-depth interviews are examples of SC research, which permits exploration of an individual's ideas while providing structured flexibility that promotes engagement between the researcher and the interviewee (Harding & Fox, 2015). Losantos and colleagues (2016) describe the dynamic unfolding of this process, with the actors involved in the research constructing meanings and realities as they go along.

What becomes essential is the necessary transparency concerning the role of the researcher in both the data collection and subsequent analysis (Losantos et al, 2016). The analysis is formed through the relationship between the researcher and the participants as an active part of the data. Therefore, the findings are not presented as independent and objective material, but as a result of the subjective construction (Losantos et al, 2016).

This undertaking is facilitated by the researcher taking on a position of 'not knowing', which suggests an attitude that transforms both how the researcher states the research questions as well as how the data analysis in conducted. It is believed that doing so enriches the understanding of the participant's experience (Losantos et al, 2016).

Addis and Cohane (2005) mention how it is encouraging that current research directions in the psychology of masculinity are steering more attention towards the variability within a

gender category (ie. between-men differences regarding adherence to restrictive masculinity norms) as opposed to sex differences. They assert that qualitative approaches to research concerning men's characterizations of mental health problems are well suited to handle the complex and shifting constructions of meaning in ways that classical empirical and quantitative methodologies fall short of (Addis & Cohane, 2005).

By attending to the subtleties of context in men's lives, a social constructionist lens offers a valuable opportunity to access 'commonality as well as diversity' in how masculinity converges with behaviors over the complexity of individuals lives (Wenger, 2011). Another critical element that SC researchers are aware of is the need to be self-reflective, with the recognition that social constructionism theories themselves are products of a society at a given time and in a given context (Losantos et al, 2016). Therefore, Losantos and colleagues (2016) emphasize that the,

> *...psychological discourses that provide a frame of reference for research are understood as social products within cultural traditions that have the power to generate or degenerate the people describe. (p.30)*

**Principles of Social Constructionism Applied to Research in Psychology**

Included here is a list, compiled by Losantos and colleagues (2016), of eight premises of social constructionist epistemology applied to the field of research in psychology which gives a broader summary of what was discussed earlier:

1) *It is anti-realist: it understands psychology as a socially constructed discipline, based on the interactions of authors with their historical, cultural and social context. Thus, findings depend on the moment when research is conducted; therefore, they may not be generalizable, absolute, or replicable.*

*2)*      *It is anti-essentialist: it challenges the psychological notion that people have a unique*

         *nature which can be discovered. This implies that people are in a constant movement and*

         *growing process, thus by the time the researcher approaches a person, s/he has already*

         *changed.*

*3)*      *It is based on the understanding that language constitutes reality: researchers seek to be*

         *aware of the theoretical frameworks from which the investigations are born; nonetheless,*

         *theoretical references are considered to be embedded in language that shapes thinking*

         *and understanding of the world.*

*4)*      *It focuses on interaction and social practices: It does not intend to take an X-ray*

         *(emphasis added) of the subjects under investigation. It rather understands the*

         *impossibility to grasp the individual essence. That is why the interaction process from*

         *which the data is generated is also part of the analysis.*

*5)*      *It recognizes the impossibility of the existence of a universal psychology: on the contrary*

         *it comprises the historical, cultural and social context of psychological knowledge and*

         *analyzes it as a part of the research data.*

*6)*       *It understands investigation as a form of social action: therefore, it invites researchers*

         *to reflect on the responsibility that accompanies the action of writing about other people.*

         *Consequently, the language used to present findings is carefully constructed as it may*

         *influence the way in which persons under investigation relate to society and its*

         *institutions and vice versa.*

*7)*      *It focuses on processes: it seeks to generate knowledge from the dynamics within the*

         *interaction of relationships. It emphasizes on processes more than structures; therefore,*

         *knowledge is understood as something that is constructed, not something one possesses.*

*Consequently, the power dynamic between the researcher and the researched is*

*balanced, whereby everyone brings their experience and expertise in their own fields to*

*the research encounter.*

*8)        It promotes curiosity within the research process: this attitude is based on the premise of*

*not knowing, presented by Anderson and Goolishian (1992) that challenges the*

*researcher to deviate from theories or models that attempt to explain or make sense of*

*their own data.*

*Rather it is an invitation to recognize research as a liberating experience, where the researcher*

*is willing to acknowledge which data fits with their prior knowledge and which does not.*

(Losantos et al, 2016, p.31)

**SE Research Application For the Purposes of This Study**

SC is used in the field of research through an investigation as a collaborative process

between the researchers and participants, with the intentions of constructing new ways of

knowledge (Losantos et al, 2016). For the purposes of this paper, I, the researcher, will take a

number of statements from relevant academic studies and newspaper articles collected in the

literature review to be representative of the participants.

The findings will be separated into what could be characterized as either 'Traditional'

or 'Emerging' masculine roles regarding help-seeking, based on whether they fit the criteria (ie.

ideals and value system) indicated in Chapter 2, section 1) Socialization process and Masculine

Ideals. Further categorization. From there, analysis of the findings will be made as a way of

identifying patterns of help-seeking behavior within the context of masculine roles and ideals.

Discussion of the results will ensue.

## Chapter 4: Results

This section of the paper will cover the outcome of the research, undergone through the social constructionist approach, from materials found in the literature review--such as academic journals and newspaper articles--that relate to the topics of concepts of masculinity and help-seeking behaviors in men.

The first portion of the chapter will be the 'Findings', which divides the participant statements into two sections based on whether or not they seem to conform to the status quo of values and behaviors regarding concepts of masculinity and help-seeking. This distinction will be characterized as either 'Traditional' or 'Emerging' masculine roles regarding help-seeking. Further sub-categorizing of the statements will be made that address reoccurring themes and/or identifiers regarding each role.

Following this will be an 'Analysis of the Results', which will provide a more detailed overview of the findings for each section, as well as point out possible trends based on the dynamic of masculine ideals and help-seeking behavior (ie.Traditional and Emerging Trends). By doing so, we can have a better understanding of the processes involved in this dynamic for men, including elements of change; and if so, highlight possible motivators for this development, as well as towards the extent that this change is happening.

Snippets of the participant statements will be included in the analysis, as well as other material from sources found in the literature review.

**Findings**

**Traditional Masculine Roles Regarding Help-Seeking**

**Independent and Avoidant**

*(IA-1)* Indeed, as I once wrote about male depression, "A man is as likely to ask for help with

depression as he is to ask for directions." (Real, Sept/Oct 2017, p.36)

*(IA-2)* "Men don't generally talk to each other about these things since we've been taught it isn't

`manly.' Most of us walk around as I did, thinking everyone else has the key to the good

life, and what is their secret? It was a revelation to me when I discovered that other men

were in the same boat I was." ~ author (O'Neil, Jul-Sept 2005, p.2)

*(IA-3)* "I can't remember the last time I was in a room with all men," I said. "I actively avoid

these situations. And maybe that's quite strange." ~ author (Godwin, March 9, 2018, p.1)

*(IA-4)* "I was trapped in my room the whole time...because nobody could comprehend...how I

was feeling...all I did was play games...just trying to get my mind out of the world" ~ 18

year old male participant (Lynch, Long, & Moorhead, 2018, p.142)

*(IA-5)* "They use alcohol to cope...alcohol numbs them, mentally and physically so that...they

don't feel those problems, it's a little escape" ~ 20 year old male participant (Lynch et al,

2018, p.143)

*(IA-6)* "If I hadn't been married or in a close relationship, I wouldn't have done anything. My

wife suggested it for quite a while...I think we might have had a doozy of an argument

and then that was maybe when..." (Max) (Harding, Fox, 2015, p.454)

*(IA-7)* "...grow the hell up, accept some responsibility, live an honorable life." ~ Jordan Peterson

(Bowles, May 18, 2018, p.2)

*(IA-8)* "If you go and ask for professional help, you are not really a man" ~ 20 year old male

participant (Lynch et al, 2018, p.143)

**Strong and Dismissive**

*(SD-1)* One fire-fighter (Stuart) viewed men who trivialised symptoms and diminished their need

for help as ''naive, I wouldn't say that's masculine'', but the group acknowledged that it

still happened: ''unfortunately I know it's completely moronic, I mean, it's caveman

stuff, but that is to a certain extent how guys still operate'' ~ male participant (O'brien et

al, 2005, p.513)

*(SD-2)* "You just have to try and be as strong as you can, to live through the situation, if you

know what I mean. Just carry on with your life. You don't have to seek help all of the

time." ~ 68 year old male participant (Smith et al, 2007, p.330)

*(SD-3)* "Men are supposed to be strong when…things get tough, the tough get going. It is put

into our psyche. And I think men are expected to perform, and I think this is probably

why we have trouble admitting when things are bad." ~ 50 year old male participant

(Fogarty et al, 2015)

*(SD-4)* "I think the hardest thing is to address the problem or to identify there's a problem with a

man. You have to be willing to fall flat on your face. You have to let go of your ego.

You have to say, "It's ok to cry. It's ok to let out emotions, to show that you're equal and

not superior." ~ Participant (Chuick et al, 2009, p.309)

*(SD-5)* "you would definitely be seen as a weak member of the group if you were [seeking

counseling]" ~ 23 year old male participant (Lynch et al, 2018, p.142)

*(SD-6)* "So he's somebody who doesn't really take a lot of notice of symptoms and things and

tends to rely on me for everything, to make decisions and to identify things and do

something about it." ~ wife of 67 year old male participant (Fish, Prichard, Ettridge,

Grunfeld, Wilson, 2018, p.7)

*(SD-7)* "If I said—Dad I'm not feeling well today, I'm feeling depressed . . . Dad would say

—cop on, grow up" ~ 18 year old male participant (Lynch et al, 2018, p.143)

*(SD-8)* Paul's initial consultation was also disheartening with the GP being dismissive—"Oh,

you're just experiencing panic attacks mate. He gave me a DVD to watch . . . didn't do

much to stop them." ~ early 40s male participant (Harding, Fox, 2015, p.455)

**Non-Emotional and Body Estranged**

*(NEBE-1)* "For a lot of us, it feels too feminine, even if they [males] were to admit to just having

low moods. . . . Males can't admit to having a moody or a low day; that's what

women do." ~late 20s male participant (Harding, Fox, 2015, p.457)

*(NEBE-2)* "He's totally willing to talk about it [depression]. Our relationship is, in some ways

I'm more typically male and he's more typically female because he's not afraid to

cry and cry right into the ground if you know what I mean, just circle down and I'm

more of, 'well what are you going to do about it, let's fix this." ~ 37-year old woman

regarding male partner (Oliffe et al, 2017, p.778)

*(NEBE-3)* "I lean toward him."What are you so mad about?" I ask him, knowing that anger and

lust are the only two emotions men are allowed in the traditional patriarchal set-up."

~ author (Real, Sept/Oct 2017, p.39)

*(NEBE-4)* "When you get really personal . . . it's hard to express it sometimes" ~ 18 year old

male participant (Lynch et al, 2018, p.142)

*(NEBE-5)* "Violent attacks are what happens when men do not have partners... and society needs

to work to make sure those men are married." ~ Jordan Peterson (Bowles, May 18,

2018, p.2)

*(NEBE-6)* "He doesn't have any perception of how his body works and what sort of things can

happen." ~ wife of 67 year old male participant (Fish et al, 2018, p.5)

*(NEBE-7)* "We've heard women complain for years that they're just too tired to have sex," she

says. "Well, the same holds true for men. Sometimes, they just shut down." ~ Laurie

Betito, clinical psychologist and sex therapist (Gillis, Oct 31 2005, p.29)

## Help Seeking as Singular, Static Process

*(HPSS-1)* "I've tried talking before and I've been taken aback by the [negative] responses I've

got" ~ 23 year old male participant (Lynch et al, 2018, p.142)

*(HPS-2)* "It takes a point where I'm actually about to have a meltdown . . . to actually go see

someone" ~ 23 year old male participant (Lynch et al, 2018, p.143)

*(HPS-3)* "I'd like a health service that operates like a car service– take it in, fix the problem, go

home!" ~ 57 year old male participant (Smith et al, 2008, p.4)

*(HPS-4)* "I won't look at that on the Internet. I only believe what the doctors and nurses are

telling me, I don't believe that thing. I like to get my information from word of mouth,

eh." ~ 68 year old male participant (Fish et al, 2018, p.7)

*(HPS-5)* "Because it's Ireland . . . families don't talk . . . that whole Catholic guilt thing is still

hanging around . . . the only means of self-betterment was through God" ~ 20 year old

male participant (Lynch et al, 2018, p.143)

*(HPS-6)* "That's why I wouldn't go to a doctor . . . if they gave you medication you'd need it to

feel normal . . . I'd rather just feel how I'm supposed to feel, rather than have

medication" ~ 24 year old male participant (Lynch et al, 2018, p.143)

*(HPS-7)* "I'm the wife so I think the big part of that is being supportive, hearing and validating,

and I don't always get an A plus on that because there are times when I do try and

switch the focus to something more positive. I say to him maybe I'm not the person you

should be talking to about this, because I don't think it's helping." ~ 31 year old wife of

male participant (Oliffe et al, 2017, p.778)

**Masculinity as Fixed, Universal Identity**

*(MFU-1)* "My mum told me that men are wrong and men are sick. That's something I

internalised. And that's part of patriarchy. Hating ourselves is social conditioning, this

idea that there's only one way to be, and if we don't feel that way, we should be

ashamed." ~ David Pickering (Mansplaining Masculinity) (Godwin, March 9, 2018,

p.3)

*(MFU-2)* "It's fear of actually finding out that you're not normal" [regarding seeking mental

health services] ~ 24 year old male participant (Lynch et al, 2018, p.142)

*(MFU-3)* "We're on a retreat [religious] . . . they talk about homosexuality like, it is a mental

illness" ~ 19 year old male participant (Lynch et al, 2018, p.143)

*(MFU-4)* "The masculine spirit is under assault...It's obvious." ~ Jordan Peterson (Bowles, May

18, 2018, p.1)

*(MFU-5)* "There is a certain poetic justice in the reversal. But that doesn't make it a sensible,

effective or morally decent approach to any particular societal problem. I can only say

what members of these marginalized groups have said for years: Get your hands off

my...gender" ~ author (Sartwell, June 2, 2018, p.1)

*(MFU-6)* "You can't change it [masculinity]. It's not possible. This is underneath everything. If

      you change those basic categories, people wouldn't be human anymore. They'd be

      something else. They'd be transhuman or something. We wouldn't be able to talk to

      these new creatures." ~ Jordan Peterson (Bowles, May 18, 2018, p.1)

*(MFU-7)* "Yes, their experimentation with appearance-remaking themselves on ever more

      feminine principles-has torn down weary stereotypes. It may even help them

      understand life from a woman's point of view. But men now run the risk of obscuring

      the meaning of male altogether, of robbing the sexes of that age-old friction that,

      however frustrating, happens to be the stuff of life" ~ author (Gillis, Oct 31, 2005,

      p.32)

### Emerging Masculine Roles Regarding Help-Seeking

**Collaborative and Engaged**

*(CE-1)* As Andy describes: ''if you're in a watch, a station, my philosophy is if there is

      something wrong you'd tell the men''. This was in stark contrast to the majority of

      groups who believed the subject of health and illness was ''not men's talk'' ~ participant,

      fire-fighter (O'brien et al, 2005, p.514)

*(CE-2)* "I felt part of a...team, and really wanted to be there for other people no matter what

      condition I was in". ~ male participant (as cited in Galdas et al, 2014, p.14)

*(CE-3)* "Yeah, she definitely initiated it and I thought it was the only way of fixing it or bringing

      it all out...From there it led to me seeing him [current psychologist]" ~ early 30s male

      participant (Harding, Fox, 2015, p.454)

*(CE-4)* "If...you're talking to a youth worker...over a period of six months...you're not just

talking about your problems, you're having the craic with them and then if you need to

talk about something, you can." ~ 22 year old male participant (Lynch et al, 2018,

p.144)

*(CE-5)* "...Forums were definitely very helpful. The great thing about them is that it can bring a

lot of like-minded people with similar experience together. It's really good to sort of

share knowledge and experiences...makes you realize you're not alone." ~ late 20s male

participant (Harding, Fox, 2015, p.456)

*(CE-6)* "I sort of look at a problem, look at what's really going on...to get the facts, to marshal

the facts, to consider what the best options are...and to take responsibility to make

decisions...full responsibility for my health, not partial, full. Because you know, I make

the decision to do it." ~ 57 year old male participant (Smith et al, 2008, p.3)

(CE-7) "That is, I've had to look after myself for so long and that if it starts to get to the stage

where I can't...I might then give up altogether. But until such time that I can, even if it's

only roughly, I'll continue to do so. I've been independent for so damn long!" ~ 70 year

old male participant (Smith et al, 2007, p.330)

**Brave and Inquisitive**

*(BI-1)* "At the end of the day I think you've got to find out for yourself. And the only way you

find out for yourself is to ask questions. I've never been afraid to go and ask

questions...I'm the sort of person who likes to do my research. I like to make sure that I've

sought other people's opinions where necessary...this helps me gauge my own health. ~ 54

year old male participant (Smith et al, 2008, p.3)

*(BI-2)* "Just teaching . . . even the toughest of men can have problems . . . everyone can have a

mental health problem . . . you're only as strong as your mind" ~ 22 year old male

participant (Lynch, et al, 2018, p.144)

*(BI-3)* "I sort of like to know what's going on. Like scientifically. I quite like science, even if I

don't understand it...I like to analyze. It's sort of like being a detective… you're trying to

work out what's going on." ~ 52 year old male participant (Smith et al, 2008, p.3)

*(BI-4)* "People [men] are hungry for information, what is the latest in research … People are just

dying to get their hands on the latest information". ~ male participant (as cited in Galdas

et al, 2014, p.15)

*(BI-5)* "I call it clutter removal. All the things that clutter up my life that are unnecessary, I will

remove. I will simplify my life." ~ 69 year old male participant (Fogarty et al, 2015,

p.182)

*(BI-6)* "[Knowledge] not only gives you the information to feel comfortable, but also gives you

the information and a tool to check the physician. Not just his reputation but also the

information he is giving you" ~ male participant (as cited in Galdas et al, 2014, p.15)

*(BI-7)* "I think a lot of times it's just a culture. And a lot of these people [doctors] might be

knowledgeable, but they're not knowledgeable of the people they're dealing with" ~ male

participant (Malebranche, Peterson, Fulliove, & Stackhouse, 2004, p.102)

**Emotionally Expressive and Body Conscious**

*(EEBC-1)* "This might be the wrong thing to say… but I just accept that I am going to feel shit

sometimes… and it's not going to kill you." ~ 30 year old male participant (Fogarty

et al, 2015, p.183)

*(EEBC-2)* "It's [mental health issues] not nothing I'm against or ashamed of," DeRozan told the

Toronto Star on Feb. 25. "At my age, I understand how many people go through it."

~ DeRozan, professional basketball player (Regino, April 2, 2018, p.1)

*(EEBC-3)* "You can't separate support from understanding. … there's nothing more supportive to

me than when someone says, "Yeah, I know" or "I understand" or 'its happened to

me'…that commonality" ~ male participant (as cited in Galdas et al, 2014, p.14)

*(EEBC-4)* "A few years ago, I might have said that men didn't take care of themselves enough,"

she says. "Now they're doing so more and more maybe too much. With these men, I

could not fall in love." ~ Michele Pujos-Gautraud, physician and andrologist (Gillis,

Oct 31 2005, p.28)

*(EEBC-5)* "…know my stupid body by now. I know if something strange happens to me, but I

also need to know what's basically going on, to fix it myself." ~ 59 year old male

participant (Smith et al, 2008, p.3)

*(EEBC-6)* "I'm getting to the stage where I need to consider that I need to keep healthy to live as

full a life as I can—quality of life too. Not just the length but how long you'll be able

to look after yourself and do the things I want to do." ~ 52 year old male participant

(Smith et al, 2007, p.330)

**Help-Seeking as Multiple, Dynamic Process**

*(HSMD-1)* "Yeah certainly the clinic that I go to has my GP, psychologist and physio all in the

one place. They're all the people I need and all in the one spot . . . location and

convenience." ~ 20-something male participant (Harding & Fox, 2015, p.458)

*(HSMD-2)* "You've got to be aware that you've got a problem. Obviously that's the first thing.

And then you've got to assess as to whether or not you can fix it yourself, or find

somebody who knows more about it than you do." ~ 75 year old male participant

(Smith et al, 2008, p.3)

*(HSMD-3)* "You just need someone who can talk to . . . you can let it out to, who cares" ~ 24

year old male participant (Lynch et al, 2018, p.144)

*(HSMD-4)* "I feel relaxed to know that the [health] system is there if I did need help. I certainly

wouldn't take a chance if I thought I had a serious problem. But I just don't consider

that I should take advantage of the system" ~ 38 year old male participant (Smith et

al, 2008, p.4)

*(HSMD-5)* "Provide the right conditions and then provide all the right key information . . . I think

eventually they'll reach for the help and the support" ~ 18 year old male participant

(Lynch et al, 2018, p.144)

*(HSMD-6)* "And sometimes the decisions need to be made by the support base to make sure

things at least get on, you know, get started, to be dealt with." ~ 70 year old male

participant  (Fish et al, 2018, p.6)

*(HSMD-7)* "I'm not one to seek help straight away. I like to figure things out for myself. But if

she (wife) thinks I'm not doing the right thing, she'll certainly let me know!" ~ 74

year old male participant (I) (Smith et al, 2007, p.330)

*(HSMD-8)* "I can tell you what my wife thinks. She thinks I'm pigheaded and stubborn… I'm

pretty independent, I'll acknowledge that. I don't like relying on other people. But

sometimes you have to." ~ 74 year old participant (II) (Smith et al, 2007, p.330)

*(HSMD-9)* "I had nothing to lose at this point. but I had plenty to lose if I didn't." ~ 37 year old

male participant (Oliffe et al, 2017, p.779)

**Masculinity as Fluid, Multiple Identities**

*(MFM-1)* "We as men have denied the effects of patriarchy for centuries. We can't deny that.

But if we lump all men and patriarchy in together, men end up nailed to the tree of

history and feel a sense of shame that they will never escape from." ~ Robert,

participant (Godwin, March 9, 2018, p.2)

*(MFM-2)* "There has to be a way to expand what it means to be a man without losing our

masculinity. I don't know how we open ourselves to the rich complexity of our

manhood. I think we would benefit from the same conversations girls and women

have been having for these past 50 years" ~ author (Black, Feb 22, 2018, p.2)

*(MFM-3)* "Talking about toxic masculinity is not about vilifying boys, men or any of the

particular qualities society has deemed "masculine." Rather, it is an opportunity to

begin to reconstruct a more positive model of masculinity that makes room for the

many different ways to be a boy or man and allows all individuals to feel secure in

their masculine identity." ~ def from The Good Men Project (Caroline, Proux, April

12, 2018, p.3)

*(MFM-4)* "We also need to treat people as individuals and move away from the notion that group

identity is the defining characteristic of a person. Humans vary along a multitude of

dimensions, the least important of which may be the characteristics (e.g. race and

sex) they did not choose for themselves." ~ author (Maharaj, Feb 7, 2018, p.1)

*(MFM-5)* "The End of Men isn't nigh, nor is macho dead. But its definition should be broadened

to include both Mr. T and Mr. Mom. It's time, in other words, for a New Macho: a

reimagining of what men should be expected to do in the two realms, home and

work, that have always determined their worth." ~ author (Romano, Nov 20, 2010,

p.2)

*(MFM-6)* "women want the men to work, which is the opposite of what I hope for in my own

household." ~ 31 year old wife of depressed male, participant (Oliffe et al, 2017,

p.778)

*(MFM-7)* "What we need to do as a society – but particularly as men – he says, is to redefine

"healthy masculinity". A masculinity that is no better or worse than femininity, but

that stands as its opposite, equal pole." ~ David Fuller (Godwin, March 9, 2018, p.2)

**Analysis of Findings**

**Independent and Avoidant (IA) to Collaborative and Engaged (CE)**

***Traditional Trends***

What seems evident from the findings is that there are still elements of stigma tied to

help-seeking behavior, at least for a portion of the male population sampled here, which

reinforce the traditional gender role ideals of independence and taking responsibility. This is

alluded to with the statements that "men don't generally talk to each other about these things"

*(IA-2)*, and that men are as likely to ask for help with depression as they would directions *(IA-2)*.

Lynch et al (2018) connect on this subject with the suggestion that a man's self image can be

damaged as a result of seeking help by being experienced as a perceived loss of self-reliance. In

effect, seeking help, especially professionally, can jeopardize your legitimacy as a 'man' *(IA-8)*.

Instead, one should "grow the hell up" and "accept some responsibility" in order to uphold an

"honourable life" *(IA-7)*.

Having a limited range of acceptable options, these men will resort to using ineffective

coping strategies--such as minimization, ignoring, and escaping--in order to maintain the status-

quo of their identity (Lynch et al, 2018). Examples of this would be isolating oneself with video games *(IA-4)* or through numbing with alcohol *(IA-5)* as a means of attempting to push away the emotional pain housed within. Other forms of denial for men can be found in overly optimistic outlooks towards their situation, offering a rationale of patient bystander--ie.'the symptoms will take care of themselves'--for delayed help-seeking (Fish et al, 2018).

The potential outcomes of this closed-off mentality is that heterosexual men will rely on the continual encouragement of their female partners in order to address symptoms of distress (IA-6), or that men will feel varying degrees of discomfort in social engagements--especially when amongst only other men *(IA-3)*.

### *Emerging Trends*

What also seemed to emerge from the findings was a more tolerant position for a number of men when it came to help-seeking behavior. Farrimond (2012) describes this sentiment as 'taking action', where men are engaging with outside sources as a way of getting on top of their mental or physical presenting issues. This suggests an alternative narrative that health is something that men are willing to bring up, as opposed to the more traditional attitudes that imply this subject matter is "not men's talk" *(CE-I)*.

The drive for seeking help does not necessarily come with the desire for receiving validation for their feelings, with many offering limited emotional details of their problems (Farrimond, 2012). Galdas et al (2014) offer the suggestion that in order for men to access and continue in engaging in support structures, there needs to be a clear purpose for the support activities that addresses an unmet need. Doing so thus legitimizes their involvement and preserves their identity as a man. Examples of this would be firemen seeking help among colleagues in order to maintain active duty, thereby securing their masculine ideal of

responsibility to protect others (*CE-1*), or through online forums, which gives men the opportunity to "share knowledge" and meet "a lot of like-minded people" while also helping them realize they are not alone with their experiences (*CE-5*).

Harding and Fox (2015) attend to what they believe is a critical enabling factor towards help-seeking, which relates to when the behavior is presented in a positive frame. If done so effectively, this repositioning turns the act into a perceived norm which is more likely to be enacted in the future. Opportunities where men are able to disclose vulnerable feelings and thoughts breeds connection as they are able to be seen and understood (Shepard, 2004). Men's group-work can provide these moments, leading to individuals feeling like "part of a team" and "wanting to be there for other people" (*CE-2*) when interventions are successfully deployed.

The development towards more disclosure and support seeking for men is not always a smooth process. In Fogarty et al's (2015) study interviewing men who had found effective strategies for preventing and managing depression, a number of the participants had mentioned needing to get out of their comfort zones in their efforts to connect with others, seeing the positive values of doing so as outweighing times which were confronting or difficult.

Another aspect of men situating themselves in a more active role when it comes to help-seeking behavior is that it offers them a way of regaining a sense of control (Galdas et al, 2014). This may seem counterintuitive, as the practice of help-seeking tends to be labeled with dependence, vulnerability, or even submission to someone with more power that goes against societal pressures of striving for independence (Mahalik et al, 2003). However, Addis and Cohane (2005) found that the same masculine discourse that promotes active problem-solving and independence can be repurposed to justify the help-seeking process--ie."I don't care what people think. I'll do whatever I need to beat this thing, even if it means seeing a shrink." (p.640).

This emphasizes a man to "take responsibility to make decisions" *(CE-6)*, which includes enlisting the help of others if necessary.

A therapy setting can be a good example of this, as the intimate one-on-one client-centered approaches allows male clients a measure of control in directing the conversation; where "you're not just talking about your problems", but "if you need to talk about something, you can" *(CE-4)*.

Maintaining independence is something that seems to garner alot more attention for older men, as their advanced aging entails more challenges that the majority of younger men do not need to consider. Therefore, reliance on others is not automatically ascribed as 'unsuccessful aging', but is "...placed on a continuum of achievements that are not necessarily subject to simplistic normative assessments of success or failure" (Smith et al, 2007, p.326). As long as there is some small possibility in which they can "look after" themselves they will "continue to do so" *(CE-7)*.

Therefore, what is developed here is an expanded notion of help-seeking among men. As Farrimond (2012) asserts, "This goes beyond the individualistic recreation of the body as part of a self-reliant, entrepreneurial role...It means being a compliant yet active patient who responds to medically initiated health promotion and intervention" (p.232). And for those who may delay or even avoid formal requests for help in the case of certain conditions, this does not mean that they are inactive (Wenger, 2011). Whatever their chosen route of help seeking, these men went about it in a conscious manner; "it was not just something they did, but something they thought about" (Smith et al, 2008, p.3) This is not so much about prioritizing alternative identities, but reformulating dominant ones (Farrimond, 2012).

**Strong and Dismissive (SD) to Brave and Inquisitive (BI)**

*Traditional Trends*

Among the findings was evidence of statements that suggested leanings towards a traditional masculine ideal of needing to be strong, which presented itself in the form of being dismissive when it came to addressing symptoms in help-seeking behavior.

A number of the participants had tied-in the ideal of strength with other motivational euphemisms, such as needing to "live through the situation" *(SD-2)*, to "just carry on with your life" *(SD-2)*, and that "when things get tough, the tough get going" *(SD-3)*. All these sentiments are aimed at encouraging movement through self-reliance tactics which are in alignment with the previous ideals of independence and taking responsibility. Ironically, even those who recognized the possible shortcomings with this do-it-yourself mentality in responding to signs of distress, describing it as "naive...completely moronic...caveman stuff" *(SD-1)*, still acknowledge that for the most part this is the de facto practice for men.

This strong positioning of dismissive behaviors could be related to the enculturation practices that all men undergo throughout their lives, whereby 'expectations to perform' and uphold their masculine identities creates challenges to "identify there's a problem" *(SD-4)* or "admitting when things are bad" *(SD-3)*. As Lynch et al (2018) reflect on, help-seeking can be regarded as a coping mechanism for times in which the "...task demands exceed people's coping ability or resources" (p.138). This notion of not being able to handle the situation on one's own by seeking counselling services can therefore contribute towards an aversion or shame in pursuing these activities, as men might fear anticipatory rejection and ridicule that comes with being perceived as a "weak member of the group" *(SD-5)*.

Keeping this in mind, it is understandable why some men might seem to actively resist the notion of looking for outside help, or at least come with the mindset that "you don't have to seek help all the time" *(SD-2)*. This places the majority of responsibility when it comes to health concerns onto the female partner, which leads to the belief that their man "tends to rely on me for everything" *(SD-6)* when it comes to identifying symptoms and decision making.

This dependency is bolstered by the idea that men simply do not have the same level of health knowledge as women (Fish et al, 2018). The reason for this, however, may be because men do not want the knowledge, as they are reluctant to perceive themselves as vulnerable to health issues (Fish et al, 2018): to "let go of your ego", "to cry" and "let out emotions", and "to show that you're equal and not superior" *(SD-4)*.

Even when males are able to step outside of their comfort zone, their efforts can get derailed from less than enthusiastic responses from those in positions of power. Examples of this can be found with one participant being told by his father to "cop on, grow up" *(SD-7)* after disclosing feeling depressed, while another man being told by his doctor that he's "just experiencing panic attacks mate" *(SD-8)*, which can be disheartening experiences.

### *Emerging Trends*

Another trend that seems to be emerging among some of the male population is the repositioning of help-seeking as a display of courage. What was previously considered a show of weakness is now being presented as a 'brave enterprise', with the proposition that it takes strength for men to ask for help (Hoy, 2012). Examples of this from participants were statements of "never been afraid to go and ask questions" *(BI-1)*, which emphasizes a brazen do-it-yourself attitude, while also normalizing the help-seeking process by attesting that "even the toughest of men can have problems" *(BI-2)*.

The notion of taking courage to ask for help can be seen as a means of appealing to men's traditional values of being competitive and success-oriented, which previously was attributed to avoidance of reaching out to others (Rochlen, Hoyer, 2005). What also seems to aid help-seeking in gaining legitimacy as a masculine act is that it is guided by a practical purpose of efficiency, via "clutter removal", which will "simplify...life" *(BI-5)*.

Going beyond the personal, help-seeking as a courageous act ties in to men's sense of duty, or responsibility to others, especially when taking in the considerations of their spouses-- either to maintain active duties in the relationship, or seeking help during or after bereavement (O'brien et al, 2005)

Highlighted throughout a number of the studies were statements that expressed men's desire for information relevant to their condition and symptoms, revealing a more active engagement in health practices. Participants frequently referenced notions of wanting "to know what's going on" *(BI-3)*, "hungry for information" *(BI-4)*, and being "the sort of person who likes to do...research" *(BI-1)*. This corroborates with Farrimond's (2012) findings of patients in preventive medicine being described as 'active or as an 'expert'; where a person "...takes charge of their illness and becomes equal to the health professionals treating them" (p.214).

Activities that follow endeavoring to be experts entails men subscribing to relevant magazines, as well as searching the internet for research or social support (Farrimond, 2012). This also can involve interacting with others in-person and gathering "other people's opinions where necessary" *(BI-1)* so that one can uncover the best available options--"sort of like being a detective" *(BI-3)*. For one participant, being able to search for information was more a source of comfort than for finding answers, stating "even if I don't understand it...I like to analyze" *(BI-3)*.

Smith et al (2008) discuss the importance their male participants placed on making informed decisions when electing to seek help. The researchers found that these decisions were based on pertinent knowledge that are in alignment with the decision maker's values and can be behaviorally carried out (Smith et al, 2008). Another detail that comes with this renegotiated status is that men feel more able to question their professional health practitioners, which includes persisting in help-seeking elsewhere when not satisfied by their initial encounter (Farrimond, 2012). A participant in this paper touched upon this sentiment of knowledge-as-balancing power with asserting that learning up on one's conditions "gives you the information and a tool to check the physician" *(BI-6)*.

What seems to stand out here for some men is a felt sense of distance and being misunderstood when it comes to the client-practitioner relationship, with one participant summing up his feelings around health professionals as, "a lot of these people might be knowledgeable, but they're not knowledgeable of the people they're dealing with" *(BI-7)*.

Participants in Lynch et al's (2018) study stated the need for mental health services to connect with families and young men with information that can promote help-seeking behavior. Galdas et al (2014) add that in order to get the intended results, the information needs to be presented in 'everyday language' that can be integrated in daily life, as opposed to overly complex or technical information that can lead to anxiety and overwhelm. In a word, the information needs to be *relatable*. This gives men the freedom to learn in their own way without worrying about being judged for their lack of knowledge about specific health and illness topics, thereby improving accessibility (Galdas et al, 2014).

**Non-Emotional and Body Estranged (NEBE) to Emotionally Expressive and Body**

**Conscious (EEBC)**

### *Traditional Trends*

What frequently came up among the participants of various studies was their self

described challenges in connecting with and expression of emotions. This seems to especially be

the case for the more vulnerable, deeper layers of emotion. Examples of this can be found in

statements in alignment with hegemonic masculine scripts, where a male participant suggests

that "it feels too feminine...to admit to just having low moods" *(NEBE-1)*, while another

admonishes that, at times, "when you get really personal...it's hard to express it" *(NEBE-4)*.

These statements attend to Lynch et al's (2018) findings on how denial of emotions and

low mental health literacy have been considered to be common contributors to avoiding seeking

help. Discussion from Fogarty et al's (2015) study also corroborates this, perceiving that

conforming to stereotypically male behaviors, such as the inability to talk about emotions, is a

problem, and can be detrimental to one's mental health.

To say that men are unemotional, however, would be inaccurate. A more apt assessment

might be that their range of acceptable emotional expression is severely limited; where "anger

and lust are the only two emotions men are allowed in the traditional patriarchal set-up" *(NEBE-3)*.

And when men do diverge from their 'traditional programming', it seems their behaviors can be

met with a mixed reception. In Oliffe et al's (2017) study that focused on the relational dynamics

between heterosexual couples with men diagnosed with depression, a number of the woman took

on an ambivalent stance towards their 'trading places' in gender roles. This sentiment can be

found in one woman's statement who saw her male partner as "more typically female because

he's not afraid to cry" *(NEBE-2)*, positioning herself in a more typically male role by responding,
"well what are you going to do about it, let's fix this." *(NEBE-2)*.

Another concern which emerged in the findings which has been linked to reasons for
males being emotionally limited was the assertion of men being disconnected from their bodies.
An example of this idea can be found with one female lamenting that her male participant partner
as not having "any perception of how his body works and what sort of things can happen" *(NEBE-6)*. Not only can this be concerning towards maintaining men's physical and emotional health,
with one female physician and andrologist suggesting men can sometimes "just shut down"
*(NEBE-7)* [pertaining to functionality and performance in sex], but also, that this estrangement
from their bodies and emotional lives can leave men being more prone to "violent attacks"
*(NEBE-5)* and a potential threat toward others. Therefore, it is the belief of one popular male
figure in the media that the only way to tame men's more aggressive nature is through female
intervention, and that "society needs to work to make sure those [more liable] men are married
*(NEBE-5).*

### *Emerging Trends*

While there were samples which reinforced the more traditionally masculine way of
avoidant behavior when it comes to identifying emotional and bodily symptoms, there also were
examples among some men which suggest a more conscious involvement in these matters.

Men in Fogarty et al's (2015) study were able to acknowledge when they began to feel
down, as well as connecting with attributable causes which led them to feeling this way. The
participants were also able to articulate the processes they used to respond to such times,
delineated in both proactive and reactive management terms (Fogarty et al, 2015). Emphasized in
the discussion for these men was challenging the expectations that precludes emotional
expression.

The way they proposed going about this was by developing additional resources and recognizing the need to solve or lessen problems contributing to feeling down or depressed (Fogarty et al, 2015). For a number of the men, just creating a sense of perspective was found to be helpful, under the guise of rationalized acceptance "that I am going to feel like shit sometimes...and it's not going to kill you" *(EEBC-1)*. This reasoned perspective-taking resulted from the ability to be open to new experiences and the wisdom that accrued from those experiences. Doing so affords these men a greater sense of control, as asking questions and actively considering their different options creates a more optimistic view as opposed to being at the mercy of their feelings (Fogarty et al, 2015).

Consistently found throughout the studies being reviewed was a mentality that underscored support and speaking up about emotionally difficult situations as a more acceptable avenue. Examples of this can be made with a statement by a professional basketball player disclosing his challenges with mental health and adding that it's "nothing I'm against or ashamed of...", and that he can "understand how many people go through it *(EEBC-2)*. Participants from Galdas et al's (2014) review also highlight the virtue of support that comes from understanding, where men are connecting with "that commonality" that comes about when someone else can say "Yeah, I know..." and "its happened to me" *(EEBC-3)*. These ties of shared experiences, or 'commonalities', both validate and normalize men's symptoms, thereby reinforcing help-seeking behavior.

When it comes to men's relationship with their bodies, it seems a new trend is emerging that emphasizes physical health as a gateway to better mental health. This coincides with the preventative model in the health system which promotes self-care, via physical activities (such as running), as inextricably linked with mental health (Fogarty et al, 2015). The idea behind it is

that the more time and energy invested in behaviors that directly benefit overall health, the better

the outcome in the grand scheme of things (Fogarty et al, 2015).

This mindset is presented in the findings with the admission of one male participant

wanting to "know my stupid body by now..." so that he is more able to "fix it myself" *(EEBC-4)*.

The goal behind this more active involvement is based on a man having the "need to keep

healthy..." so that he can "do the things I want to do" *(EEBC-6)* which will lead to a full and

meaningful life.

This valorization of health in Western society is also consistent with the masculine ideals

of competitiveness and success-driven behavior which places value on achievement. The body

thus becomes a site of status and power, as a highly sought after social identity has become one

of being 'healthy' (Farrimond, 2012). This situates men in an arena where "...social values of the

Protestant work ethic of self-control, self-denial and individual responsibility can be displayed"

(Farrimond, 2012, p.213).

Enacting this value system that is ideologically driven sets up a distinction between what

is 'healthy' and good, compared to those that are 'unhealthy', and thus less morally worthy

(Farrimond, 2012). In this way, the middle class project their notions of 'unhealthiness' onto

already stigmatized groups, such as single mothers or working-class families, as a means of

maintaining their power (Farrimond, 2012). Suddenly, being 'healthy' is presented as a duty for

all citizens to realize: to engage in protective behaviors and handle the threats to their

environment (Farrimond, 2012).

It could be argued that this newfound focus on one's body--as a site of power and

improvement--has led some men to get caught-up in the aesthetics of it, leaving some women to

believe that "with these men, I could not fall in love" *(EEBC-4)*.

**Help Seeking as Singular, Static Process (HSSP) to Help Seeking as Multiple, Dynamic**

**Process (HSMD)**

### *Traditional Trends*

Something that stood out from the findings, via a number of the participant statements,

was a narrowed, singular view towards the help-seeking process which reified a one-method

preference of assistance--typically leaning towards the formal route. This process is defined by

Lynch et al (2018) as being "...understood as an intentional action that starts with awareness,

problem recognition, and definition...Once a decision to ask for others for assistance is made,

information is disclosed to others in exchange for help (p.138).

We see here the more common conception of viewing health professionals as the only

legitimate source of help-seeking for mental health issues via one participant's assertion that "I

only believe what the doctors and nurses are telling me" *(HSSP-4)*. Along with this comes the

notion of help-seeking as a static process, which Pescosolido and Boyer (1999) refer to as the

'rational choice approach' that is based on a single decision: did one seek medical help or not (as

cited in Wenger, 2011). It is with this rationale that much of previous research for men and

health  has taken a 'ballistic approach', where individuals are regarded as missiles to be launched

into the health system as researchers determine factors influencing successful deployment

(Wenger, 2011). This somewhat depersonalized view would coincide with one participant's

desire to have a health service that functions like a car service: "take it in, fix the problem, go

home!" *(HSSP-3).*

Having a directed outlook towards help-seeking can complicate matters, as the stigmas

generated through internalized ideals of traditional masculinity can inhibit the likelihood of some

men reaching out to these practitioner-helpers. One participant attends to these aversive attitudes

by stating that his suffering and symptomatology would need to get to a point where he would be experiencing "a meltdown...to actually go see someone" *(HSSP-2)*. This touches upon how young men may experience discomfort, embarrassment, fear, and shame around asking for help (Lynch et al, 2018), as it contradicts the independent/self-reliant ideals forwarded through traditional conceptions of masculinity.

The added stigma of dependency that comes along with the notion of possibly needing medication for their symptoms also deters some men from visiting their physician, as strong associations have been made between seeking medical help and receiving prescription pills. Holding onto the ideals of presenting as strong, toughening it out, and taking responsibility for their situation, one participant stated, "I'd rather just feel how I'm supposed to feel, rather than have medication" *(HSSP-6)*. Instead, what is common among men, but particularly young men, are alternative coping mechanisms--such as alcohol, drugs, and aggressive behavior--that attempt to relieve emotional and physical pain (Lynch et al, 2018).

Peers and family can be highly influential in determining a man's course of action in reference to help-seeking behavior. For many, the ingrained belief that seeking professional help is a sign of weakness engenders fear of rejection and ridicule by their peers (Lynch et al, 2018). This was shown by one participant's shock of all the "negative responses" *(HSSP-1)* he received after disclosing sensitive information pertaining to his mental wellbeing. Ideals of stoicism and reservation can be reinforced in the house-hold, as another participant emphasized that "families don't talk" *(HSSP-5)*. This inevitably creates a negative attitude toward mental health services which promote communicating personal material (Lynch et al, 2018). The only acceptable informal means of help-seeking described by participants in Lynch et al's (2018) study were either through alcohol-induced pep-talks or finding "self-betterment...through God." *(HSSP-5)*.

For some female partners, the stresses that come with being in a caregiver role, of "being supportive, hearing and validating..." for men experiencing prolonged signs of distress, can lead to encouraging a more direct formal route of help-seeking--ie. "maybe I'm not the person you should be talking to about this" *(HSSP-7)*.

### *Emerging Trends*

What can also be found in the research is a more multifaceted, complex understanding of help-seeking for some of the male participants which signifies a dynamic process that evolves over time. This process seems to suggest a much more nuanced account of conscious considerations and decision making for men that goes beyond the rational choice approach suggested previously by researchers.

In fact, these men are utilizing their traditional masculine ideals of rational problem-solving towards body awareness and self-monitoring behaviors for the purposes of maintaining physical and emotional well-being. An example of this can be found with one male participant who recognized the need "to be aware that you've got a problem...", which can only come with a growing capacity to connect with and be concerned over one's emotional and bodily experiences, while also acknowledging the viability in seeking help, "or find somebody who knows more about it than you do" *(HSMD-2)* when unable to 'solve the problem' on one's own.

This statement endorses what Wenger (2011) describes as a dynamic approach to help-seeking, which is "an ongoing, interactive process of decision making" (p.491). This perspective is informed by sociological inquiry into illness which recognizes that individuals interpret symptoms within a powerful sociocultural context (Wenger, 2011). It is argued that this approach addresses some of the key limitations of the rational choice approach, which is 1) conceptualizing help-seeking as an either/or decision, 2) a limited synthesis of deep

understandings (ie.meanings, processes, and practices), and 3) a lack of awareness around the

impact that health problems have on one's life (Wenger, 2011).

By attending to the complexity of signs and challenges of illness, the question no longer

becomes relegated to fixating on masculinity as a determinant of whether men view help seeking

as a viable option, but expands as to *how* men are negotiating with a diversity of needs and

supports across illness (Wenger, 2011). Instead of being actively resistant or disagreeable

towards formal help, some men may feel comforted "to know that the [health] system is there"

*(HSMD-4)*, but feel compelled to go only if experiencing serious problems due to concerns of not

wanting to "take advantage" of it. This reveals help seeking as having multiple decision points,

with each point including a range of factors that can either accelerate or regress progress

(Rickwood, Mazzer, & Telford, 2015).

What also emerged from the findings is the notion that help-seeking can take on a variety

of appearances. This can express itself via a discussion about a problem or a specific request for

support in a number of settings (Wenger, 2011). For one participant, the convenience of having

his "GP, psychologist and physio all in one place" *(HSMD-1)* points towards a growing awareness

and preference towards having multiple sources of support.

This can also translate to men going beyond the traditional treatments of medication and

therapy to the more informal means of social support for coping strategies (Hoy, 2012). This

information is not entirely new, as Rickwood et al (2015) acknowledge the longstanding

understanding of the role family and friends have in help-seeking for mental health problems,

and how informal support is the preference for young people. This is important to note, as family

is considered to be a stronger influence for males than females for all age groups, which could be

significant towards the larger mental health treatment gap evident for males (Rickwood et al, 2015).

It seems that, above all else, there is a growing desire among men to connect with others during these periods of distress. As Lynch et al (2018) found among their participants, whether it was speaking with a stranger or someone familiar, a group or one-on-one, there was a common understanding of knowing that someone cared about you as being a priority; to "need someone who can talk to...[where] you can let it out" *(HSMD-3)*.

In order to be able to receive care from others, a degree of trust needs to be established between the men experiencing signs of distress and those in helper positions. And what precludes trust is requiring a felt-sense of safety--especially when considering disclosing sensitive personal information, which would most often times be considered a foreign and potentially identity-threatening concept among men. This is why Lynch et al (2018) found that one of the things that their young male participants suggested was an enabling factor for opening up about their problems was in having an environment that provided "...some choice, control, and where there are equal power relations" (p.144).

One such example of a supportive informal environment could be through community youth work settings. Given the notion that men have a greater need for confidentiality, which coincides with elements of control, young men could feel more comfortable talking with professional youth workers as the relationship entails 'chum-like' qualities that extends outside of their problems (Lynch, Long et al, 2018). Galdas et al (2014) would agree, insisting that granting men some control over their level of involvement in interventions (ie.physical activity or discussion-based support) can also improve acceptability.

Another means of informal support which has been gaining attention is the rapid

proliferation of web-based health information and interactive sites (Wenger, 2011). This mode

also aids in negotiating men's desire for control, as participants are able to adjust the level of

their involvement when engaging in online forums. These online users can choose to 'lurk'

rather than post, which gives men the ability to feel out the process, learn the rules, and gain a

sense of confidence before eventually deciding to open-up to others (Galdas et al, 2014). What

we are finding here are a number of creative solutions for men, with the idea that if you "provide

the right conditions and then provide the right key information...they'll reach for the help and the

support) *(HSMD-5)*.

When we open up the concept of help seeking as a subjective, interactive process "guided

by a variety of approaches and strategies that lead to a range of short-and-long term outcomes

over the course of an illness experience" (Wenger, 2011, p.488), methods that before have been

considered to be avoidant behaviors can now hold a place of legitimacy. The term 'negotiating'

seems the most poignant descriptor in this regard, as men acknowledged the need to consider

alternative options throughout the course of their symptom progression when perceived to be

necessary.

A big influential factor for some was the mediation of their female partners in instigating

seeking help. Examples of this can be found with one male participant insisting that some health

decisions be made by the support base to make sure "things at least get on..to be dealt with"

*(HSMD-6)*, suggesting a compliant attitude regarding help-seeking behavior. This interaction

dynamic is consistent with findings presented by Karabenick and Newman (2006) of a lesser

known help-seeking strategy men can use which includes "the act of relying on others to do what

one does not want to do himself (as cited in Wenger, 2011, p.494). Another male participant,

while presenting as liking to "figure things out" for himself, also forwarded a sense of collaboration with his wife that could lead to future help-seeking behavior by insisting that "if she (wife) thinks I'm not doing the right thing, she'll certainly let me know!" *(HSMD-7)*.

While indirect methods have been associated with unsupportive responses from prospective health providers, (Wenger, 2011), other sources cite informal help as a first step that can lead to professional services down the road (Rickwood et al, 2015). Even for those who may present as being adverse to "relying on other people", there also was a recognition that, due to the context and nature of the illness, "...sometimes you have to" *(HSMD-8)*. Weighing the pros and cons of the situation, one participant describes what arguably could be the 'male predicament' for many men in seeking help by saying "I had nothing to lose at this point, but I had plenty to lose if I didn't" *(HSMD-9)*.

**Masculinity as Fixed, Universal Identity (MFU) to Masculinity as Fluid, Multiple Identities (MFM)**

### *Traditional Trends*

Amidst the studies and newspaper articles one can find language that suggests a governing philosophy of masculinity as being a fixed, singular entity that is more-or-less consistent across North America. As Mejia (2005) asserts, this comes with the assumption that "men are synonymous with masculinity, and masculinity is somehow an intrinsic property of maleness. As one participant affirms, "You can't change it [masculinity]. It's not possible" *(MFU-7)*.

Tied-in to this unified notion of masculinity are characteristics of power, resource, and authority (Oliffe et al, 2017). This description would fit the hegemonic model of masculinity, which is what Farrimond (2012) assigned towards the dominant view of masculinity that is

considered acceptable within a patriarchal culture--ie. what it means to be a 'real' man. Having this single-minded view towards masculinity, and therefore, one's identity, seems to create an internal conflict for some men, as it suggests that "there's only one way to be, and if we don't feel that way, we should be ashamed" *(MFU-1)*, leading to avoidance of help-seeking for fears of "finding out that you're not normal *(MFU-2)*.

This touches upon the struggles that many men go through who are unable to reproduce the dominant masculine ideals--of being stoic, tough, and neglecting self-care. It is believed that this struggle starts with early socialization experiences where boys are made to feel shameful for their more vulnerable feelings, such as weakness, fear, and despair (Mejia, 2005).

Other men have an additional threat to manage with regards to their sexuality. Although sexuality is considered to be a normal component of human development, subtle or not-so-subtle societal messages and traumatic experiences can disrupt young men's sexual development (Mahalik et al, 2003). One such example would be how a participant who was on a religious retreat found the staff talking "about homosexuality like it is a mental illness" *(MFU-3)*. This dualistic way of viewing the world creates an implicit distinction that to be traditionally masculine means to avoid any features connected to femininity or homosexuality (Mahalik et al, 2003). It is through these discriminatory practices that it is understandable why one participant, David Pickering, would state "Hating ourselves is social conditioning" *(MFU-1)*.

Recently there has been a lot of attention given to gender role socialization, with particular scrutiny towards traditional masculinity as being 'toxic' via the #MeToo movement. This has subsequently led a number of figures in the media to voice strong concerns, with statements made by male participants here purporting that "the masculine spirit is under assault" *(MFU-4)*, and to get your hands off my...gender" *(MFU-5)*. This attends to how gender politics is

deeply ingrained in the fabric of society (Mejia, 2005), and the desire for men such as this to be

complicit, or keep the status quo when it comes to upholding traditional Western social practices

(Oliffe et al, 2007).

      While one journalist participant concedes that "experimentation...has torn down weary

stereotypes" when it comes to men wanting to remake themselves on more feminine principles,

this is also followed up with the notion that "men now run the risk of obscuring the meaning of

male altogether" *(MFU-7)*. This idea gets taken further, as Jordan Peterson surmises that "if you

change those basic categories, people wouldn't be human anymore. They'd be something else

*(MFU-6).*

### *Emerging Trends*

      Upon gathering extensive literature, from a range of difference sources (ie.academic

studies, online segments and newspaper articles), there also seems to be a growing consensus

among men for the desire of an expanded conception of masculinity. This desire comes with the

recognition of men's previous denial of "the effects of patriarchy for centuries" *(MFM-1)*, and

how it can no longer be ignored. Yet it also appears crucial among these men that this

development needs to be done "without losing our masculinity" *(MFM-2)* while they make "room

for the many different ways to be a boy or man" *(MFM-3)*. This corroborates with Courtenay and

Keeling's (2000) belief that "redefining masculinity does not, then, require discarding everything

we think of as manly" (p.246)

      In fact, as Mahalik et al (2003) insist, there are a number of masculine ideologies which

have been associated with positive functioning, such as having strengths in areas of problem

solving, logical thinking, appropriate risk taking, and assertive behavior. These culturally based

scripts can be quite important to the personality composition for men, and are proposed to be

adaptive if flexibly enacted (Mahalik et al, 2003). An example of this adaptive enactment can be

found by Fogerty et al (2015), where men demonstrate their capacity for problem solving with the ability to take a new perspective, leading to a change in how problems are interpreted. Mahalik et al (2003) also attend to the diversity of experiences, and thereby 'strengths', by stating that "some scripts may be important for some men but not for others" (p.124).

This recognition of diversity is critical, as participants caution against the "notion that group identity is the defining characteristic of a person" and to "treat people as individuals" *(MFM-4)*. Not doing so, and lumping "all men and patriarchy in together", will only lead to "a sense of shame that they will never escape from" *(MFM-1)*.

The very purpose of talking about 'toxic masculinity', as forwarded by the founder of '*the Good Men Project*', is "not about vilifying boys, men or any of the particular qualities society has deemed 'masculine'. Rather, it is an opportunity to reconstruct a more positive model of masculinity" *(MFM-3)*. This reconstruction will therein instruct what it means to be "a man", and how he's encouraged to act in the world (Real, Sept/Oct 2017). In a practical way, this is "a reimagining of what men should be expected to do" *(MFM-5)* that stresses receptivity over action. How author and speaker Terry Real (Sept/Oct 2017) suggests this could look like in relationship is "being curious about your wife, learning to be quiet and leave space for her, drawing her out, truly negotiating." (p.40).

Much of the discussion found in the findings has suggested, rather than a fixed identity, conceptions of masculinity are continually being negotiated and changing through the lived process of interaction. Examples of this in the findings can be found in the household, where the traditional notion of the man being the breadwinner was "the opposite of what I hope for" *(MFM-6)* for the wife of a male participant, with another journalist participant encouraging a broadened definition of masculinity to include "both Mr.T and Mr.Mom" *(MFM-5)*.

de Boisem and Hearn (2017) cite a list of social research which indicates that men not

only have an active understanding of their emotional lives, but even appear to practice a 'more

emotional' form of masculinity than formerly documented or assumed.

This train of reasoning would be in alignment with a constructionist perspective, which

regards emotions as forming from discursive arrangements of power via linguistic and cultural

differences (de Boisem & Hearn, 2017). A critical distinction made by the authors here is that

this framework does not portray men's emotions, or men's discussion of emotions, as 'new' or

contradictory to masculinity/ies. This is significant, as it rejects the 'softening masculinity'

theory which proposes men's increasing capacity to express themselves emotionally as

fundamentally redefining masculinity.

Overall, there appears to be a strong push towards practicing a more "healthy

masculinity...that is no better or worse than femininity" *(MFM-7)*; that recognizes that "humans

vary along a multitude of dimensions" *(MFM-4)*; and allows "individuals [men] to feel secure in

their masculine identity" *(MFM-3)*.

# Chapter 5: Discussion

## Summary

Help-seeking has been considered to be an integral component in addressing mental health issues, as it requires recognizing a problem, interpreting symptoms, and navigating services to act in a supportive function. Frequently associated with help-seeking is disclosure, which requires the afflicted individual to provide personal information as a means of enlisting support.

This last part is significant to this paper, as studies have indicated that men typically have a weaker tendency in utilizing formal mental health care services, and a perceived contributor to this is a general unwillingness for emotion-talk (Lynch et al, 2018; Mejia, 2005; Rochlen & Hoyer, 2005). Much research has linked this proclivity towards stoicism in men as part of the collective ideals of traditional/hegemonic masculinity, brought about through early and ongoing socialization experiences, which has been forwarded as a determinant for aversive help-seeking behavior (Courtney, 2000; New, 2001; Mahalik et al, 2003; Addis & Cohane, 2005; O'brien et al, 2005).

While these gender-studies provide a much needed spotlight on men's health, in which many have suggested to be in a state of crisis, the findings from this somewhat narrowed focus (ie.characterizing men as a group-identity) has cast essentializing assumptions that equate masculinity with attributions of deficiency. The roles and ideals of men in postindustrial Western societies seem to be in question, as traditional masculinity has received much critical attention in the public eye due to the #MeToo movement and subsequent discourses around toxic masculinity. Highlighted in the discussion are the harmful effects--to men, women, and society-- that proceed as a result of subscribing to tenets of hegemonic masculinity.

Considering the gravitas of our current societal situation, as well as the ascribed importance of help-seeking behavior in remediating these detrimental living conditions, it seemed necessary to further explore the relationship between current conceptions of masculinity and help-seeking behaviors in men.

This thesis sought to open up the lens of inquiry by incorporating a social constructionist framework research method which is able to attend to the diversity of male experiences. This would enable us to discover not only if but *how* men are navigating help-seeking over time. Another area of interest related to this was also how others interpret their help-seeking behavior through *their* internalized conceptions of masculinity.

I anticipated that there would be a number of attributes associated with traditional masculinity that deter males from seeking help (ie.no space for vulnerability; stoicism and rationality over emotional expression; independent, competitive and success-driven; ignore bodies and health concerns; engage in risk-taking behavior)

I also anticipated that society is going through a transition time where these traditional gender roles are being questioned and negotiated, leading to hybrid forms of help-seeking that may not be recognized by formal health-care providers

My guiding assumption was that there are present gaps in knowledge and/or mixed responses towards when and how men are seeking help, which could be narrowing the visibility and viability of a range of support for men experiencing symptoms of distress.

The results of the research proved to be quite compelling, as indeed there was a vast range of experiences and attitudes pertaining to help-seeking among men. It appeared that a strong underpinning which guided these behaviors was coming from internalized masculine ideals--with a conscious awareness of evaluating their behaviors within the context of what it

means to be 'a man'. However, how this interactional dynamic presented itself could be described in two categories: traditional trends and emerging trends.

For the traditional trend category, the masculine roles regarding help-seeking was represented by: 'independent and avoidant', 'strong and dismissive', 'non-emotional and body estranged', 'help-seeking as singular, static process', and 'masculinity as fixed, universal identity'. What was found here were attitudes of stoicism, self-reliance, and perseverance, whereby help-seeking (and particularly emotional disclosure) was highly stigmatized and regarded as a last-resort option. And if they did finally 'break down' and seek help, it would typically be the formal route--of seeing a physician--to which there were mixed feelings towards actual helpfulness.

Body awareness in this group was stated to be at a minimum, as well as emotional competency for men when it came to attempting to describe 'the personal'. Overall there seemed to be a fixed conception of masculinity that promoted "one way to be", which was either a great source of pride or shame for individuals, depending on if their self-image fit the imagined criteria.

The emerging trend category for masculine roles regarding help-seeking was represented by: 'collaborative and engaged', 'brave and inquisitive', 'emotionally expressive and body conscious', 'help-seeking as multiple, dynamic process', and 'masculinity as fluid, multiple identities'. Here what was found was a population of men who seemed to be going against their traditional conditioning of 'masculine behaviors' in favour of a more interactive, ongoing process that enlisted the help of others and encouraged disclosing personal material. However, upon further exploration, it could be said that what is being promoted in not an alternative, or 'new' narrative but a reconceptualization of the dominant discourse.

The traditional ideal of 'being strong', which previously was associated with independence and 'toughening it out'--leading to symptom dismissal--suddenly becomes recast as 'being brave', which relates to a strength-in-vulnerability position of speaking up and asking for help regarding health concerns. Elements of courage are attributed to this act, as it encourages a man to go beyond his comfort zones, or outside his cultural molding, into an unfamiliar interactional territory. This 'going against the grain' attitude can be perceived as leadership qualities which align with traditional masculine ideals of competitiveness (ie.leader of the pack), independence and taking responsibility--for oneself, for family and friends, and for society.

It could be argued that these same ideals mentioned earlier is what is driving much of the growing awareness around bodily concerns and self-monitoring practices--as an attempt in upholding their sense of leadership by maintaining their active duties as a responsible man, parent, and citizen. Also highlighted as a motive among some of the more mature participants was the desire for enhancing not only the length but the quality of their lives as their age progresses. And quality to these men entailed maintaining notions of independence which included activities and practices that would typically go beyond the scope of acceptability for younger demographics.

For the emerging trend group, conceptions of help-seeking went beyond the one-stop shop of medical care, which included a number of means of informal support, such as family, spouse/partner, peer group mediation, community youth workers, and online mental health forums. Going to a trained therapist was another legitimate source of formal support. The time-line and progression of seeking and obtaining these forms of help was not consistent, as these men seemed to be negotiating a range of needs, unique to each person, that evolved over the

course of their illness/symptoms. A common theme was the desire for more information relevant to their condition so as to become an 'expert' in their illness and become equal to their attending health professional.

This group was able to conceive of a broader definition of masculinity, which seems to include multiple ways of being 'a man' while remaining true to core conceptions of 'manhood'. There was a recognition of the damaging effects of patriarchy, but also that the range of practices attributed to the oppression of women varied among men and should not be cast as a group-identity. This personalized identity formation is described as a fluid experience that is upheld and contested through ongoing interaction.

## Implications

The implications of these findings are far reaching, as they reveal the everyday practices and attitudes among men which highlight the personal and inform the political; information which could prove to be quite useful for counsellors, policy makers, and citizens to have in order to better understanding and offer support for this community.

It appears that there is a growing population of men who are experiencing mental health issues, yet there are obstacles among those affected which inhibit discussion around these concerns. What results is that many suffer in silence, feeling confused, isolated, and dejected, with worries of being a burden on others/health system.

These deeper, more vulnerable feelings can feel too confronting, as they go against their internalized ideals of needing to present as strong, independent, stoic, and invincible--forwarded by traditional conceptions of masculinity. Therefore, an exaggerated position of bravado and indifference towards one's symptoms can emerge as an attempt in convincing others, and themselves, that they are ok, thereby preserving their self and public image.

However, when these men do reach out, they are oftentimes surprised that they are not alone in their experiences. This active engagement can lead to strengthened connections of mutuality among men and a renewed sense of purpose in sharing information and being part of 'a team'.

Evidence from the findings also suggests that not all coping strategies for men are harmful. While there were a number of statements among the men that supported the more common-place maladaptive strategies--such as alcohol, drugs, and video-games--as a sedative from experiencing pain, there were also signs which suggested incorporating mindfulness and body-oriented practices, geared towards self-monitoring and surveillance, as a way of proactive management and emotional competency building. This offers an expanded viability of self-help strategies compared to previous research.

What also deserves special attention is the importance women have in shaping men's help seeking behavior. Consistent with past findings, the wife or girlfriend of men experiencing symptoms of distress were instrumental in either initiating or bolstering utilization of formal health services, while also providing a supportive role in the household by acting as a confidante and caregiver. That being said, some women seemed to have had more challenges in maintaining an empathic position than others, due to multiple factors which include caregiver stress and trading places in gender roles.

This last point is significant, as it touches upon an interesting avenue which has not received much attention pertaining to the extent of women's involvement in maintaining the status-quo of patriarchy. Much talk has emerged around men's influence in upholding the traditional ideals through shame-based practices of 'policing' masculinity, however little discussion is made towards the subtle or not-so subtle feedback offered by women in everyday

interactions which can act to guide men's outlier behavior back into the fold of typical stereotypes.

How this can present itself is through mixed messaging of interests, whereby a woman will vocalize her desire for a more attentive, emotionally responsive partner, yet reveals varying levels of discomfort when their man 'breaks down' in front of them. Another example, forwarded by women, that could deter help-seeking behavior could be found in minimizing symptoms through a familiar reference to 'Man-colds', suggesting an embellishment or over-exaggeration of levels of distress. Both can reinforce in men the 'Man up' philosophy of internalizing over disclosure so as not to jeopardize their personal identity and identity-in-relationship.

The age factor was another interesting variable in the findings to consider, as there was an equal balance of older and younger male participants in each category (traditional and emerging).  This suggests an overlapping of attitudes, or intergenerational continuity, whereby a sizable number of the younger generation are adopting and replicating the values of their predecessors. That being said, one can also surmise from a number of participant statements aligning with the emerging trend that there is a portion of the older generations who are active in promoting a more engaged and acceptable outlook towards help-seeking behavior. This is significant, as it reveals that the proponents of influence which either lead to further reinforcement or change spans across the ages, and that perhaps we are amidst a transition time in gender roles regarding help seeking in Western society.

A compelling part of this development would be the expanded space for emotions in men's lives that go beyond the limited range enforced through patriarchal practices. While originally felt to be uncomfortable or difficult by some of the men in the emerging trend,

perseverance and ongoing commitment enabled them to challenge previous expectations and learn healthy models of emotional expression.

An underlying theme promoted in these discussions concerning conceptions of masculinity and help seeking behavior came back to personalized valuations of maturity--ie.taking responsibility, 'growing up', and what it is to be a 'real man'. And yet, it seems that the majority of academic attention surrounding maturity tends to remain on early adulthood-to-later working life, while neglecting the more mature male community. This is significant, as we may be receiving an incomplete value system that advances the voice of the 'young', and therein missing out on valuable insights acquired from our older male population.

### Recommendations for Counsellors

The application of these findings for counsellors is extensive, which is why it felt necessary to categorize the suggestions into three stages: (1) Pre-Therapy, (2) Onset of Therapy, and (3) Therapy Over Time. A brief overview of these categories is defined below:

The Pre-Therapy stage essentially covers the promotion of services, geared towards attracting male clientele. This includes i) Making it Relatable, ii) Offering More Online Materials, and iii) Offering Local Presentations/Open-door Discussions.

The Onset of Therapy stage focuses on the initial phase of counselling, with regards to variables that factor into the therapeutic relationship and creating a space of relative safety for men. This includes: i) Gender Matters!, ii) Describing the Process, iii) Challenging Presentations, and iv) Becoming an Ally.

The Therapy Over Time stage highlights possible areas to address and be aware of as the counselling progresses with male clients. Included here would be: i) Collaborative Work, ii)

Social Learning Education, iii) Attending to Loss/What is Not Present, iv) Becoming Aware of

Biases, v) Group Work, vi) Enlisting Support, and vii) Therapist as Role-Model.

**Pre-Therapy Stage**

**i)       Making it Relatable**

It seems that a primary consideration with regards to engaging more men in seeking

formal mental health services is by making the language and delivery of services more relatable

to this population. This requires incorporating 'everyday' language that is understandable to

men, as opposed to relying too heavily on medicalized terms which can lead to confusion and a

felt sense of inadequacy. Highlighting the 'problem', including a list of symptoms of distress, as

well as the possible outcomes of therapy, which include goals congruent with men's values,

creates a 'why' one would go to therapy, thereby legitimizing help-seeking behavior.

**ii)      Offering More Online Materials**

Consistent with the emerging trend in help seeking behavior, it seems that men place a

high value on acquiring information pertaining to their conditions as an active means of

addressing their symptoms and in creating more informed decision-making. Therefore, it could

prove useful in providing a range of online materials on one's counselling website, such as

relevant academic studies, newspaper articles, and multimedia videos, which cover critical areas

of known concern for men.

Given the recognized knowledge gap around therapy for men, these materials could also

outline the basics of therapy, including the setting (ie.therapy room), what therapy entails, and

what it is not (ie.addressing some of the myths or erroneous conceptions of psychotherapy),

offering a list of referrals to other health-care professionals for issues outside of one's scope of

practice. An increased understanding of the nature and environment surrounding therapy can set

some of the men's internalized stigmas around counselling at ease, while instilling a sense of

confidence through been filled-in on part of the working process--fulfilling the desire for

knowlege-as-balancing power with their health practitioner.

Recognizing the role therapists play as social agents of change, the website could include

materials that highlight the socialization process and gender role formation, including traditional

conceptions of masculinity and how this impacts our daily lives (ie.attitudes to help-seeking

behaviors), and ways in which these practices are being contested and negotiated already in

western society--providing possible role-models while also normalizing a diversity of

values/experiences.

**iii)       Offering Local Presentations/Open-door Discussions**

Working from the therapist-as-social agents of change premise, another way counsellors

can actively work towards engaging men in mental health services is by getting involved in their

local communities. This can be done through offering presentations and open-door discussion

groups tailored towards addressing current conceptions of masculinities, how this impacts men,

women, and society, and what can be done--both individually and as a community--to promote a

more aware, gender-conscious attitude that breeds healthy interactions.

**Onset of Therapy**

**i)       Gender Matters!**

An important factor to consider at the beginning of therapy is that, even before the

counsellor goes over their therapeutic approach or demonstrates their level of attunement with

the client, it may be their gender which will orient the client to the nature of the therapeutic

relationship and determine the level and direction of disclosure. A male therapist will provide a

different experience than a female therapist, based on the male client's socialization and personal

history. It can be helpful in remembering this point, and perhaps voice the possible interactional dynamic (ie.man-to-man or woman-to-man interplay) if deemed to be an enabling or limiting factor to the developing working-relationship.

**ii)      Describing the Process**

It seems that for many male clients the decision to start therapy had come after years of experiencing symptoms of distress. This could be coming from a desire to conceal their symptoms and attempt to 'fix' their problems on their own, regarding going to counselling as a 'last resort' option. As a result of their delayed help-seeking, these men may be coming to the counselling room with a heightened sense of urgency and impatience in alleviating their presenting issues. On top of this, apparent gaps of knowledge around therapy and the role of the therapist may be creating a perception of a medicalized model of assistance, whereby the client tells their story and the therapist-as-expert will diagnosis their problem and offer them solutions. Both of these factors may be creating unrealistic expectations which leads to future frustrations, disappointments, and early drop-outs among male clients.

Therefore, it could be helpful in also providing some education around the counselling process, while answering any questions they may have, so as to promote more feasible goals that a man can get on-board with. This will require some flexibility on the therapist's part towards their approach, as an emphasis on emotion-work early on may scare off a portion of the male-clientele. That being said, one could assume a certain level of exposure to this subject-material if there is sufficient information on emerging trends around expanded space for emotionality in men found on the therapist's profile and website, thereby creating a soft-entry opportunity for discussion in working on this (emotional) level.

**iii)     Challenging Presentations**

This last point on retaining client interest is significant, as it attends to a challenge that many therapists have voiced concerning the perceived resistance in men to undergoing therapy. Markers that have been used to support this have been in statements that suggest coming to therapy was against their will, such as: "I don't know why I'm here", "My wife suggested I come", and "I don't really believe in this talking-it-out stuff", as well as feedback that have indicated a strong aversion to connecting with emotions: .ie."I don't *feel* anything", "I don't *do* emotions", and "Emotions are for girls and sissies".

While this can certainly be discouraging for a therapist to hear, it may also be helpful to remember the impact early and continued socialization experiences have on men, and that their behavior could be presentations of what they have internalized as how they *ought* to behave as opposed to what they may be authentically feeling. Their seeming emotional void may be shaped by the narrow confines of what emotions are regarded as legitimate for men within a patriarchal system. Coming from this lens, a deeper understanding of the processes involved around cultural conditioning and identity formation can facilitate a new way of relating with the behavior that promotes curiosity and openness over the tendency of ascribing a fixed character-assignment arising from a position of knowing.

**iv)     Becoming an Ally**

Due to the implications of cultural conditioning and varying degrees of subscribing to traditional gender roles, men may be experiencing both internal and external doubt towards the legitimacy of their symptoms, leading to feelings of confusion, shame, and avoidance behaviors. It may also lead to and increased propensity towards self-help strategies as a means of addressing the concerning issues so as to 'save face' and keep the peace in the relationship. This is why the role of the therapist-as-ally can be enormously helpful for male clients--validating their

experience as well as efforts in self-care practices. This can encourage a felt sense of safety for the client, as not only their struggles but their attempts in addressing them are being witnessed and recognized as credible.

**Therapy Over Time**

**i)        Collaborative Work**

The more active involvement in help-seeking found in an increasing population of men has been attributed to a fairly new role of the 'expert' client promoted in preventative medicine and a number of post-modern psychology theories. The concept of this approach suggests a balancing in the power dynamic between health practitioner and client, as the 'expert in their lived experiences (the client) teams up with the expert in their field (the practitioner-helper) so as to form a work-based partnership tasked with facilitating meaningful change in the client's life.

How this looks in the course of therapy-work is for the counsellor to come from a position of 'not-knowing' when relating with the client; learning *from* the client just as much as he or she is learning about the client. This translates to a much more conversational feel to the sessions, whereby the therapist is adopting the client's language and framework for understanding the world. The intention behind this is being able to offer informed questions meant to spur further reflection and insights in the client that get more poignant as time and their relationship progresses and evolves.

**ii)      Social Learning Imprinting**

Associated with attending to language in therapy sessions is uncovering the main narratives which organize the client's rationale for behaviors, from both past and present, to fit a coherent sense of self. This social learning/social constructionist view towards identity formation enables clients in therapy to examine the lens from which they relate to life through a gender-

entrenched world and identify the relevant gender scripts they may be subscribing to (Addis & Cohane, 2005). Included in these efforts would be asking the clients questions such as: "What does it mean to be a man/husband/father?" and "What does it mean to be in a healthy relationship?", which could be applicable for both individual and couples work.

This enables the client an opportunity to recognize the impacts of growing up in a social environment governed by patriarchy, bringing to light the adoption of values and beliefs that may have been unconsciously acquired as a result of subtle conditioning. The goal behind this being that the growing awareness around this cultural imprinting creates more space going forward to create more conscious choices in how to act and be.

**iii)      Attending to Loss/What is Not Present**

An interesting intersection to consider tied-in to the presenting reluctance to therapy treatment in men is around the perceived attachment avoidance towards the therapist and fears of intimacy as being a result of early childhood experiences (Mahalik et al, 2003). The early separation from their caregivers, encouraged by societal ideals that promote independence in young boys, can be felt as quite traumatic, leaving an imprint of distrust towards people in positions of care. Therefore, men's ambivalent attitude in sessions may be an enactment of old emotional wounds where a primal connection had been severed. Considering the role women have traditionally had as primary attachment figures to their children, female therapists may experience heightened projections from male clients which can act as barriers to the therapeutic relationship if not properly attended to.

**iv)      Becoming Aware of Biases**

While it is important to recognize the multiple socio-cultural considerations that may be influencing a male client's behavior, it is also necessary for therapists to appreciate that they too

have undergone the same socialization process which will undoubtedly have an effect on how they interpret and respond to this population. This is where personal introspection and collaborating with other therapists (including ongoing therapeutic work as a client themselves) can be critical in gaining a better perspective of the ideals, beliefs, and values one has so as to become more mindful of when they may be getting projected onto the client.

Included in this would be the therapist's own conceptions of what it means to be "a man/woman/in a healthy relationship", as well as evaluating the degree of heteronormative ideologies one may be holding onto as a result of their upbringing. Another key discussion point regarding the therapy-room would be on the therapist's assumptions as to what qualifies as a legitimate emotion--are they assigned from primarily 'feminine' conceptions of expression or is there space for a more unconventional repertoire that connote signals of feeling?

How willing are we, as therapists, to listen and work with what *is* as opposed to attending to a fantasy of what we would *like* these men to be?

**v)      Group Work**

Aside from working with clients individually, it could be helpful to include men's groups as an elective part of therapy treatment. This option comes from feedback which suggests men's preference for the possibility of mutuality and reciprocation in a therapeutic setting. Having a bunch of men come together to listen and/or share their experiences can be an effective way in normalizing what they are going through, as well as instilling connections on a level that they may not find themselves able to do elsewhere. Group-therapy could be done in tandem with individual work, as well as a stand-alone option for those still uncomfortable with one-on-one counselling or those who have undergone counselling in the past but are wanting a refresher and/or an opportunity to contribute their knowledge with fellow men-in-need.

**vi)**        **Enlisting Support**

Therapy is tough. And the time spent together between therapist and client is only a sliver of the client's daily schedule. Which is why it becomes imperative in connecting these men with resources that they can use outside of the counselling room. This could include inquiring about their support system--who do they go to when they are struggling, how often, and how does that look like.

Considering the internalized stigmas that many men still hold around help-seeking, a certain mindfulness is necessary when delivering these questions, requiring the therapist to tune-in with each client to determine the specific wording around this. Examples that could be used for men who may seem to have their identity syntonic with traditional masculine values would be: "Who do you feel 'has your back' in challenging times", "Who do you consult with when you need a second opinion", or "Who's your go-to when you feel stressed out and need to unwind?"

It could also be helpful in asking the client about the internal resources that they have already developed in the past which they found useful. Doing so validates the man's self-help strategies, and thereby acknowledging his desire for independence. And as they discuss these together, possibly refashioning it to fit the male client's present concerns, suddenly these self-help strategies become a collaborative undertaking.

As the treatment progresses, it might prove useful for some men in having their partner and/or family members to join them. This could provide another perspective from those persons closest to the male client, while also creating opportunities to explore the interactional cycles between them and create a dialogue around dynamics that stood out for them.

**vii)**        **Therapist as Role-Model**

A point that many studies have made is that the strongest determiner towards the efficacy of therapy is the therapeutic relationship between the therapist and their client. Factors that have been associated with this is the degree of presence, relatability, attunement, and competency that a therapist demonstrates on a continual basis with the client. Why this becomes so important is because what this translates to is the unspoken contribution of the therapist as a role-model for male clients.

For male therapists working with men, there will be a certain degree of observing and modeling behavior by male clients as they are reconstructing parts of their identity and looking for examples to fashion from and emulate.

Another significant part of therapy is offering a corrective emotional experience, which male therapists can provide through male-to-male interactions that offer a level of intimacy and safety that perhaps the client has never experienced before. Depending on the age of the therapist and client, projections of father and peer figures can be enacted and engaged with successfully.

For female therapists working with men, there may be another kind of modeling going on for the client in which they recognize qualities in the therapist--as a woman--in which they wish to seek for and encourage in either their current or potential partner.

Female therapists may also offer a corrective emotional experience in either the form of working with mother-attachment projections, as well as in peer interactions in which the man feels inadequate or uncertain of how to relate with women. This seems to be especially relevant given the current aftermath of the recent #MeToo movement and discourses around toxic masculinity.

**Areas for Future Research**

The analysis of the findings suggests that research can benefit from attending to a more nuanced account of women's role in shaping men's help-seeking behavior. This could include the role of female partners as being an enabling factor, where men may gravitate to partners to validate their presenting concerns (Wenger, 2011), as well as being a possible barrier through 'policing masculinity' practices that occur when presented with men showing more vulnerable emotions. An interesting intersection to explore further would be the growing trend towards trading-places in gender roles of heterosexual relationships, and how this is impacting individual health and overall relationship satisfaction.

What also becomes painfully apparent is the lack of literature on men's help seeking behaviors within the queer community. Among the topics to be considered would be towards gay couples and the role of the afflicted individual's partner--what is perceived to be supportive, and to what extent is this happening? Another would be on transgender men and their attitude towards help-seeking.

More research could attend to the degree of influence one's gender has, in either a researcher or therapeutic setting, in shaping the disclosure of male participants/clients. And if so, in what ways? This line of inquiry comes from Farrimond's (2012) assertion that "talking about health with researchers constitutes a performance of health in its own right" (p.233), and that several of the men in their study found it easier talking with a woman about their health.

This also attends to another research topic which requires more attention: exploring how services are conceptualized and delivered (Hoy, 2012). Do health-practitioners have a different attitude and approach when working with men as opposed to women. And if so, why, and in

what ways? Added attention could go towards studies that focus on effective self-care strategies

for men, which traditionally have been dismissed and labeled as maladaptive means of coping.

Much of the past research demographic has targeted the working-class males, which has

the potential in overgeneralization their results to the entire male population. It could be useful in

providing more research that examines the relationship between conceptions of masculinity and

help-seeking in pre-adolescent males. An example of this could be a longitudinal study that

observes the evolution of pre-adolescent's attitudes to help-seeking over time. More research that

covers older males' experiences and views towards help-seeking could be enlightening,

especially in relation to conceptions of male maturity.

A final consideration might be in exploring people's views towards the extent (if any) of

change in traditional masculine norms, and at what time this development might have originated.

This could reveal the perceived rate and extent of gender role transitioning, possibly suggesting a

turn-over pattern of dominant societal ideals, as well as point to indicators of influential factors

that could be contributing to this development.

## Final Thoughts

I feel it necessary at this time to present a little information about myself, the author, so

as to inform the reader of my personal views which shapes the way I see the world, and

consequently, interpret the information being examined. I do so, in alignment with Noblit and

Hare's (1988) contention that "...researchers undertaking meta-ethnographic interpretation

should make their theoretical frameworks and biases explicit to situate themselves in relation to

the research area" (as cited in Hoy, 2012, p.204). This is undertaken with the recognition, held

implicitly within social constructivist research, that bias in social science research cannot be

eliminated. What distinguishes high quality qualitative research from conjecture, therefore,

entails the conscious unpacking of one's biases, preoccupations, and worldview being revealed

to the reader (Hoy, 2012).

A primary consideration towards the relevancy of this paper is that I am a man. My

personal history and experiences of being socialized in a patriarchal society have had a great

impact on the way in which I see myself in relation to the world--of what it means to be 'a man',

and how one *ought* to behave. Having identified with much of the traditional masculine ideals

growing up and into my early adult life, I too have felt the 'double jeopardy' of heightened

distress whilst simultaneously feeling constricted to reach out for help, for fear of being

dismissed and/or ostracized.

I also have found myself becoming more conscious of the political nature of my gender

as being seen as oppressive, through the recent discourses on toxic masculinity invoked by the

#MeToo movement and gender-specific work-compensation inequality. While I think these

discussions are absolutely necessary towards the evolution of a more just, humane society, I have

also found at times for the conversations to become somewhat polarized and noninclusive when

only certain persons or views are considered to be valid and acceptable within the particular

subject-topic--ie. unless you are a member of the persecuted group in question, or have gone

through what *they* have experienced, then you do not have a legitimate voice in the matter.

The result being that we designate people into us-and-them categories, thereby confining

the problem on an individual level through recent interactions as opposed to recognizing the

larger historical socio-cultural influences that may be engendering these issues. Of primary

concern, regarding the discussions on toxic masculinity, should not only be in educating men on

what is acceptable or unacceptable behavior, but should also be related to inquiring as to what it

is that leads some men to behaving so 'badly' in the first place. Could their actions not be

maladaptive coping strategies, resulting from oppressive internalized masculine ideals, signaling, indirectly, a call for help?

This in no way is meant to discredit, or take away from those individuals/women who have been victimized by men, nor is this meant to act as a rationale for condoning abuse on any level. My hope was (as cited earlier from Conrad and Barker (2010)) to provide a spotlight to that which "ordinarily eludes us", seeing that 'privilege' comes at a cost--and one in which I personally feel men are paying dearly for.

I think that men can learn alot from women--from their traditional ideals of embodying cooperation and connection with others over individualistic pursuits and autonomy; of care, attunement and emotional maturity; as well as their hard-fought qualities acquired through the feminist movement that required mass-scale organizational efforts, courage, and gender-role flexibility. That being said, I think that, at this time in our global political socioeconomic environment promoting the 'rise of women', women can also learn from men so as not to recreate the same cycle of oppressive shame-based practices supported by patriarchy.

Something that perhaps we should all be asking ourselves is what are the values we are striving towards in our quest for equality? Fair wage compensation for women is obviously a development that is long overdue and needs to happen. But what also seems to be happening is that some women have adopted the fierce competitive, autonomy-over-connection ideals in business and sports so fervently that, in some ways, are only reinforcing the shackles of patriarchy with the silent cries of "Me too!"

How this fits into the material being covered in this paper is that this necessary process of change in men--promoting an expanded capacity for emotions, for being vulnerable, and seeing help-seeking as a worthwhile pursuit--does require courage, but that courage will need to be

supported in order for there to be any lasting results. Unlike the suggestions by some of the authors found in the literature review, this is *not* something men can do on their own.

This requires a collaboration with women working alongside men as allies--as family members, partners, friends, peers, researchers and policy makers, and of course, as therapists-- which will require flexibility in supportive measures, as well as keeping an open mind. As uncovered here, there are many ways help-seeking can be enacted which go beyond the traditional formal route. And when viewing help-seeking from a dynamic approach, the personalized paths men take, which may start out in informal/indirect avenues, can eventually lead to more interactive options as their situation and needs evolve over time.

If we were to look at promoting equality from an expanded range of values, and liken it to a simple bar chart, while the rise towards balance of one bar suggests progress, there are still others that deserve attention--with men's mental and physical health being among them. This does not preclude supportive efforts towards women's interests; in fact, by recognizing the collateral damage that occurs as a result of men's muted voice, one could recognize the shared interests involved in attending to men's struggles as being mutually reinforcing for women.

A point that needs to be clarified is that, while there are certain parallels towards the feminist movement for women, the current proposition for men is decidedly different, as this is not about 'empowerment'. It is through men's systemic practices of power that have arguably resulted in their current health crisis. No, this is more about liberation--liberating men from their restricted roles and the notion that there is only *one* way to be a man; liberating men from the idea that stoicism and isolation are the only acceptable ways to deal with symptoms of distress; and liberating men around the belief that asking for support is a sign of weakness.

Through men's willingness to reach out and be vulnerable with their partners, this consequently empowers women, as these men can look towards them as a source of strength and refuge. This does not diminish man's sense of ableness. On the contrary, it signifies a desire for the relationship to be played on an even-level, and to reach new heights, together, on what is possible in satisfaction and intimacy when willing to work as a team.

Help, and western society's masculine ideals are currently under construction. It is our job, as active co-creators and shareholders in this development, to be mindful of the impact of our interactions, and above all, to proceed with curiosity.

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