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Exploring Men’s Experiences of Engagement with Community-Based Projects Promoting Men’s Mental Health

Ditte Holm Sørensen

Doctorate in Clinical Psychology
The University of Edinburgh
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Thesis portfolio abstract

Differences may exist between men and women regarding the experience and expression of mental illness. Men are less likely to seek help for mental illness and engage with statutory health care services less frequently than women. Such differences are likely driven by gender socialisation and adherences to Western stereotypical masculine ideals of emotional restriction. Reduced help-seeking and non-disclosure of psychological difficulties may negatively affect men’s mental health. Due to men’s reticence in help-seeking for mental health difficulties from traditional health care services, men’s psychological needs may be better met in other, non-clinical settings. Recent years have seen an increase in men-only community-based projects that seem successful in engaging men with their health. At present, research has focused mainly on community-based projects targeting men’s physical health, while less is known about similar initiatives promoting mental health.

To better understand what men value about participating in community-based projects for men’s mental health the existing qualitative research literature was reviewed systematically. By synthesising the research investigating positive participant outcomes, it was hoped that recommendations for project design could be developed that may increase mental health benefits for participants. The findings from the qualitative research were synthesised using thematic synthesis. Three descriptive themes were identified: Intrapersonal benefits, Interpersonal benefits, and Programme-related values. Encapsulated in these three themes were eleven subthemes. Five analytical themes were developed from the descriptive themes that emerged from the analysis of the primary studies. The analytical themes informed recommendations for the development of future similar interventions.

While research into community-based projects gender sensitised for men has focused mainly on physical health promoting initiatives, less is known about the lived experiences of mental health difficulties and the use of community-based projects as told by the project users themselves. Using Interpretative Phenomenological Analysis this study explored what engagement with community-based services promoting men’s mental health meant to men with a history of mental health difficulties. Eight men, who all used community-based men’s groups for emotional and psychological support, were interviewed. From the analysis of the interviews emerged three superordinate themes: Managing emotions as a man, Locus of control and Group experiences, including a total of eleven subthemes. The study results are discussed including strengths and limitations of the study and based on the study findings recommendations are given for further advancement of men’s mental health in community-based settings.
Lay Summary

Research has found differences in how men and women experience and express mental health difficulties. Compared to women, men are less likely to discuss and seek help for mental illness, which can result in detrimental outcomes for men. Men use traditional health care services for their mental health needs to a lesser extent than women and recent research has found that men’s health needs may be better met in less formal, community-based settings. Much research has investigated community-based projects promoting men’s physical health but less is known about similar initiatives focusing exclusively on mental health needs.

In the first journal article the current literature is reviewed relating to positive outcomes of engagement with community-based projects for men’s mental health as reported by the participations. Overall, project participation was related to an increased sense of wellbeing and social connectedness while reducing feelings of isolation.

The second journal article explores individual experiences of mental health difficulties and use of community-based projects promoting men’s mental health. Eight men, who all used men’s groups, were interviewed about their personal experiences of both mental health and project use. Participants’ accounts of use of community project for men’s mental health were analysed and themes around project engagement emerged from the data relating to male ways of experiencing and managing emotions, experiences of clinical health care settings and experiences relating to participating in the men’s groups. The findings were discussed in relation to the existing research.
Acknowledgements

First of all, I would like to thank the participants who kindly agreed to take part in this study. I am truly grateful for your willingness to share your personal stories and experiences with me.

I would like to thank my supervisors, Dr Ingrid Obsuth and Dr Richard Browne for your feedback, insights and support along the way. Additionally, I would like to extend a special ‘thank you’ to Professor Ethel Quayle for your consultancy, helpful feedback, and encouragement.

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Thank you,

Ditte
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5
Service users’ experiences of community-based projects supporting men’s mental health: A systematic review and thematic synthesis of qualitative research

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Abstract

Evidence suggests that men show hesitance in seeking help for psychological difficulties and under-utilise statutory mental health services. Community-based projects (CBPs) supporting men’s health and wellbeing may offer a compelling alternative for men’s health engagement. This systematic review aimed to synthesise the findings of the existing qualitative literature exploring participants’ reports of the benefits of male-only community-based projects promoting men’s mental health. Eleven studies were identified systematically, and the findings were thematically synthesised. Three descriptive themes summarised positive outcomes of participation relating to intrapersonal, interpersonal, and programme-related values. CBP participation was found to increase emotional wellbeing, self-confidence, and social connectedness, while decreasing isolation. Recommendations for future CBPs promoting men’s mental health are included and study limitations are discussed.

Keywords: men, mental health, community, systematic review, thematic synthesis
1. Introduction

Research has found that many men can be hesitant to seek help for psychological difficulties and show reticence in accessing professional health care services (Seaton, Bottorff, Jones-Bricker, Oliffe, Deelenheeer & Medhurst, 2017). According to the mental health charity Mind (2020) only 35% of those accessing NHS’s psychological therapy services for people with mild to moderate levels of mental illness, Improving Access to Psychological Therapy (IAPT), were men. Additionally, statutory health care services have been found to regularly fail to engage men with their mental health (Seidler, Rice, River, Oliffe & Dhillon, 2018). Therefore, alternatives to conventional forms of treatment are needed to promote and successfully engage men with their mental health (Robertson, White, Gough, Robinson, Seims, Raine & Hanna, 2015). Community-based projects (CBPs) may offer an alternative to standard health care services and have been found to effectively promote health and prevent diseases (Okoro, Nelson, Whitherspoon, Whitherspoon & Simmons, 2021). So far, research has focused predominantly on CBPs promoting men’s physical health and less is known about similar projects targeting men’s mental health. To further advance and promote CBPs for men’s mental health, a review of what works from the perspectives of project users is needed. This review synthesised the existing evidence of the positive outcomes of engagement with men-only community-based mental health initiatives as told by the project users.

1.2 Community-based projects for men

The last two decades have seen an increase in CBPs aimed at promoting men’s wellbeing (Oliffe, Rossnagel, Bottorff, Chambers, Caperchione, & Rice, 2019). Importantly, such community initiatives are based in non-clinical settings familiar to projects users, are male-friendly and often contains an aspect of socialising with other men (Oliffe et al., 2019). These CBPs are male-gender sensitised, which means that they ‘recognize the specific needs and realities of men based on the social construction of gender roles’ (WHO, 2007, p.4). Oliffe and colleagues (2019) offer insights into what seems to be effective in CBPs for men. They emphasise that when designing CBPs to meet the needs of the targeted project users, men’s health practices and masculinities, that is qualities, attributes, and behaviours characteristic of men, must be considered. However, a challenge not addressed in their article relates to the difficulty in assessing these needs especially if the project user audience is very diverse. Oliffe and colleagues (2019) suggest that to ensure that a community-based intervention is effective in engaging men, activities and interactions should purposefully be built into the design. They add that programmes that incorporate activities may appeal to traditional Western masculine values such as problem-solving, competitiveness, and physical prowess, which promote social connectedness and positively impact on physical health. Though authors note that men also connect by talking, this is seen as occurring alongside activity engagement rather than being the project focus. Situating CBPs within surroundings familiar to the users is understood as a relative strength compared to clinical health care settings as well-known spaces may provide project users with a sense of security while circumventing the hierarchical
power imbalanced patient-professional relationship (Oliffe et al., 2019). An important challenge to keep in mind, though, is that what constitutes a male-friendly CBP will be context-dependent, vary according to individual project user preferences and be subject to change over time (Oliffe et al., 2019).

Though Oliffe and colleagues (2019) offer important insights into what works when designing health related CBPs for men, recommendations are based on the authors’ subjective, albeit extensive, experiences rather than scientific, rigorous, systematic evaluations. Furthermore, as the article largely focuses on CBPs targeting physical health, it is unclear whether and to what extent the lessons learnt apply to mental health promotion.

1.2.1 Community-based projects promoting men’s physical health

Some research into CBPs promoting physical health have focused on specific health issues and/or populations. For example, Borrero and colleagues (2020) investigated a boxing exercise intervention for men with Parkinson’s disease, while Kang and colleagues (2021) explored community-based groups for black men with hypertension. Similarly, Okoro and colleagues (2020) evaluated a CBP that increased African American men’s health knowledge and aimed to change negative attitudes to help-seeking for health issues.

Extensive research has investigated CBPs promoting men’s physical health often within sports-related settings (e.g., Duffel, 2019; Grant, 2012; Robinson, Robertson, McCullagh & Hacking, 2010). Football appears to provide a popular context and has a growing evidence base as a public health intervention improving physical health and wellbeing (Friedrich & Mason, 2017). Examples of men’s football-based interventions include an initiative for suicide prevention through peer education delivered by suicide-educated footballers (Tighe & McKay, 2012) and the promotion of physical activity and health engagement developed in collaboration with English Premier League football clubs (Curran, 2013). Furthermore, Carone, Tischler & Dening (2016) investigated the impact of a weekly group intervention for men with early onset dementia, which provided physical activity through football. Additionally, men’s symbolic attachment to football clubs and contexts has been used effectively in group-based weight management projects (Bunn, Wyke, Gray, Maclean, Hunt & Anderson, 2016). The specific football settings have also been used to explore and help overcome barriers for older men to engage in healthier lifestyles (Lozano-Sufraguei, Pringle, McKenna & Carless, 2019). Furthermore, research has explored community-based football exercise programmes for men with prostate cancer (Bjerre, Leth, Hammer, & Midtgaard, 2018; Rørth, Tjørnhøj-Thomsen, Cormie, Oliffe & Midtgaard, 2019).

While there is generally a dearth of research exploring CBPs promoting men’s mental health only, one study reviewed the research on football-based interventions for mental health difficulties (Friedrich & Mason, 2017). Studies reporting evidence from both quantitative and qualitative data were included in this review. The findings from the qualitative evidence related to increases in self-esteem, emotional wellbeing and experiences of inclusion and connectedness. The authors reported that the quantitative findings were scarce and that most
studies failed to reach significant levels and did not include control groups. It is important to note, that a learning point from the review relates to football interventions as an addition to and not a replacement of conventional mental health treatments for people with severe mental health difficulties (Friedrich & Mason, 2017).

It is not clear from Friedrich & Mason’s (2017) review whether a quality assessment was made of the studies included in the review. Furthermore, while some of the included studies specified how better physical health would be reached, it was not clear what steps or measures were taken to promote mental health even though specific aims were set for mental health improvement. This makes it difficult to infer anything about causality and raises the question of whether mental health is expected to improve as a secondary gain of engagement in physical activity. Though some of the studies reviewed by Friedrich & Mason (2017) were male-only, the review findings were not specified for men and several studies included mixed genders. The review pointed to gender issues as a potential point of conflict in mixed-gender projects, however, no elaboration followed as to why or how this could be an issue. Moreover, the review focused on football interventions that improved mental and/or physical health rather than being specified for one or the other. Consequently, the heterogeneity of the studies impeded the conduction of an in-depth systematic review. Taken together, the authors assessed the findings as inconclusive due to great variability of methods, interventions, and samples.

Friedrich & Mason (2017) emphasise that an issue with exercise based CBPs is that they run the risk of becoming competitive for participants, which might have negative mental health implications like the generation of performance anxiety or fear of failure. This stands in contrast to the recommendation made by Oliffe and colleagues (2019) encouraging competition to enhance social connectedness. As such, there is conflicting evidence as to whether competitiveness promotes or impedes men’s wellbeing.

1.2.2 Men’s Sheds

Alongside CBPs promoting men’s physical health is the Men’s Sheds movement, which originated in Australia in the 1990s, and has since grown globally. The Men’s Sheds, which are predominantly used by older, retired men and unemployed men, offer communal spaces with workshop areas where men can engage in metalwork, woodwork, and gardening among other activities (Kelly, Steiner, Mason & Teasdale, 2019). The Sheds offer an environment that encourage socialising and activity engagement with the opportunity to share and develop practical skills (Ballinger, Talbot, & Verrinder, 2008; Kelly et al., 2019). An objective of the Men’s Sheds is to advance the health and wellbeing of its members (Golding, 2015) and much research has examined the physical health and wellbeing impact of Men’s Sheds engagement (Reynolds, 2011; Ballinger et al., 2008; Taylor, Cole, Kynn & Lowe, 2018; Ormsby, Stanley & Jaworski, 2010; Nurmi, Mackenzie, Roger, Reynolds & Urquhart 2018). Some of this research has focused on exploring the effects of social connectedness through Shed participation for older men (Reynolds, 2011; Milligan, Payne, Bingley, Cockshott, 2015) while Taylor’s
mixed-methods study looked at the health and wellbeing benefits from the viewpoint of the project users.

Kelly and colleagues (2019) reviewed and synthesised findings from Men’s Sheds research and subsequently explored the causal pathways between Shed participation and health and wellbeing. Overall, shed participation positively impacted health and wellbeing. Of the 16 studies reviewed, the most frequently reported mental health benefit was an increased sense of meaning and purpose. For a small number of participants across the studies, shed activity decreased depressive symptoms and suicidal ideation by providing members with a safe space for mental recovery where they could share difficulties and experiences with others. For these men, shed participation also positively impacted on a sense of self-efficacy and increased social support (Kelly et al., 2019).

The findings from the study were split into intermediate and long-term outcomes, however, it was not specified how this was measured and no indication was given in terms of the time-length covered. The intermediate positive effects of shed participation related to increased social connectedness (reported in 68% of the studies), increased motivation to leave the house (56% of studies) and increased sense of safety, security, relaxation, and contentment (31%). Regarding long-term effects, positive outcomes related to increased sense of purpose (68%), happiness and enjoyment (62%), increased sense of confidence and self-esteem (56%) and decreases in social isolation and loneliness (56%) (Kelly et al., 2019). Overall, the outcomes of shed participation seemed to positively affect wellbeing. However, the findings from the studies reviewed were based on small sample sizes, self-reported data, and low response rates. Taken together these knowledge gaps make it difficult to generalise the findings. Furthermore, the quality of the papers was not assessed, which could have added transparency regarding the standard of evidence on which the findings were made. Additionally, the findings have not been compared to other gendered interventions, which makes it difficult to infer how the Men’s Sheds fare against similar initiatives. Lastly, a limitation of the Men’s Sheds is a narrow demographic as they are predominantly utilised by middle-aged or older, white men (Golding, 2015).

1.3 Research gap

While significant amounts of research investigate physical health and activity-focused CBPs for men such as the Men’s Sheds, there is a scarcity of research exploring CBPs specifically focusing on promoting men’s mental health. Even less research has examined the impact of mental health specific CBPs systematically. When addressing poor male health engagement systematic reviews are needed to elucidate the potential relative power of CBPs as alternatives to statutory health care settings. As such, by systematically reviewing positive mental health outcomes of CBP participation in projects promoting men’s mental health the emerging evidence may be used to help overcome barriers to engage men with their mental health. Furthermore, such reviews may help shed light on the specific factors that promote men’s mental wellbeing and project engagement. In this context, Oliffe and colleagues (2019) have called for systematic reviews to advance CBPs
promoting men’s mental health. In response to this call, the current review aims to add valuable insights to the existing knowledge base of what works for participants of mental health focused, male-only CBPs. By systematically reviewing the existing evidence for what promotes mental wellbeing in men, this study aims to guide and advance the research into community-based initiatives supporting men’s mental health as these initiatives continue to grow in popularity.

Most existing research into CBPs promoting men’s mental health, including the majority of the studies included in this review, focus on particular challenges that negatively affect mental wellbeing, such as homelessness, unemployment, or physical health difficulties like HIV or prostate cancer. However, this review sought to go beyond such specific mental health challenges and examine whether communalities existed across the reviewed CBPs. Such communalities may elucidate universal characteristics of CBPs for men that promote mental wellbeing irrespective of the particular challenges of the individual community-based initiatives.

1.3.1 Review question
The aim of this review was to assess how participants in CBPs promoting men’s mental health perceive the mental health benefits of the project. The review asked the following question:

- What positive impacts on mental health do men report from participating in community-based interventions promoting men’s mental health?

It was hoped that by collating evidence across studies investigating positive participant outcomes, recommendations for project design can be developed that would increase the likelihood of positive mental health outcomes for participants. To answer the exploratory review question, a systematic review of the qualitative literature was deemed suitable as qualitative evidence may help develop an understanding of the mechanisms behind the impact of CBPs for its users.

2. Methods
What was perceived as beneficial to project users was investigated by systematically synthesising the qualitative evidence available. According to Flemming & Noyes (2021) the aim of a qualitative evidence synthesis is to develop new cumulative understandings from the findings of the primary studies. This may allow for an in-depth understanding and interpretation of a phenomenon, which may be richer and more detailed than the primary qualitative research alone (Flemming & Noyes, 2021). Additionally, synthesising qualitative evidence can lead to increased understandings of the impact of interventions on project users (Noyes, Booth, Cargo, et al., 2019). Furthermore, greater meaning can be constructed from a synthesis of qualitative evidence of primary studies which may inform the development of intervention guidelines or policies (Boland, Cherry & Dickson, 2017). While no single standard approach exists for synthesising
qualitative evidence (Dixon-Woods, Shaw, Agarwal & Smith, 2004), this review used thematic evidence synthesis as described by Thomas & Harden (2008).

Following the guidelines for qualitative systematic reviews developed by Popay and colleagues (2006), the current review process included searching relevant electronic databases to identify suitable studies, a critical appraisal of the quality of included primary literature and synthesis of the findings. Prior to review initiation, PROSPERO was searched to ensure that a similar review had not already been done or was underway. None were identified.

2.1 Search strategy
In consultation with the subject librarian, who had extensive experience with systematic reviews, the following databases were identified and searched for the purpose of this review: PsychInfo, EMBASE, Medline, Applied Social Sciences Index & Abstracts (ASSIA), Sociological Studies, and ProQuest. The search was undertaken in spring 2021. Only studies in English were included. The search strategy tool SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) (Cooke, Smith & Booth, 2012) was used to develop the search terms. SPIDER is a search strategy tool specifically developed for synthesis of qualitative evidence and is recommended for qualitative systematic searches as an alternative to the PICO tool used for quantitative searches (Cooke et al., 2012).

Table 1. Search terms used in database searches.

<table>
<thead>
<tr>
<th>Search terms</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample/population</td>
<td>Men OR mens OR male* OR men’s*</td>
</tr>
<tr>
<td>Phenomenon of Interest</td>
<td>communit* OR peer*</td>
</tr>
<tr>
<td></td>
<td>AND group* OR intervention* OR project* OR program*</td>
</tr>
<tr>
<td></td>
<td>AND health* OR “mental health” OR wellbeing</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Experience* or attitude* or perspective*</td>
</tr>
</tbody>
</table>

The database searches were extracted and stored in the reference management software, EndNote X9. From EndNote references were imported into Covidence, which is a screening and data extraction software for systematic reviews (https://www.covidence.org/). Here articles were screened first at title and abstract level, and subsequently at full-text level.

2.2 Eligibility criteria
Only studies that met the inclusion criteria listed in Table 2 below were included. In line with the specific focus on men’s mental health, this study reviewed CBPs developed for and targeting men only. This focus was chosen to increase awareness of and support research on men’s mental health. Furthermore, this male specific focus was deemed important as men may engage differently in men-only projects compared to mixed-gender groups. For example, previous research (see Mackenzie et al., 2017) has pointed to that some men may engage
in emotional conversations differently in male-only contexts as compared to in the presence of women and feel more comfortable expressing emotional and psychological concerns in male only settings. Moreover, the choice to include men-only CBPs was also informed by an aim to investigate how men in particular engage with their health in non-clinical settings. As such, this review may help uncover whether unique factors exist in relation to how men engage with their mental health, which may not be evident from mixed-gender studies. Studies were included if they explored male participants’ attitudes, views, perspectives, or beliefs about the mental health focused CBP they engaged with, reported through qualitative or mixed methodology. To capture and reflect contemporary views and perspectives, only studies published from 1990 onwards were included. Male mental health promoting initiatives had to be based in the community, which was conceptualised broadly as any setting out-with professional or clinical health care settings, such as hospitals and medical centres, and correctional facilities such as prisons. As the aim of the review was to assess user perspectives of gender-sensitised mental health promoting initiatives for men, studies including mixed-gender or non-binary samples or studies where results could not be explicitly attributed to male participants were excluded. A decision was made to exclude studies focusing specifically on behaviour change rather than mental health for example studies on intimate partner violence.

Table 2. Inclusion and Exclusion Criteria

<table>
<thead>
<tr>
<th>Sample</th>
<th>Include</th>
<th>Exclude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men, any age, who engage with the community-based mental health/wellbeing promoting initiatives.</td>
<td>Studies including women, mixed-gender studies, non-binary populations.</td>
<td>Studies focusing on physical health exclusively.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study design</th>
<th>Include</th>
<th>Exclude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative research including mixed methods.</td>
<td>Quantitative research</td>
<td>Review articles or commentaries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conference abstracts or summaries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Book chapters</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Settings</th>
<th>Include</th>
<th>Exclude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based, any country</td>
<td>Clinical settings (hospital, medical centres etc.), forensic settings e.g., prisons</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study focus</th>
<th>Include</th>
<th>Exclude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviews of the benefits of project engagement from the perspective of the project user.</td>
<td>Reviews of interventions by staff or anyone else other than project users</td>
<td></td>
</tr>
<tr>
<td>Must be a group element to the project.</td>
<td>1:1 interventions</td>
<td></td>
</tr>
<tr>
<td>Project must focus on mental health promotion</td>
<td>Interventions as part of treatment orders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Projects that target specific behaviour change rather than mental health.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Include</th>
<th>Exclude</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990-up to the date of database searches (June 2021)</td>
<td>Published before 1990</td>
<td></td>
</tr>
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<table>
<thead>
<tr>
<th>Language</th>
<th>Include</th>
<th>Exclude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Studies written in English</td>
<td>Studies written in any other language</td>
<td></td>
</tr>
</tbody>
</table>
2.3 Study selection

The process of study selection, outlined in Table 3, drew upon the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) (Moher, Liberati, Tetzlaff & Altman, 2009). From the database searches \( n = 4,824 \) studies were identified. Following de-duplication, \( n = 1,417 \), \( n = 3,407 \) studies were imported into Covidence. Following the first stage of screening at title and abstract level, articles that appeared to meet inclusion criteria or where inclusion or exclusion could not be established based on title and/or abstract were screened at full text level \( n = 372 \) of which \( n = 363 \) were excluded. Reference lists of included studies were searched manually, which identified a further \( n = 2 \) articles. A total of \( n = 11 \) studies were included in the review.

The screening and study selection process was conducted by the first author (DS) only and therefore may be subject to bias. Furthermore, whether every relevant article could be identified and retrieved also depends on the quality of the indexing in databases (Cooke, et al., 2012; Shaw, Booth, Sutton, et al., 2004). Whether relevant articles can be effectively retrieved depends both on the clarity of the title and abstract, but also on the indexing terms chosen, which is determined by the indexer’s understanding of the article (Cooke et al., 2012). In qualitative research, a discrepancy might exist between how the searchers and authors define concepts (Evans, 2002), which will affect retrieval terms and consequently studies included. Flemming & Noyes (2021) also point to non-informative titles and abstracts along with diffuse terminology as additional challenges to retrieving relevant qualitative studies for evidence synthesis.

Figure 1. PRISMA diagram
2.4 Data extraction

Data extraction was done by the first author (DS) for all included studies. Extracted study characteristics related to country, project format, study objective, participants, sample size, methodology and analysis. Lastly, a summary of themes and subthemes were included where these were reported in the studies. An overview of the studies included in this review can be found in Table 3.
<table>
<thead>
<tr>
<th>#</th>
<th>Author(s) (year)</th>
<th>Country</th>
<th>Project format</th>
<th>Objective</th>
<th>Participants, sample size</th>
<th>Methods &amp; Analysis</th>
<th>Themes/subthemes</th>
</tr>
</thead>
</table>
| 1 | Abotsie, Kingerlee, Fisk, Watts, Cooke, Woodley, Collings & Teague (2020) | UK      | Football-based group intervention       | The article reviewed the football-based intervention ‘All To Play For’, which aimed to raise awareness of men’s mental health and increase access to men’s mental health support networks and groups. | Participants: Men (not otherwise specified) Sample size: 12                                                                                                           | Open-ended, participant written evaluations. Mixed-methods surveys and qualitative content analysis     | Feelings  
Self-belief  
Friendly  
Inclusivity  
Impact  
Lifeline  
Steppingstone  
Physical Health  
Supports mental well-being |
| 2 | Bailey & Davidson (2003)                 | Canada  | Choir for homeless men                  | The study explored the experiences and perceptions of members of a community-based Homeless Choir regarding life changes that occurred since joining the choir.                                                      | Participants: Homeless men Sample size: 7                                                                                                                          | Semi-structured interviews. Interpretative Phenomenological Analysis                                      | 1) Emotional health,  
(2) Social interaction and reconnection through performance,  
(3) Group process,  
(4) Mental stimulation |
| 3 | Dixon, Belshaw, Johnson & Flynn (2019)  | UK      | Football-based mental health intervention | To appraise a local community-based mental health intervention. The project used football fan culture as a medium to encourage men to talk about issues and increase mental health resilience. | Participants: middle-aged men recently made redundant following the closure of a local steelworks Sample size: 12                                                       | Interactive group discussions. Thematic Analysis                                                      | No themes reported. Evidence organised under the following headings:  
1) The language of football and shared identity for initiating and sustaining engagement in the boot room  
2) Active ingredients of the boot room: peer-support, mentoring and member-led activities  
3) The boot room as a vehicle for building mental health resilience  
4) Sustainability of the boot room |
| 4 | Harris & Alderson (2007)                | Canada  | Counselling and peer support service    | To investigate the experiences of gay men living with HIV/AIDS who received counselling and peer support services                                                                                      | Participants: Gay men with HIV/AIDS Sample size: 12                                                                                                                  | Semi-structured interviews. Transcendental phenomenology                                               | Counselling  
Benefits of counselling  
Counsellor qualities  
Therapeutic alliance within individual counselling  
Issues addressed in individual counselling |
|   |                                          |         |                                         |                                                                                                                                                                                                              |                                                                                                              |                                                                                                        | Peer support program  
Benefits of peer support  
Relationships  
Role models                                                                                       |
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Title</th>
<th>Overview</th>
<th>Participants</th>
<th>Method</th>
<th>Findings/Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Kronenwetter, Weidner, Pettengill, Marlin, Crutchfield, McCormac, Raisin &amp; Ornish (2005)</td>
<td>USA</td>
<td>Prostate Cancer Lifestyle Trial (PCLT): an intervention aimed at improving diet, exercise, stress management, and group support</td>
<td>The study examined the psychological, emotional, social, and spiritual reactions to both a prostate cancer diagnosis and participation in the PCLT intervention.</td>
<td>Participants: men with prostate cancer</td>
<td>Sample size: n = 26</td>
<td>Semi-structured, individual interviews. Results given in codes rather than themes.</td>
</tr>
<tr>
<td>7. Reddin &amp; Sonn (2003)</td>
<td>Australia</td>
<td>Men’s support groups</td>
<td>To gain an understanding of experiences of men’s groups and to explore how the groups facilitate self-understanding and change.</td>
<td>Participants: men’s groups attendees</td>
<td>Sample size: 12</td>
<td>Semi-structured interviews. Thematic analysis.</td>
</tr>
<tr>
<td>10</td>
<td>Stewart, Hart, Mann, Jackson, Langille &amp; Reidy (2001)</td>
<td>Telephone support group</td>
<td>The project aimed to test the feasibility of a 12-week telephone support group intervention; one group for men affected by haemophilia and HIV/AIDS and one group for family caregivers</td>
<td>Participants: Men with haemophilia and HIV/AIDS and family caregivers</td>
<td>Sample size: Men’s group (n = 3), family caregiver group (n = 6; 5 females, 1 male)</td>
<td>Recordings of group discussions, researcher’s notes, and individual interviews</td>
</tr>
</tbody>
</table>
2.5 Quality assessment

As qualitative research evidence can inform policies, practice, and clinical decisions it is important to establish the quality of the findings on which recommendations are based. The inclusion of studies of poor quality in a review risks distorting the findings of the synthesis and may impede interpretation (Dixon-Woods et al., 2004). In this review, the Critical Appraisal Skills Programme was used to assess study quality (CASP, 2018, see Appendix 2). CASP is a well-established and commonly used checklist tool for appraising qualitative research. The tool, which has been approved by Cochrane and WHO, was designed to be used with health-related research, is user-friendly and has been recommended for novice researchers (Boland et al., 2017; Long, French & Brooks, 2020). Furthermore, the CASP tool has been used in other reviews of participants’ views or experiences (Butler, Hall & Copnell, 2016). For these reasons, it was chosen for quality assessment of the included studies.

The CASP tool contains 10 questions focusing on different methodological aspects for the reviewer to consider if the findings are appropriate, well-presented, and meaningful (Long, et al., 2020). The tool consists of three response categories in its original form to indicate whether a characteristic is present (‘Yes’, ‘Can’t Tell’, and ‘No’) but has been adapted by Butler and colleagues (2016) to include a numerical scoring system, where ‘Yes’ = 1 point, ‘Can’t Tell’ = 0.5 points and ‘No’ = 0 points. In Butler and colleagues’ adaptation (2016) the 10 points are added up to a Total Score and papers achieving a total score between 9-10 receive a global quality rating of ‘High’. A total score between 7.5-9 receive a global rating of ‘Moderate’ quality, and papers with a total score of 7.5 or less receive a global rating of ‘Low’. Butler and colleagues (2016) recommend excluding studies scoring 6 points or less. To facilitate comparison between the reviewers, a decision was made to use Butler and colleagues’ adaptation of the CASP scoring system.

Table 4 provides an overview of the quality of the included studies. Most of the studies (n = 5) received a global quality rating of ‘High’ (6, 7, 9, 10, 11), four (n = 4) studies received a ‘Moderate’ rating (1, 2, 3, 4) and two studies (n = 2) were rated as ‘Low’ in quality (5, 8). As the lowest total score given was 6.5 (5, 8), no studies were excluded from the review. For a significant number of studies (n = 8) low scores were given when a discussion of the researcher’s role in the study was either inadequate or absent. Additionally, ethical considerations were frequently underreported or not clearly stated across the studies (n = 6).

2.6 Inter-rater reliability

The first author (DS) assessed the quality of all studies included (n = 11). An assessment check was completed independently by a second rater (JW) on 55% of the studies selected at random. Cohen’s kappa (κ) was calculated to determine the level of agreement between the two raters. There was a good agreement between the raters, (κ = .766, p < .0005) based on Altman’s (1999) classification of Cohen’s kappa (κ). Where inconsistencies existed between raters, these were discussed and subsequently resolved by the first author recoding articles assessed by both raters and rechecking the assessment accuracy of the remaining articles.
Four studies obtained the same total score and global rating by both reviewers (6, 7, 10, 11). For two studies (3, 4) total scores differed between the raters by 0.5 points, which resulted in different global ratings as scores fell at the cut-off point.
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Abotsie (2020)</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>0.5</td>
<td>1</td>
<td>1</td>
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<td>1</td>
<td>8.5</td>
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</tr>
<tr>
<td>2</td>
<td>Bailey (2003)</td>
<td>0.5</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
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<tr>
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<td>Dixon (2019)</td>
<td>1</td>
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<td>0.5</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>8.5</td>
<td>Moderate</td>
</tr>
<tr>
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<td>Harris (2007)</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>0.5</td>
<td>0.5</td>
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<td>1</td>
<td>1</td>
<td>8.5</td>
<td>Moderate</td>
</tr>
<tr>
<td>5</td>
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</tr>
<tr>
<td>6</td>
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<td>1</td>
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<td>1</td>
<td>1</td>
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<tr>
<td>7</td>
<td>Reddin (2003)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0.5</td>
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<td>1</td>
<td>8.5</td>
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<td>8</td>
<td>Sandstrom (1996)</td>
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<td>0.5</td>
<td>1</td>
<td>0.5</td>
<td>0</td>
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<td>Low</td>
</tr>
<tr>
<td>9</td>
<td>Spandler (2013)</td>
<td>1</td>
<td>1</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>9</td>
<td>High</td>
</tr>
<tr>
<td>10</td>
<td>Stewart (2001)</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>10</td>
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</tr>
<tr>
<td>11</td>
<td>Voisard (2019)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0.5</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>9</td>
<td>High</td>
</tr>
</tbody>
</table>
2.7 Thematic synthesis

Findings from the included studies were synthesised using thematic synthesis (TS), which is an interpretative approach to qualitative evidence synthesis developed by Thomas & Harden (2008). TS is one of the most used synthesis frameworks (e.g., Walker, Tong, Howard & Palmer, 2019; Naidoo, Nguyen, Ravaud, et al., 2020; Lovell, Etkind, Bajwah, Maddock & Higgins, 2019) and according to the Cochrane methods guidelines TS is recommended as the first choice for a qualitative synthesis (Noyes et al., 2019). TS is commonly used to identify themes across studies exploring people’s views, attitudes, experiences, or perspectives and examines the appropriateness or acceptability of a given intervention (Boland, et al., 2017; Barnett-Page & Thomas, 2009). Accordingly, this approach was selected for the current systematic review as its goal was to explore men’s experiences in community-based interventions targeting mental health.

The strengths of TS relate to its accessibility. This clearly structured and straightforward approach can be applied to ‘thin’ data to produce descriptive themes. Additionally, descriptive themes can be produced from ‘thicker’ data and developed into more in-depth analytic themes through an inductive coding approach (Noyes et al., 2019; Flemming & Noyes, 2021). Conversely, a relative weakness of the approach is its limitations in interpretative ‘power’; it risks becoming too descriptive and over-simplistic and thus may not adequately inform decision making (Noyes et al., 2019). Furthermore, the approach may lack clarity on how findings can be translated into actionable points (Flemming & Noyes, 2021).

In terms of its epistemology, TS has been criticised for the absence of a problematised view of reality. Within TS is an inherent assumption that synthesised evidence relate to a shared reality and can be reproduced, which may be explained by the fact that it is designed largely to inform policies and guidelines (Barnett-Page & Thomas, 2009).

TS is conducted in three stages which include line-by-line coding of individual study findings, development of ‘descriptive themes’, and the production of ‘analytical themes’ (Thomas & Harden, 2008). All three stages of the thematic synthesis process were carried out by the author (DS). Where data included both quantitative and qualitative evidence, only the latter was included in data analysis.

3. Results
3.1 Summary of included studies

Of the eleven studies included $n = 8$ used qualitative methodology (2, 3, 4, 6, 7, 8, 10, 11) and $n = 3$ used a mixed-methods approach (1, 5, 9). Variation in qualitative methodology and analysis was found across the studies with four studies using thematic analysis or a variation thereof (3, 7, 9, 10), two studies using a phenomenological approach (2, 4), two studies used grounded theory (8, 11), and one study used qualitative content analysis (1). For two studies (5, 6) the method of analysis was unclear. In terms of data collection, individual semi-structured interviews ($n = 7$) were most frequently used. One study used written words (1),
another used group discussions only (3), one used focus groups (9), and one study combined group discussions, researcher’s notes, and individual semi-structured interviews (10). One study (10) reported data obtained from both male users of a telephone support group and a family caregiver support group, however, as the data was clearly distinguishable between the two groups, only findings from the male support group are included here. Similarly, another study (8) reported results from three groups of participants: long-term group participants, brief participants, and non-participants; only data from the first two groups are included.

Four studies were conducted in Canada (2, 4, 10, 11), n = 3 in the USA (5, 6, 8), n = 3 in the United Kingdom (1, 3, 9), and one (n = 1) in Australia (7).

The most common format were variations of support groups (n = 6), including in-person groups and telephone support groups (4, 6, 7, 8, 9, 10). Three studies (1, 3, 10) reported findings from football-based projects. The intervention of one study (2) was a choir for homeless men and one study (11) reported findings from a housing/shelter project. One study (5) combined employment status and mental health in the intervention. In terms of participants, four studies (4, 5, 8, 10) were aimed at men with HIV/AIDS, of which (n = 1) focused specifically on African Americans (5). Two studies (2, 11) included homeless men. One study (3) was directed specifically at middle-aged men made redundant following the closure of a local steelwork (3) and one study (6) included men with prostate cancer who participated in a support group. The remaining studies (1, 7, 9) did not specify participant characteristics beyond gender. Project sample sizes ranged from 3 to 38 participants. The mean sample size was 12, which was also the mode (n = 4).

3.2. Synthesis of findings

Data was extracted from Findings/Results or Discussion/Conclusion sections of the included studies. Depending on how evidenced in the primary study, verbatim findings or summaries of findings were typed into an Excel spreadsheet where each line was coded inductively according to its meaning and content (Thomas & Harden, 2008). New codes were developed and added with each study and in some cases several codes were applied to the same sentence. From the initial 33 codes 3 themes emerged: intrapersonal benefits, interpersonal benefits, and programme-related values. Table 5 summarises themes and subthemes listing the studies with theme representation. A decision was made to include subthemes with a representation across 5 or more studies. Wherever possible participant quotations are used to evidence themes, however, some studies did not include quotations. The subthemes summarised below are not mutually exclusive and contents may overlap. The answer to the review question of what men value about participating in CBPs for men’s mental health is summarised below.
Table 5 Overview of themes across studies

<table>
<thead>
<tr>
<th>Theme/subtheme</th>
<th>Contributing studies</th>
<th>Percentage of included studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrapersonal benefits</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Increased self-confidence</td>
<td>1, 2, 5, 9, 10</td>
<td>45%</td>
</tr>
<tr>
<td>Increased wellbeing</td>
<td>1, 2, 5, 6, 8, 9, 11</td>
<td>64%</td>
</tr>
<tr>
<td>Reduced isolation</td>
<td>1, 3, 4, 7, 8, 9, 10, 11</td>
<td>73%</td>
</tr>
<tr>
<td>Personal and emotional development</td>
<td>2, 6, 7, 9, 10</td>
<td>45%</td>
</tr>
<tr>
<td>Interpersonal benefits</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Mutual support and reciprocity</td>
<td>1, 2, 3, 4, 8, 9, 11</td>
<td>64%</td>
</tr>
<tr>
<td>“In the same boat”</td>
<td>3, 4, 6, 7, 9, 10</td>
<td>55%</td>
</tr>
<tr>
<td>Creating meaningful social connections</td>
<td>1, 4, 6, 7, 8, 11</td>
<td>55%</td>
</tr>
<tr>
<td>Practical help</td>
<td>3, 4, 5, 8, 9, 10, 11</td>
<td>64%</td>
</tr>
<tr>
<td>Programme-related values</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Non-judgmental environment</td>
<td>1, 4, 7, 8, 9, 11</td>
<td>55%</td>
</tr>
<tr>
<td>A steppingstone*</td>
<td>1, 3, 8, 9, 10, 11</td>
<td>55%</td>
</tr>
<tr>
<td>Project structure</td>
<td>2, 3, 4, 7, 9, 10, 11</td>
<td>64%</td>
</tr>
</tbody>
</table>

3.2.1 Intrapersonal benefits

The theme summarises reported positive outcomes related to how participants felt about themselves following project participation.

3.2.1.1 Increased self-confidence

Increases in self-confidence were reported by participants in 45% of the studies (n = 5). Some participants linked self-confidence to achieving individual goals and developing problem-solving skills, which caused a sense of empowerment to make better decisions and respond better to future challenges. Increased senses of self-confidence were associated with improved mood states and physical fitness levels, being part of a team, and a willingness and ability to help other participants. “I definitely feel more confident now. I feel like I can go out without fear” (9).

3.2.1.2 Increased wellbeing

An increased sense of wellbeing was evident from n = 7 studies and described as an improvement in physical health while reducing symptoms of anxiety and depression. Some participants reported increases in optimism, positivity, and hope, and a direct link was made between community involvement and improvement in depressive symptoms. For some, increased wellbeing was connected to a sense of personal achievement and being able to stick with the programme, where ongoing engagement had previously been deterred by depression. For others, setting and achieving small goals brought about a sense of validation, which improved mood states. “My mental state is more positive due to this group; it gives me something to look forward to” (1).
3.2.1.3 Reduced isolation
In most of the studies (n = 8), feelings of reduced isolation or increased socialising was a frequently reported positive outcome of CBP engagement. Struggling with mental health difficulties was experienced as isolating causing a withdrawal from society, leaving many unable to leave their homes or talk to other people. Feeling excluded and isolated was countered by project engagement where the men got the opportunity to socialise with others experiencing similar difficulties. Being able to share feelings with people, who understood what they were going through brought about a sense of normalisation for some participants. One participant identified "The feeling of support. Feeling of not being alone…” (7) as the most positive outcomes of project participation.

3.2.1.4 Personal and emotional development
In just under half of the studies (n = 5) participants reported a sense of personal development as a positive outcome of project engagement. Several of the men spoke about an ‘emotional softening’ and becoming better able to put into words what they were experiencing emotionally. “The group therapy, that was a new experience for me, probably helped me get in touch with the ‘softer side,’ which I find interesting and pleasing actually” (6). The sense of increased awareness and emotional insight had, for some, improved close interpersonal relationships with friends and families. Others spoke of noticeable changes to their identities feeling more attuned to themselves and other people and feeling happier. “Since I started with the choir, it's like a second life for me. [...] I am less aggressive and more sociable, kinder” (2).

3.2.2 Interpersonal benefits
This theme summarises reported benefits of CBP participation regarding engagement with other project members and includes subthemes relating to how project engagement benefited the individual while positively affecting interpersonal interactions out-with the project.

3.2.2.1 Mutual support and reciprocity
This subtheme was evident across n = 7 studies and includes participants’ accounts of the perceived benefits of taking part in a structure that allowed for giving as well as receiving support. Helping others were linked to increased positive feelings, as supporting others were described as bringing about feelings of joy and happiness. For some men, mutual support enhanced feelings of wellbeing and self-worth, which countered mental health difficulties and suicidal thoughts. For others, supporting others gave them respite from their own problems, allowing them to focus on something else, which was associated with elevations in mood. "There are a lot of others like me [...] we can talk about our fears and that sort of thing, and you can concentrate on them rather than yourself, so you tend to forget about yourself and start worrying about others” (4).
3.2.2.2 “In the same boat”

The sense of shared experiences or ‘being in the same boat’ (4) as other group participants was emphasised positively across more than half the studies (n = 6). Having shared experiences provided a sense of community and gave participants a common denominator that allowed for clear communication about their difficulties. “[...] what I found was the greatest or biggest thing for me, was that I suddenly was among a group of men who I could relate to in quite a deep way, and trust, and a feeling of camaraderie that I had never experienced in any other place.” (7) Commonalities between project participants meant that some men felt better understood and felt they could ‘take strength’ from each other (3), which made them better able to support and empathise with others. Shared experiences also fostered a sense of belonging and intimacy between project members. Some spoke about how shared experiences created a supportive environment, which felt like a positive change from a competitive male society. The group’s informal setting offered an alternative to standard health care settings, and for some participants being in a group with people with similar experiences increased a sense of normalisation. One participant spoke about the importance of having shared experiences within a group setting, pointing out that as doctors haven’t experienced the same difficulties, they can’t help in the same way (4).

3.2.2.3 Creating meaningful social connections

A common theme across several of the studies (n = 6) was how project participation allowed for the creation of new and meaningful interpersonal relationships. For many, project engagement led to a sense of camaraderie among participants. Several pointed to the forming of new friendships within the CBP as the biggest gain from project participation, which became essential to coping with individual difficulties. One participant described the group ending causing a significant personal loss: "It was detrimental when my support group ended because that was something that was lost-that connection with other HIV positive people, to know their needs and to connect your needs to theirs. [...] [I]t left me without a place for dealing with or expressing my own HIV needs” (8).

3.2.2.4 Practical help

Across n = 7 studies practical help and advice from other project members were perceived as an important positive outcome, which meant some participants transitioned into employment following CBP participation. Furthermore, the exchange of illness-related information was deemed highly useful. Some found that they could get information and resources through the group that they did not get from health care professionals. Intra-group support meant sharing information on sources of locally available support services, medical information, and help with practical issues including accommodation. "It's very useful for providing basic information-when it comes down to sharing information about the legal system, the social service system, and the medical system" (8). For some, getting help and support with practical issues also reduced feelings of isolation.
3.2.3 Programme-related values

This theme summarises reported positive outcomes associated specifically with the design and contents of the project.

3.2.3.1 Non-judgmental environment

Being able to engage with a CBP in a non-judgmental environment was emphasised by participants in over half of the studies \((n = 6)\). For some, engaging in a structure where they were not judged because of their mental illness positively affected self-confidence and abilities to socialise with other people. Being able to speak about difficulties and being listened to nonjudgmentally and empathically reduced feelings of fear and shame for some men. “I didn’t feel judged, that’s important […] I think they had a good understanding of what was going on—they understood better than me what was going on […] that’s kind of what I was looking for by coming here” (11).

3.2.3.2 “A steppingstone”

In more than half of the studies \((n = 6)\), CBP engagement helped participants take important steps in their lives out-with the programme. Across the studies there was a sense of getting a boost from programme involvement that allow the men to (re-)engage with people or activities, which had been abandoned or finding courage to reach out to or speak more openly with other people about their difficulties. For some, CBP engagement had been the springboard to getting employment, starting college, or taking up volunteer work, or for a homeless man to get accommodation. One participant described his CBP involvement as life-changing: “It has turned my life around, from being on heroin to being a volunteer and drug free” (9).

3.2.3.3 Project structure

Factors relating to CBP structure were emphasised in most of the studies \((n = 7)\). A flexible, informal project structure was viewed positively by some participants along with a sense of individual agency and control over content and development. “We take expertise from each other… and we take it in turns to be facilitator” (7). For others, participating in a CBP became an anchor point which brought structure to their lives. Several participants compared the CBP to conventional mental health care and found the informal structure more compelling and less threatening. The sense of equality in programme participation was contrasted against the imbalanced patient-professional relationship and some participants emphasised the positive aspect of being actively involved in their recovery rather than being passive recipients of care. A shared language was deemed essential in this regard, which was apparent especially across the projects with a football context (1, 3, 9): “In the health centre I usually feel like I’m labelled…. [the football venue] helps you feel normal and relaxed” (9).

3.3 Analytical themes

The descriptive themes that emerged from the analysis of the primary studies were used to inform the development of analytical themes, which sought to go beyond the original content and consider implications
for the development of similar interventions. Where the descriptive themes sought to answer the question ‘what are the positive outcomes of CBP participation for mental health?’, how and why project users perceived the CBPs as beneficial were sought answered through the analytical themes. Based on the evidence synthesis and analysis the following points should be considered to increase the chances of engaging men with their mental health and benefitting from CBP participation:

1. The CBP supports group cohesion. Project members should share a common denominator. A sense of shared experiences increases connectedness between members, which reduces competitiveness and isolation and instead allows for the development of friendship and camaraderie, which may be essential to coping with individual mental health difficulties.

2. The CBP aims must be relevant to its members. This ensures ongoing project engagement while giving participants something meaningful to do. These factors may provide participants with a sense of purpose that positively affects mood states.

3. The CBP structure is informal, inclusive, and where possible, non-hierarchical. A sense of equality between project participants and being on the same level may make the environment more friendly and relaxed and less threatening.

4. CBP participation allows for reciprocation between project members. The possibility of mutual support, both emotional and practical, enhances feelings of purpose, and increases feelings of self-worth and personal value, which positively affects mood.

5. The CBP incorporates opportunities for empowerment. If a project includes elements that allow for personal development e.g., of specific skills, this may provide participants with increased sense of individual agency and personal achievement, which is linked to feelings of validation, increased self-confidence, and enhanced wellbeing.

4. Discussion

This review synthesised findings from the qualitative literature exploring participants’ perspectives on what works in male-only CBPs promoting men’s mental health. From the evidence synthesise emerged three descriptive themes: intrapersonal benefits, interpersonal benefits, and programme-related values. Five analytical themes were derived from the descriptive themes and translated into recommendations for the development of future CBPs for men’s mental health.

CBP participation was found to positively affect mental wellbeing by increasing mood and feelings of self-confidence while decreasing symptoms of anxiety and depression. Echoed across the studies and present in several subthemes was the sense that connecting with other men with similar difficulties brought feelings of normalisation while reducing isolation. Additionally, the group aspect allowed for engagement with other men with shared experiences, which was valued by many. Importantly, the opportunity for reciprocation of support
was viewed as crucial and positively affected mental health by adding a sense of purpose and self-worth. The sense of equality between members may foster and encourage this reciprocation, which may be the greatest structural difference between CBPs and clinical health care settings. At the crux of professional health care is the power imbalanced patient-care provider relationships, which may reduce the patient’s sense of individual agency in their recovery. This power imbalance is to a large extent reduced if not removed in CBPs, which may be an important aspect in engaging men with their mental health.

From previous research it has been emphasised that men connect by doing (Oliffe et al., 2019). This review expands this claim as findings suggest that men may also connect by talking. ‘Doing’ may not only refer to an activity but may also incorporate offering advice, support, and practical help. As such, interpersonal connectedness among men may be strengthened by participating in a practical or activity-driven project but may also be related to being something for each other and connecting emotionally. Connectedness among men may in large parts be driven by a sense of shared experiences and equality in the interaction regardless of whether the interaction is centred around a physical activity such as sports or an emotional activity such as support group participation.

This review focused solely on the positive outcomes of CBP participation and did not include negative outcomes. This decision was made as a minority of the reviewed studies included both positive and negative project evaluations. Furthermore, in the studies where both positive and negative feedback was obtained, positive findings outweighed the negative considerably and the current review sought to reflect this focus while being mindful of space available. Moreover, positive feedback may potentially be more helpful and valuable for future project development than negative feedback as it highlights what developers of future, similar projects should be mindful of including or focusing on to increase the chances of positive mental health outcomes for project users.

From the studies that included negative feedback or suggestions for change some noteworthy points emerged. It was highlighted that not enough referrers knew about locally available male friendly CBPs, and suggestions were made for better use of social media for project promotion (Dixon et al., 2019; Spandler et al., 2012). This may simultaneously raise awareness of men’s mental health. Another important limitation of some CBPs highlighted by participants was the time frame, which was frequently viewed as too short with the risk of losing important new interpersonal connections and reverting to feelings of isolation (Spandler et al., 2012, Stewart et al., 2001). A way of ensuring project continuation might be found in the empowerment of project participants. If participants are involved with project design and facilitation, there may be a possibility of continuing the project perhaps in a reviewed or altered format beyond the original project time frame. Naturally, this would depend on CBP format and practical factors such as access to facilities.

A relative strength of the current review was the heterogeneity of the studies included as the variability reflects breadth of evidence. However, the great heterogeneity may also complicate both synthesis and generalisability.
of findings, and subsequent recommendations. Dixon-Woods and colleagues (2004) argue that due to the variance in types of qualitative data such as participant observations, interviews, focus groups etc. different appraisal criteria may be required. Conversely, including studies from diverse settings may contribute to a higher level of abstraction (Thomas & Harden, 2008). One could argue that the studies included here are so diverse that systematically synthesising the findings might have been more meaningful if focusing on specific groups separately. However, as commonalities exist relating to reported positive outcomes across all the CBPs included, this allowed for broader inferences to be made as to why such initiatives work. As such, universal characteristics exist across CBPs for men’s mental health despite differences in settings and/or participant characteristics.

Like the Men’s Sheds review by Kelly and colleagues (2019) and the review of football interventions for mental health by Friedrich & Mason (2017), this review found that programme participation positively impacted on mental wellbeing. Across all three reviews CBP participation was found to increase self-worth, emotional wellbeing, and social connectedness. Similarly, decreases in social isolation and loneliness was also found across all reviews. It is important to note that like the Men’s Sheds review, the current review also found evidence of CBPs providing a safe space for mental health recovery and increased senses of meaning and purpose for participants. However, these findings were not included in the descriptive themes as evidence across included studies fell below the cut-off for theme inclusion.

The overlaps and similarities in participant reported positive outcomes across the different formats of CBPs for men (Men’s Sheds, physical health interventions, mental health projects) indicate that universal benefits of male-only CBP participation exist regardless of the specific project focus. Therefore, a tentative conclusion can be made that participating in gender sensitised CBPs promoting men’s health and wellbeing increase wellbeing while reducing isolation despite format. The current review raises the question of whether it is meaningful to make a clear distinction between interventions targeting either physical or mental health. Especially if the benefits reported of both forms of interventions are very similar. Importantly, components of health separated into physical and mental health categories are not always mutually exclusive and frequently overlap (Kelly et al., 2019) and will interact and affect each other reciprocally. For example, physical activity or lack thereof may impact mental health, while emotional wellbeing will affect motivation for physical activity. Furthermore, many mental health promoting interventions are centred around sports or exercise activities with good effect. For example, in their meta-analysis of efficacy studies for mood disorders Stathopoulou and colleagues (2006) found exercise to be an effective intervention for depression and recommended that clinicians consider incorporating exercise into their treatment interventions. Additionally, interventions that promote physical health for people with mental illness may effectively address both psychosocial recovery and particular physical health needs found in this population like cardiovascular issues (Friedrich & Mason, 2017).
It has been suggested that community-based projects promoting men’s mental health may be best conceptualised as an adjunct to formal mental health treatments or interventions rather than a replacement of statutory mental health care (Friedrich & Mason, 2017). However, this might depend on the format and focus of the CBPs. Activity-based projects where mental health promotion may be a secondary focus may be conceptualised in this way, yet CBPs with a talking approach such as emotional support groups may indeed provide an attractive alternative to conventional mental health care for some men.

4.1 Limitations and future directions

A limitation of this review relates to large parts of the process being done by the first author alone (DS), which leaves the findings vulnerable to subjective bias. However, the decision of having only one reviewer was made due to significant time restrictions for review completion. Future reviews would benefit from having more reviewers involved at all stages of the process.

Another criticism relates to the search terms chosen. Though the term ‘community-based projects’ was deliberately left open to interpretation to allow for broad inclusion, the lack of specificity led to difficulties in assessing which studies to include. This may have caused the exclusion of studies that might have been included by another reviewer’s interpretation of the eligibility criteria. Additionally, specific mental health difficulties were not included in the search strategy and therefore, possibly relevant interventions for psychiatric diagnoses such as depression or anxiety might have been overlooked. It is likely that including specific diagnostic labels in the search terms would have generated more studies, however, a decision was made against this as doing so would create the issue of establishing how many and which diagnostic labels to include. Furthermore, the review aim was not to assess effectiveness for symptom reduction in specific diagnoses but rather explore benefits of mental health interventions more broadly.

Regarding quality assessment of the included studies, some limitations relate to the use of the CASP tool. Though good at measuring transparency, the CASP tool has been found to be relatively inferior when compared against other tools such as the Evaluation Tool for Qualitative Studies (EQTS) and the Joanne Briggs Institute (JBI) tool. Here the CASP tool has been found to be the least sensitive to validity (Hannes, Lockwood & Pearson, 2010). A practical limitation in the application of the CASP tool relates to the hints given within each of the ten questions, which are included to aid the reviewer in deciding whether the specific criterion has been met. The number of hints vary between questions, and it is not clearly defined how many hints should be ticked before it can be concluded that the overall criterion has been met. This leaves the quality assessment open to the individual reviewer’s subjective judgment, which may increase the risk of bias (Long et al., 2020).

This review looked specifically at gender-sensitised CBP promoting men’s mental health but did not include comparison groups. As such, it is not possible to establish the relative effectiveness of different approaches to men’s mental health and whether gender-sensitised initiatives more effectively support men’s mental health
compared to mixed-gender CBPs. Previous research has found inconsistent evidence as to whether male-only projects are more effective than those mixing genders (Robertson et al., 2015). Therefore, research is needed to better understand what works best for men’s mental health support. Furthermore, a general limitation of gender-specific research is that it does not account for individual variation. What works for some men might not work for others. What affects people’s mental health will be based on more specific factors than their gender, including age, ethnicity, employment status, socio-economic background, and severity of mental health problems to mention a few.

This review did not distinguish between the talk-focused and activity-driven approaches but instead sought to be inclusive of both. Future research may benefit from reviewing the two approaches separately, exploring the relationships between the two and comparing their relative benefits and effectiveness. This would allow for more homogeneous studies being reviewed, which may ease the translation of the results into actionable points when informing guidelines for the development of similar future approaches promoting men’s mental health.

Future research would also benefit from including quantitative methods to triangulate the existing qualitative findings. Furthermore, as increasingly more initiatives find digital presence, it will be necessary to redefine what is considered a community, which will be important when considering future projects promoting men’s health (Oliffe, et al. 2019). Therefore, future research should aim to investigate the benefits of online interventions especially in terms of how they compare to or intersect with in-person initiatives.

5. Conclusion and Implications

This systematic review thematically synthesised the qualitative evidence of participant reported benefits of CBPs for men’s mental health and found that positive outcomes could be summarised under the following three descriptive themes: intrapersonal benefits, interpersonal benefits, and programme-related values. The analytical themes from this study, which have been presented in the format of five recommendations, can be used by developers of future CBPs promoting men’s mental health. When designing future male-only mental health-focused CBPs the evidence from this review should be considered alongside similar research to increase the chances of interventions successfully engaging men with their mental health.

The review adds evidence that community-based projects supporting men’s mental health increase men’s wellbeing and may offer an attractive alternative to conventional mental health treatment. Such initiatives might help ease the growing burden on health care systems like the National Health Service (NHS). To ensure effective CBP utilisation, partnership-working between statutory health care providers and community-based organisations should be strengthened, for example, through social prescribing. This necessitates that health care workers have up-to-date knowledge of what is available in the local communities. With increased use of CBPs, professional mental health services like NHS may move away from being the end station for mental health treatment to being a stop along the road to recovery.
While the review provided an insight into what participants report as beneficial in CBP participation, the evidence synthesised here is largely based on responses to project evaluations with fixed questions rather than open explorations of individual experiences of CBP engagement. The following article explores the individual experiences of men with mental health difficulties who engage with community-based projects as told in their own words.
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“Hearing other men talk about their struggles and their difficulties just really makes it... okay to feel the way I do”. Exploring experiences of community-based projects supporting men’s mental health using Interpretative Phenomenological Analysis

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Abstract

Some men experience mental illness differently than women and some mental health difficulties having a clear male overrepresentation. A reticence for help-seeking combined with biases in statutory health care settings means male mental health needs risk being overlooked. Community-based projects (CBPs) for men seem to effectively engage men with their health. This study used interviews to explore subjective experiences of engagement with CBPs promoting men’s mental health as described by men using such projects. Data was analysed using Interpretative Phenomenological Analysis. Three superordinate themes were identified from the interviews: Managing Emotions as a Man, Locus of Control, and Group Experiences. Men-only CBPs for mental health support may offer a promising alternative to standard health care for male mental health management.

Keywords: men, mental health, community-based projects, interpretative phenomenological analysis
1. Introduction

Men and women are thought to experience and express mental illness differently. This may be driven by gender socialisation, which place different expectations on men and women in terms of thinking, feeling, and acting (Smith, Mouzon & Elliott, 2016). Men typically express and discuss emotive issues to a lesser extent than women (Smith et al., 2016), and are less likely to seek help for their mental health needs (MacKenzie, Visperas, Ogrodniczuk, & Oliffe, 2019). In fact, negative attitudes towards mental health services have been found as early as in adolescent boys (Chandra & Minkovitz, 2006). Non-disclosure of mental illness and reticence in help-seeking may have important negative consequences for men’s wellbeing. Indeed, some mental health concerns have a significant male overrepresentation including substance misuse and suicide (Affleck, Carmichael & Whitley, 2018). Though women are more likely to attempt suicide, an estimated three quarters of all completed suicides in the UK are male; in 2019, men accounted for 74% of all suicides in Scotland (National Records Scotland, 2020) with similar numbers for England and Wales (Office for National Statistics, 2020).

The mental health disparity between men and women may be further complicated by a lack of attention to and proper understanding of men’s health by clinicians (Baker, 2016; Bilsker, Fogarty & Wakefield, 2018; Courtenay, 2000). Taken together, this calls for a better understanding of men’s mental health and how to meet their mental health needs, including a consideration of the settings that may effectively support and promote men’s mental wellbeing.

This study explores lived experiences of using community-based projects (CBPs) that promote men’s mental health from the perspectives of men with a history of mental health difficulties. The study aims to generate knowledge relating to how CBP participation may help men manage their mental health.

1.1 Mental health literacy

Research has pointed to a disparity between men and women in their knowledge and understanding of mental health. Men’s insufficient understanding and knowledge of mental health may lead to impaired coping (Grace, Richardson, & Carroll, 2018). Indeed, poor emotional wellbeing has been linked to low mental health literacy (MHL) in college-aged men (Rafal, Gatto, & DeBate, 2018). In their study, Rafal and colleagues (2018) found gender differences in mental health knowledge and symptom recognition where men were less likely than women to correctly identify symptoms of various mental health disorders. The findings showed that the combination of low MHL and high self-stigma negatively impacted on men’s help-seeking behaviours for mental health difficulties (Rafal et al., 2018). However, broader generalisability of the study results may be limited as the study was based on a convenience sampled survey with low response rate. Due to the study design the results lack in-depth understanding of individual experiences of mental health difficulties in the researched population. Furthermore, it does not unpack causality regarding factors leading to low MHL.
conclusion, men’s low emotional literacy, including the inability to recognise and articulate emotions, reduces symptom recognition of mental health disorders, which may leave men disadvantaged. In addition to the impediment of mental wellbeing, low MHL may reduce men’s capacity for help-seeking (Chandra & Minkovitz, 2006; Cleary, 2012; Grace et al., 2018). As such, an explanation for gender differences in the prevalence of mental health disorders may be that men report less mental health symptoms in their meeting with clinicians not due to the absence of mental health issues but rather because of a lack of mental health awareness and knowledge. This raises the question of what efforts are being made to enhance men’s mental health understanding.

1.2 Traditional Western masculine ideals may impact health behaviours

Gender can be understood as a dynamic, social construction enacted through beliefs, attitudes, and behaviours in interpersonal interactions (Courtenay, 2000). Gender is increasingly conceptualised as fluid rather than binary (e.g., Hyde, Bigler, Joel, Tate & van Anders, 2019), but for the purpose of this article, ‘gender’ refers to the binary categories of male and female. The terms masculinity and femininity refer to values, behaviours, and attitudes that men and women may endorse and engage in. Though many forms of femininity and masculinity exist, gender stereotypes influence what is generally believed to be typically male or female behaviour and people are often encouraged to conform to and adopt dominant norms of masculinity and femininity (Courtenay, 2000). Stereotypical and idealised forms of masculinity, or hegemonic masculinity, is always time and context dependent (Connell, 1995). From a constructionist perspective, men and women act and think in certain ways because they adopt culturally specific concepts about masculinity and femininity (Courtenay, 2000). The perceptions of what constitute feminine and masculine behaviours are shaped societally and communicated through media, popular culture, education, and parenting (Affleck et al., 2018).

Included in social constructions of gender are expectations of how mental ill-health, distress and vulnerability are managed (Affleck et al., 2018). Along with self-reliance, stoicism, defined as the absence of emotional involvement or expression and the exertion of emotional control, constitute hegemonic masculine health practices in the Western world (Martin, 2016). Vulnerability, sensitivity, and emotionality on the other hand may be incompatible with the Western masculine stereotype (Boysen, 2017; Simon, 2007). Health behaviours, like help-seeking, can be conceptualised as ways of enacting gender; asking for help may be viewed as a weakness, going against masculine ideals of self-reliance and independence (Courtenay, 2000; Mackenzie, Roger, Robertson, Oliffe, Nurmi, & Urquhart 2017; Ogrodniczuk, Oliffe, Kuhl & Gross, 2016). As illness and therefore weakness may compromise masculinity, men may construct gender through dismissing health care needs (Courtenay, 2000). Consequently, the Western world ‘strong man’ ideal risks negatively affecting health behaviours if men are more likely to jeopardise than promote their health (Oliffe & Phillips, 2008). Furthermore, perceived parental disapproval may negatively affect adolescent boys’ willingness to seek help.
for their mental health needs (Chandra & Minkovitz, 2006), which maintains systemic, cultural, and societal gender expectations relating to mental ill-health from an early age.

As gender expectations can dictate what constitute societally acceptable emotional reactions and expressions of mental health difficulties, this may lead to gender differences in symptomatic expression and behaviour. Where women tend to react by internalising disorders, men tend to ‘act out’ or externalise, which may involve high levels of alcohol or drug intake, risk-taking behaviours, poor impulse control and increased anger and irritability (Affleck et al., 2018; Smith et al., 2016). This ‘male symptom expression’ is more socially acceptable as it is consistent with Western hegemonic masculinity as opposed to crying or talking about issues, traditionally viewed as feminine behaviours (Martin, 2016; Courtney, 2000). But enacting these masculine norms may prevent men from showing vulnerability for fear of stigma (Simon, 2014), which further complicates the identification of common psychiatric disorders in men (Smith et al., 2016). Externalising behaviours may also increase social isolation (Player, Proudfoot, Fogarty, Whittle, et al., 2015) hindering the development of healthy interpersonal relationships, which can provide protective factors against mental illness (Smith et al., 2016).

Smith and colleagues (2016) raise the question of whether endorsing Western masculine stereotypes may also provide protection against mental health difficulties. Though externalising emotional difficulties away from the self or reacting with stoicism might offer some protection, the negative effects of enacting such masculine norms may outweigh the benefits. One study found that men who adhered to Western masculine norms and strongly identified with self-reliance was at increased risk of suicidal ideation (Pirkis, Spittal & Keogh, 2017).

It is important to note that the many ways of being male and expressing masculinity apart from traditional masculinity is often not covered in the literature. Addis & Mahalik (2003) emphasise that the issue with gender-specific research is that it does not account for individual-level or within-group variability. They argue that the degree of adherence to masculine norms, and indeed which norms, may vary depending on context and settings. Some men may endorse more masculine behaviours in some settings but not in others. As such, masculine ideals are not static but dynamic, fluid, and subject to change (Addis & Mahalik, 2003). The individual degree of adherence to masculine norms may affect help-seeking depending on context, setting and various other factors. Some might seek help in some situations but not others. Gender-specific research consequently risks making broad generalisations that may have negative connotations or impacts.

1.3 Health care contact and clinician bias

Gender disparity has also been found in the meeting with health care services. Research has found that in health consultations, compared to women, men often receive less time with physicians and are provided with fewer, briefer and more technical explanations for health issues (Courtenay, 2000). The shorter consultancy time may inhibit disclosure of difficulties (Oliffe & Phillips, 2008), which means mental ill-health risks being
overlooked. Indeed, men are often not offered support, whether formal or informal, for mental illness until they reach crisis point (Isaksen, Morrisey, Potter, Scowcroft, 2020). When they do receive support, this is frequently perceived as too short-term and focusing exclusively on a single issue, which can lead to a failure in exploring other difficulties (Isaksen, et al., 2020). Treatments offered to men may also depend on the clinician’s personal views of masculinity. Seidler and colleagues (2018) argue that clinicians’ beliefs and attitudes towards what constitute appropriate male behaviour may influence their client approach; some clinicians may nourish traditional Western world masculine ideals where men displaying emotional detachment gain more respect (Seidler, Rice, River, Oliffe, & Dhillon, 2018). Clinicians then risk propagating masculine stereotypes that impede help-seeking.

Another challenge in correctly identifying men’s mental health difficulties relate to the measures used for symptom detection. According to routine psychiatric surveys, the prevalence of common mental health disorders, such as anxiety and depression, is lower in men when compared to women, however, this may be due to underreporting of symptoms by men (Affleck et al., 2018). As symptom underreporting can be explained both by the incompatibility of masculine ideals with mental illness and by lower MHL in men, the use of self-report measures of mental health symptoms may give an inaccurate view of male symptom prevalence. However, bias in the assessment of mental health disorders may also be found in clinical measurement tools. What may be conceptualised as ‘female symptom presentations’, such as emotional expression and internalising difficulties, are often used as standards in the assessment of symptoms of psychiatric disorders (Oliffe & Phillips, 2008). The significant discrepancy between low rates of male depression and high rates of suicide is the most convincing evidence that diagnostic measures of mental health difficulties may be inaccurate (Affleck et al., 2018). As symptom expression through externalising behaviours is often not included in standardised diagnostic criteria for depression or anxiety (Affleck et al., 2018), men risk having their behaviours misattributed to other issues such as antisocial personality traits or substance misuse disorder (Smith, et al., 2016). Externalising behaviours may consequently be perceived as character issues rather than mental illness and may subsequently be mislabelled as social rather than mental health problems (Smith, et al., 2016). This puts into question the validity and reliability of some clinical measurement tools for symptom detection (Smith et al., 2016). Men may also use specific language to describe mental illness that does not concur with existing clinical criteria for psychiatric diagnoses (Bilsker et al., 2018), and thus risk being overlooked by health care professionals.

A significant issue with the predominant research into men’s mental health is the focus on the negative aspects of masculinity. Kiselica & Englar-Carlson (Englar-Carlson & Kiselica, 2013; Kiselica & Englar-Carlson, 2010) point to the fact that research and clinical attention is largely given to the difficulties and deficits created by men, which portray masculinity as ‘all bad’. Traditional male qualities like self-reliance and independence may entail not allowing others’ decisions and opinions forced upon oneself but being able to listen to and
consider input from others while remaining true to one’s own values (Kiselica & Englar-Carlson, 2010). Furthermore, these qualities may also foster healthy attitudes to solving own difficulties without being reliant on other people for support and help. Similarly, stoicism may offer some protection against adverse events when it allows the person to maintain a sense of calmness and distance, while not letting oneself become emotionally absorbed or overwhelmed, which may cloud one’s judgment and thereby impede problem solving abilities. As such, facing adverse events with stoicism without becoming emotionally overwhelmed may promote mental well-being and resilience in self and other people (Englar-Carlson & Kiselica, 2003).

However, traditional male qualities like independence, stoicism and self-reliance may become problematic when adhered to in a way that becomes overly rigid and restrictive. This may be in the form of constraining emotional expression and help-seeking behaviours to the detriment of own or other people’s wellbeing. Stoicism and self-reliance may become maladaptive when they result in suffering in silence, refusing help and pushing away others away thus risking severely limiting social support networks, which may be crucial when facing mental health difficulties. Furthermore, if stoicism results it never allowing oneself emotional expression this attitude might risk turning the person into a ‘pressure cooker’ where emotional difficulties continue to build up until the person reaches a breaking point.

Kiselica and Englar-Carlson advocate for the positive dimensions of masculinity and argue that to effectively engage men with their mental health in therapy settings, more ‘man-friendly’ approaches are needed (Cole, Petronzi, Singley & Bagliery 2019, Kiselica & Englar-Carlson, 2013; Englar-Carlson & Kiselica, 2010). Kiselica and Englar-Carlson present the Positive Psychology/Positive Masculinity (PPPM) therapy framework, which can support the promotion of male wellbeing by focusing on strengths of masculinity. Within the PPPM framework, positive, healthy, and constructive aspects of masculinity are emphasised and embraced to foster resilience and wellbeing. One study examined men’s psychotherapy preferences and found that men show a preference for PPPM to cognitive behavioural therapy (Cole et al., 2019). However, the study had several limitations. Rather than being assessed in vivo, psychotherapy preferences were based on reading vignettes of different therapy models and subsequently completing self-report measures of preference. Furthermore, when assessing hypothetically rather than in vivo other factors, which influence successful therapy outcomes such as a strong therapeutic alliance, are not accounted for. Though PPPM may offer a masculinity-sensitive therapy style that appeals to some men, further research is needed to establish its effectiveness (Cole et al., 2019). Cole and colleagues (2019) also emphasise that it is important for therapists to keep in mind that not all men are looking for ‘male-friendly’ therapy styles.

1.4 The role of community-based services in the promotion of men’s mental health

Non-engagement with health care services raises the question of whether substantively different approaches to male mental health interventions are needed. When considering low rates of health care service uptake by men, community-based projects promoting men’s health may offer a compelling alternative to engage men
with their health (Oliffe, Rossnagel, Bottorff, Chambers, Caperchione, & Rice 2019). Research has found that factors promoting men’s help-seeking behaviours include informal, community-based settings, interventions incorporating social interactions and activity-focused initiatives (Struszczyk, Galdas, & Tiffin, 2019; Grace et al., 2018). The less formal settings of the community-based spaces compared to traditional health care services offer opportunities for social connectedness, and activity-focused programmes increase the likelihood of engaging men with their health (Oliffe et al., 2019). Furthermore, CBPs promoting men’s health may offer a more strength-based and gender-sensitive approach to mental health management (Bilsker et al., 2018). Participant homogeneity such as commonalities in gender, age, and interests, within male focused CBPs may impact on the construction of a supportive environment for men to engage with their health (Bunn, Wyke, Gray, Maclean, Hunt & Anderson, 2016). If programmes have a focus that participants are engaged with and enjoy this may impact on enthusiasm linked to participation and confidence-building in the enactment of new health practices (Bunn, et al., 2016).

A popular community-based initiative is the Men’s Sheds organisation, which was developed to promote psychosocial health and wellbeing in mainly older, retired men by engaging them with activities such as wood- or metalwork (Ballinger, Talbot & Verrinder, 2008). Shed participation has been found to enhance health and wellbeing by providing men with a sense of purpose and meaning, increased social connectedness and decreases in social isolation and loneliness (Kelly, Steiner, Mason & Teasdale, 2019).

Presently, most of the research into CBPs for men has focused on promoting physical health with interventions for weight management (Bunn, et al., 2016; Lozano-Sufrategui, Pringle, McKenna & Carless, 2019), prostate cancer (Bjerre, Leth, Hammer, & Midtgaard, 2018; Rørth, Tjørnhøj-Thomsen, Cormie, Oliffe & Midtgaard, 2019) and Parkinson’s disease (Borrero, Miller, & Hoffman, 2020). Additionally, football-based CBPs are gaining increasing popularity especially in the UK (see Curran, 2013; Pringle, Zwolinska, McKenna, Daly-Smith, Robertson & White, 2013; Gray, Hunt, Mutrie, et al., 2013). Friedrich & Mason (2017) have reviewed the research that incorporate football-settings into mental health promotions and explored the outcomes of such initiatives. They found that engagement increased emotional wellbeing and self-confidence while providing participants with a sense of social connectedness and inclusion (Friedrich & Mason, 2017). However, the primary focus of the studies was on the football-based activities with increased mental wellbeing as a secondary positive outcome. As such, physical activity seemed to be central to these studies rather than mental health. Moreover, the review was not gender-sensitised for men specifically but included evidence of both male-only and mixed-gender studies.

While the Men’s Sheds literature and research into physical health initiatives for mental health both show similar positive findings relating to emotional wellbeing and increased social connectedness, there is a need for more research focusing on male specific CBPs with mental health promotion as the primary aim. Less research has looked at CBPs for men with talking as the vehicle for promoting emotional and psychological
wellbeing. As men may discuss mental health experiences with other men differently than within mixed-gender settings, men-only CBPs for mental health may play an important role in facilitating such talks and offer a promising alternative to conventional therapy in clinical settings (Mackenzie et al., 2017).

1.5 The present study
In summary, some mental illnesses, including fatal suicide, has a clear male over-representation. When compared to women, men seem to cope less well with emotional difficulties and seek help less frequently for their mental health needs. This may in part be driven by low male mental health literacy and adherence to traditional masculine ideals but may be further complicated by clinicians’ subjective biases and measurement tools that do not sufficiently account for male symptom expression.

Community-based initiatives promoting men’s health may offer an attractive alternative to statutory health care, however, at present most research has focused on activity-driven interventions promoting men’s physical health with less focus on similar initiatives for mental health support. Even though men’s understanding, and awareness of mental illness has been found to be lower compared to women, less research has focused on how to advance men’s emotional knowledge and which settings may promote this advancement. Furthermore, much of the research into men’s mental health and recommendations for what needs to change to better engage men with their mental health is based on theory development from reviews of existing evidence, survey data and self-report measures or experts’ opinions, arguably based on extensive knowledge and experience. The perspectives of the men affected by mental ill-health using CBPs promoting mental health has been explored to a lesser extent. Where evidence exists on men’s experiences with CBPs for mental health this may in large parts be elicited through service evaluations and responses to predetermined questions rather than more open explorations of participants’ subjective experiences.

This study seeks to explore how men with experiences of mental health difficulties engage with community-based services promoting men’s mental health. The study aims to generate important learning points from participants’ lived experiences to better engage men with their mental health adding empirical evidence to the existing knowledge pool of what engages men with their health (Oliffe et al., 2019).

The primary research question guiding this study was ‘what does engagement with community-based projects promoting men’s mental health mean to men with a history of mental health difficulties?’ The study sought to explore men’s individual experiences of using CBPs for mental health support as told in their own words, and therefore, Interpretative Phenomenological Analysis (IPA) was deemed a fitting methodology, as it explores individual lived experiences of important life events (Reid, Larkin & Flower, 2005). In keeping with the inductive nature of IPA, the research question for this study was formulated to be exploratory rather than explanatory (Smith, Flowers & Larkin, 2009). Rather than develop and test hypotheses based on a priori assumptions about men’s mental health and CBP use, this study sought to give voice to men with experiences
of both from their perspectives. As such, the study sought to add an in-depth understanding of individual experiences as told by the participants themselves. The findings from this research can add detailed knowledge not only of what participants’ experiences of using community-based projects are but also why they are meaningful and important to them.

2. Methods
2.1 Design
A qualitative research design was used as the study aimed to develop an understanding of individual experiences from the perspectives of the research participants (Elliott, Fischer & Rennie, 1999). Data gathered from semi-structured interviews were analysed using Interpretative Phenomenological Analysis (IPA), which provides a research framework particularly aimed at examining how people make sense of their personal and social worlds (Noon, 2018). In the present study, IPA was used to explore participants’ lived experience of mental health difficulties and their engagement with community-based projects supporting men’s mental health through their own accounts, perspectives, thoughts, and feelings.

2.2 Recruitment
In line with the IPA methodology (Smith & Osborn, 2015) the present study employed purposive sampling to obtain ‘information-rich’ interviews from a homogenous participant sample (Vasileiou, Barnett, Thorpe & Young 2018). Recruitment criteria were intentionally left broad to ensure enough participants were included for a doctorate project. A range of CBPs promoting men’s mental health in Scotland were approached by the researcher and initial contact was made over email, via website contact forms, or by phone. The researcher made contact with two ‘intermediaries’ who worked for local CBPs promoting mental health. The intermediaries, who both volunteered as interview participants, were group leaders of men’s groups and through this contact, the researcher was invited to join men’s groups meetings online to promote the research. Men interested in study participation subsequently contacted the researcher to arrange interviews. As most participants were recruited this way, the representation of community-based projects was predominantly from men’s groups. The study was also advertised on social media, specifically through Twitter.

2.3 Data collection
Verbal consent for interview participation was obtained prior to the interview. The interviewer read out six statements and the participant consented to each in turn (see Appendix 3). On the day of interview, participants completed a short mood assessment, the Positive and Negative Affect Scale (PANAS) (see Appendix 4) to assess mood prior to the interview; this was done as a part of a safe-keeping protocol (Appendix 5). The PANAS was repeated at the end of the interview to assess for any significant mood changes. All participants reported an increase in positive mood following the interview.
Semi-structured interviews were conducted and recorded through video calls using Microsoft Teams. Each interview lasted between 60 and 105 minutes with the total amount of interview time amounting to 607 minutes. The interview schedule (see Appendix 6) included questions on experiences of using CBPs supporting men’s mental health including how participants used the project and personal benefits of project engagement. To allow for the collection of rich data, participants were encouraged to talk about their individual experiences and topics important to the interviewee were explored as they arose. In keeping with the IPA principles, open-ended questions were used to minimize research bias (Smith et al., 2009). The last question of the interview related to participants views of changes needed to better engage men with their mental health. As it was not part of the IPA methodology, the responses are not reported in the Results section. However, a summary of participants’ answers is presented in the Discussion.

Interviews were transcribed verbatim using the software Transcribe by Wreally® and anonymized with names changed and any participant-identifiable details removed. Following transcriptions, interviews were played back, and transcripts double-checked for accuracy. Interview recordings were deleted following transcription.

2.4 Participants

Nine participants were recruited for interview: all participants were white, British males. Ages ranged from 42 to 68 with a mean age of 54 (see Table 1). Of the nine participants, eight were recruited from four different community-based men’s group across England and Scotland. One participant was engaged with a community-based sports initiative promoting men’s mental health. Seven participants were recruited through the researcher approaching CBPs; two participants were recruited through social media posts.

Prior to the interview, participants were screened over the phone to assess eligibility for study participation with the main criteria being lived experience of mental health difficulties past or present and engagement with a men-only CBP promoting mental health. Prior to the screening interview, participants were sent a Participant Information Sheet (see Appendix 7) containing details regarding the interview background and process.

All nine participants were interviewed; however, one interview was excluded from the main data set prior to analysis as this participant’s experience was considerably dissimilar to the others’ and therefore difficult to link to the rest of the data. While the excluded interview provided important insights into CBPs for men’s mental health the interviewee’s experiences of mental health, his community involvement, and the topics he chose to talk about were substantially different to the other participants, which compromised the homogeneity of the sample. A key part of IPA research is generating a homogenous sample to ensure that the research is personally relevant to its participants, while enabling researchers to generate knowledge about people with shared or very similar experiences (Noon, 2018). The selection of research participants should aim to reflect and represent convergences and homogeneity to increase the understanding of the researched phenomenon (Alase, 2017). The decision to exclude this interview from the overall data set was informed by the importance
of homogeneity in IPA research and reached after careful consideration and consultation with a senior member of academic staff (EQ).

Table 1 summarises pseudonyms and ages of participants including the length of their engagement with a men’s group and how frequently they attended.

### Table 6. Participant demographics

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Time in men’s group</th>
<th>Frequency of attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alex</td>
<td>51</td>
<td>6 years</td>
<td>Weekly</td>
</tr>
<tr>
<td>Hugh</td>
<td>61</td>
<td>7 years</td>
<td>Weekly</td>
</tr>
<tr>
<td>Matt</td>
<td>42</td>
<td>12 months</td>
<td>Four times a week</td>
</tr>
<tr>
<td>Tom</td>
<td>54</td>
<td>7 years</td>
<td>Weekly</td>
</tr>
<tr>
<td>Craig</td>
<td>64</td>
<td>7 weeks</td>
<td>Weekly</td>
</tr>
<tr>
<td>Lewis</td>
<td>43</td>
<td>&gt; 1 year</td>
<td>Fortnightly</td>
</tr>
<tr>
<td>James</td>
<td>47</td>
<td>7 years</td>
<td>Fortnightly</td>
</tr>
<tr>
<td>Simon</td>
<td>68</td>
<td>5 years</td>
<td>Fortnightly</td>
</tr>
</tbody>
</table>

### 2.5 Analysis

The research study was designed and analysed according to IPA methodology, which is informed by phenomenological philosophy, and explores lived experience of significant life events. As opposed to an objective description of such events, IPA is concerned with the subjective ways in which participants perceive their world (Smith & Osborn, 2015). As this study aimed to explore individual experiences of mental health difficulties and use of CBPs supporting men’s mental health as told by the participants in their own words, IPA was deemed the best fitting methodology. Furthermore, when researching this relatively ‘unexplored territory’ IPA can offer meaningful insights from the analysis into issues with limited theoretical pretext (Reid, Flowers & Larkin, 2005).

The theoretical underpinnings of IPA include phenomenology, hermeneutics and idiography. The theory of phenomenology was first conceptualised by Husserl (1931) to study and understand the meaning of human experience (Alase, 2017). Phenomenology is concerned with how people perceive their experiences and in IPA research, participants’ inner life worlds can be accessed through their thoughts, memories and feelings as retold in their own words (Noon, 2018). Hermeneutics, the theory of interpretation, inform the interpretive part of IPA and relates to participants’ sense-making of their experiences (Smith, et al., 2009). A ‘double hermeneutics’ is at play in IPA as the interviewer is trying to make sense of the interviewee making sense of their lived experience (Smith, 2004). Husserl (1931) argues that it is imperative to put aside preconceived ideas.
and perceptions about the world in order to concentrate on our perception of that world. However, Heidegger questioned whether any knowledge can exist outside an interpretative stance (Smith et al., 2009). Therefore, while acknowledging that it is impossible to completely set aside own assumptions and perspectives, in IPA efforts are made through self-reflection to ‘bracket off’ or limit the influence of the researcher’s preconceptions about the field to better understand and represent the experiences of the participants (Elliott et al., 1999) (see also section 2.6). IPA is idiographic in its concern with in-depth and detailed analysis of individual cases of lived experiences. Only after rigorous and detailed analysis has been achieved at individual case-level, an attempt is made to cross-case analyse looking for convergent and divergent themes within individual narratives (Smith, 2004; 2011). Therefore, IPA is based on small data sets and intends to provide a microanalysis of individual experiences rather than theory development for broader generalisation (Smith, et al., 2009). IPA assumes that individuals in the same situation may have different experiences, which are influenced by their subjective thoughts and feelings, beliefs, expectations, and meanings ascribed to the situations (Willig, 2008). Thus, the meanings participants attribute to their experiences of mental health and their use of community projects will shape their experiences.

While acknowledging that there is no definite, single way of doing IPA (Smith & Osborn, 2015) the data analysis in this study was informed by the 6-steps process suggested for novice IPA researchers and outlined in Smith, Flowers & Larkin (2009). It includes 1) reading and re-reading interviews, 2) initial noting, 3) development of emergent themes, 4) searching for connections across emergent themes, 5) moving to the next case, and 6) looking for patterns across cases. All interviews were read closely, and initial notes and descriptive, linguistic, and conceptual comments were added (Smith et al., 2009), which informed the process of inductive coding (i.e., codes were created based on the data rather than predefined ahead of analysis). From the codes 63 initial themes were identified. Subsequently, several initial themes were collapsed into subthemes with representation across the full data set. Subthemes were considered relevant and representative of the overall data set when consisting of evidence from at least 3 participants, which is in keeping with guidelines for good IPA practice outlined in Smith (2011). In practice, only subthemes with representation from at least four participants – half the data set – were included. In the process of developing subthemes, a continual move between the raw data and emergent themes took place to ensure that themes stayed true to the original content as evidenced in extracts from interviews. See Appendix 10 for an example of the style and steps of transcript analysis.

2.6 Sample size

According to Smith and colleagues (2009) 4-10 participants are considered sufficient for professional doctorate research projects. It is recognised that the commitment to detailed interpretative analysis inherent in IPA will realistically restrict the number of cases being studied. Conversely, doing IPA on very small sample sizes runs the risk of sacrificing breadth for depth (Smith & Osborn, 2015). However, Smith & Osborn (2015) argue that
there is no right answer regarding sample size. Rather, sample size is dependent on factors including the extent of individual case analysis, data richness, and constraints to the research process.

2.7 Ethical considerations

The study was approved by the Health in Social Science Research Ethics Committee, University of Edinburgh, from which it also received sponsorship. All interview recordings were deleted following transcription, and any personal identifiers were removed before write-up to ensure participant anonymity and confidentiality. In a further effort to ensure anonymity and data protection, a separate email address was created through the university and linked to the researcher’s student email. The research specific email ensured that all correspondence between researcher and participants was kept separate from any other correspondence. Furthermore, the separate email address allowed for easy and secure destruction of correspondence data upon completion of the research study. Though the focus of the interview was on the use of community-based projects promoting men’s mental health, the researcher recognised that some may find talking about lived experiences of mental health difficulties upsetting. Therefore, steps were taken to ensure the wellbeing of the participants. This included the development of a safe-keeping protocol to follow should the participant become distressed during testing (Appendix 5) along with the completion of a mood assessment (PANAS) before and after the research interview to see if participants’ mood had altered significantly compared to pre-interview baseline. The use of the PANAS in the interview process was a remnant of the original study focusing on male suicidality and CBP use. The PANAS was included in the present study to ensure that participants’ mood states were relatively stable and not predominantly negative prior to commencement of the interview. Repeating the PANAS at the end of the interview was done to assess the development of mood states following the interview and to ensure that mood states had not decreased noticeable. It is possible that the process of completing a mood assessment such as the PANAS prior to the interview may impact on participants’ expectations of the interview process or content and may increase nervousness. Furthermore, it is possible that commencing the interview process with a mood assessment may increase participants’ attention to their mood state at the time, which may subsequently influence the interview process, individual answers and what participants chose to speak about.

After the interview, participants were sent a follow-up email (Appendix 8) thanking them for their participation and inviting them to look over the results upon completion of data analysis and write up of results. The follow-up email also included a debrief form (Appendix 9) with contact information for relevant support agencies should participants feel distressed following the interview.

2.8 Quality check

Researchers agree on the need for ensuring the quality and validity of qualitative research and several different but overlapping guidelines exist (Elliott et al., 1999; Twining et al., 2016). Throughout the process of the present study efforts were made to ensure the quality and validity of the research. These efforts are evidenced
against the criteria outlined by Poortman & Schildkamp (2012) in Table 2 as they provide a coherent and inclusive framework for the quality assessment of qualitative research. The application of the framework has been demonstrated in both qualitative (Poortman, 2007; Cohen, 2021) and mixed-methods (Schildkamp, 2007) research.

Table 7. Quality control criteria, procedures, and evidence as outlined by Poortman & Schildkamp (2012).

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Procedure</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Controllability</strong></td>
<td>Report is publicly available</td>
<td>Thesis is prepared for publication in a scientific journal, Journal of Men’s Studies.</td>
</tr>
<tr>
<td></td>
<td>Replicability of results</td>
<td>Clear description of research process for feasible study replication that should yield similar results.</td>
</tr>
<tr>
<td><strong>Objectivity</strong></td>
<td>Use of objective data</td>
<td>Data collected through semi-structured interviews, which were participant-led and exploratory in nature. Data available for re-analysis.</td>
</tr>
<tr>
<td></td>
<td>Researcher bias avoided</td>
<td>Personal statement included to recognise and control for researcher’s own biases (see section 2.8)</td>
</tr>
<tr>
<td><strong>Reliability</strong></td>
<td>Recording of data (video/audio)</td>
<td>All interviews were video recorded.</td>
</tr>
<tr>
<td></td>
<td>Inter-rater reliability of codes</td>
<td>Codes checked and discussed with researcher with extensive qualitative experience and knowledge (EQ).</td>
</tr>
<tr>
<td><strong>Construct validity</strong></td>
<td>Explanation of underlying theoretical model</td>
<td>Theoretical underpinnings of IPA methodology outlined in section 2.4.</td>
</tr>
<tr>
<td></td>
<td>Provision of ‘chain of evidence’ including data collection notes, verbatim transcripts, check of data, analysis, and findings by other researchers, piloting of instruments</td>
<td>The researcher kept a reflective process journal throughout the study process.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Verbatim transcripts of interviews were developed using the software Transcribe by Wreally ®.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The researcher received supervision throughout the research process from two members of academic staff (IO &amp; EQ) and field supervision (RB).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feedback obtained on interview protocol from EQ. Testing of interview protocol recording equipment prior to interviews with peer researcher (NvA).</td>
</tr>
<tr>
<td><strong>Internal validity</strong></td>
<td>Patterns in respondents’ experiences</td>
<td>Evidenced in summary of findings Table 3, which provides an overview of superordinate and subthemes which emerged from the data.</td>
</tr>
<tr>
<td></td>
<td>Discussion of findings with other researchers</td>
<td>Close liaison with IO, EQ &amp; RB who read and fed back on findings.</td>
</tr>
<tr>
<td></td>
<td>Participants checking</td>
<td>Participants were sent a summary of the findings; one participant requested a copy of their interview transcript and two participants fed back that the summary accurately reflected themes from their respective interviews</td>
</tr>
<tr>
<td><strong>External validity</strong></td>
<td>Generalisability of findings</td>
<td>Description provided of participants, settings, and context along with recruitment strategy. Results situated in existing research findings</td>
</tr>
</tbody>
</table>
2.9 The researcher's perspective

As researching within a qualitative methodology is inevitably influenced by the researcher’s subjective perspective, it is important that the researcher acknowledges and addresses any preconceptions that may influence data collection and analysis (Elliott et al., 1999). Therefore, to strengthen the credibility of the current research I (DS) have made efforts to make explicit reflections of my possible influence of the data collection and analysis (Twining, Heller, Nussbaum & Tsai, 2016). How the researcher perceives and makes sense of participants’ experiences is inherently affected by socio-cultural background. Gender is an important part of self-identity and important to reflect upon in gender-specific research. Being female and researching strictly male experiences can pose a barrier to understanding gender-specific experiences of mental health for people adhering to a gender-category different from my own. For example, participants may refer overtly or indirectly to gendered experiences, expectations, or understandings that I may not understand or notice due to lack of overlapping experiences. They may also use distinct gendered language unfamiliar to me. Additionally, participants may feel uncomfortable disclosing emotional or intimate information to a person of different gender, which may affect data collection. Or they may wish to present themselves in a certain way i.e., if adhering strongly to Western, traditional male norms such as stoicism. However, it is worth noting that the above may also be true when just speaking to someone unfamiliar to them despite gender.

Furthermore, I am not British but Scandinavian and though communalities exist within northern European cultures, divergences exist too. Values and understandings of social constructions of gender inherent in my cultural background differ somewhat from British norms, for example, regarding the adherence to and enactment of traditional gender norms. Additionally, a noticeable age-gap existed between me and the participants ranging from a gap of 7 to 33 years age difference. The age-gap becomes important as understandings of subjective experiences is funded in cultural and societal context, in which time plays an important aspect.

Though consciously trying to observe my study objectively, my personal background inevitably provides me with the lens through which I perceive and make sense of the world including how I make sense of other people’s experiences and sense-making. Conversely, the limited overlap between researcher and interviewee backgrounds may be a strength as it might make me a more naïve and therefore objective researcher whereby reducing bias. Though my observations, interpretations, and analyses can by nature never be truly objective, I have strived to reduce biases by acknowledging my own limitations. Throughout the research process, I attempted to remain open, curious, and non-judgmental.
3. Results

Three superordinate themes emerged from the data: 1) Managing emotions as a man, 2) Locus of control, and 3) Group experiences. Evidence of the superordinate themes was found across all interview transcripts. A total of 11 subthemes were found with each subtheme finding evidence in at least half the interviews. Superordinate themes and subthemes are presented in Table 3 below. The themes were not mutually exclusive; rather they existed alongside each other often intersecting.

Table 8. Interview themes with participant representation

<table>
<thead>
<tr>
<th>Superordinate theme</th>
<th>Alex</th>
<th>Hugh</th>
<th>Matt</th>
<th>Tom</th>
<th>Craig</th>
<th>Lewis</th>
<th>James</th>
<th>Simon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing emotions as a man</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>You are taught to hold your emotions in</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Masculinity as barrier to getting help</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Substances as enablers</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Locus of control</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Clinical settings as power structures</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Time is precious</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Being listened to</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Long-term support maintains mental health</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Group experience</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Safe space</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>It’s okay to talk</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>More than group therapy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Spaces for men</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

3.1 Managing emotions as a man

The superordinate theme of ‘Managing emotions as a man’ emerged across the full data set and includes three subthemes: 1) ‘You are taught to hold your emotions in’, 2) Masculinity as barriers to getting help and, 3) Substances as enablers. All participants spoke about their experiences of being a white, British male spanning from how masculinity is modelled societally to how adherences to traditional Western world masculine ideals of emotion regulation negatively affected their mental health and impeded on help-seeking behaviours. This superordinate theme provides a context for understanding how male gender expectations of managing emotions within a white, middle-aged, British context affect mental health for the interview participants.

3.1.1 ‘You are taught to hold your emotions in’

Several interview participants spoke about how male norms were modelled to them within close family systems and in the wider society.

Tom: a lot of guys are not really able tae- they don't know how tae... express cos they've never been... taught how to do it, they've never been shown how tae do it cos their father had been the same, closed off as well. It's [...] a generational thing as well it's just... something has to change.
Embedded in the extract is an understanding of how male norms and expectations are passed down generations through male family members. Men rely on their fathers to learn to manage emotions, yet rather than managing emotions, holding them in has been passed down. Referring to this as a generational issue emphasises how deeply rooted the attitude is, simultaneously implying how robust it may be to change. By emphasising the need for change, ideals of male emotion regulation are challenged rather than accepted.

*Lewis:* I never got taught how to talk about things [...] I've never blamed- My dad never got taught that kind of stuff uh. He wisnae one for that, he wisnae one for talking about his feelings.

Using the word *blame* indicates a perception of not learning how to communicate emotions as a negative while at the same time expressing forgiveness as the father never got taught any different and thus did not possess emotional knowledge to pass on to his son.

*Tom:* [...] women are taught to show their emotions and everything like that and they're-their told tae, you know, if they're, if they fall or something, they get up and they cry and they are rubbing their knee and they are crying and that and whereas the guys are taught tae 'get up, shut up and dinnae greet' [inaudible]. You are taught to hold your emotions in.

*Hugh:* We have created a society of two different uh thing – the female would have more compassion.

A societal acceptance exists of girls to receive care and attention when upset, whereas boys are expected to toughen up and sort out problems in an aggressive manner from an early age. These gender expectations are also evident in how language is used in male interactions. Expectations of self-reliance, being able to manage on his own and not express emotions were communicated to Craig in a harsh tone by his stepfather.

*Craig:* 'you're a man, you're not a-a wimp', you sort things out yourself. You stand on your own two feet, and you don't need this, and you don't need that.

Moving from individual experiences of learning how to manage emotions as a male, participants spoke about how men are expected to manage their emotions by holding it in or bottling up.

*Hugh:* We’ve created this [...] real strong image, that men must be hard. They cannot show their emotions, they cannot cry, they are not allowed to cry and therefore, historically, we are in a very difficult place uhm, a lot of men, for men who go to prison.

Having to keep emotions suppressed to fit an image of ‘the hard man’ severely restricts opportunities for emotional expression leaving little room for alternative ways of coping. In the extract there is a distinction between the use of ‘we’ and ‘they’. Using the pronoun ‘we’ indicates that the image of the hard man has been created and accepted on a historical, societal, and cultural level. Furthermore, using ‘we’ may suggest how the participant sees his own contribution to this image, even if this is just by virtue of being part of a given society. However, using ‘they’ when describing the restrictions laid down upon ‘the hard man’ may suggest that Hugh does not see himself within this image. ‘They’ therefore, refers to other men.
Lewis: ...to be able to talk about things where previously, a lot of my experience was- I never, you know. I used to just bottle things up and, uh... and it would come out in other behaviours.

Lewis, who had been involved with criminal justice and substance misuse, describes how holding emotions back would result in difficulties being channelled through behaviours. Not knowing how to communicate his emotions and manage his mental health, would result in maladaptive behaviours such as substance misuse or crime. Lewis’ experiences link to Hugh’s comment on how not being able to express emotions lead to a build-up that has no outlet and then when it is let out, the consequences can be detrimental for the individual and others. Ultimately, endorsing the hard man ideal can result in becoming emotionally shut off with limited ways of coping.

Craig: I didn’t- I couldn’t show no emotions, ken. Because you had to be a-a tough individual, ken. So, you had- I-I had no emotions for donkeys years.

Craig’s interchangeable use of the personal pronouns ‘I’ and ‘you’ may suggest that he views his experiences of managing emotions as applying to men broadly rather than being unique to him. Shutting down emotions may also act as a protective defence against psychological pain though this defence may be unsustainable in the long term.

Tom: They’re carrying all this stuff behind them cos they haven’t dealt with it. I mean they- they’ve had this trauma and everything like that but they’ve no… dealt with it. It’s still there in the back of the mind and that’s how things goes on, it just gets pushed to the back of the mind. [...] yeah, so the bag literally [makes sound] you cannae carry it anymair.

Never having learned ways of managing emotions other than suppressing them, men are forced to carry their difficulties around with them like heavy baggage. Unable to effectively manage emotions, they cannot put the baggage down. Unprocessed emotions then become ever present. For these men, condemned to repeat the same process, managing emotions becomes a Sisyphean task; seemingly endless, ineffective, and futile until it breaks them.

3.1.2 Masculinity as barrier to getting mental health support

A general understanding emerged from the interviews of how men’s adherence to traditional Western masculine ideals and standards constituted a barrier to seeking and receiving help for mental health issues.

Alex: it’s that huge initial step, isn’t it, it’s that getting over that kind of macho ‘I’m alright, I can cope, it will be fine’ uhm ‘if I go to the doctor it’s I’m a failure particularly if down to my mental health’ [...] when we all know that’s rubbish.

Simon: males are worse than females for having that macho masculine image and you just don’t talk about issues. You don’t talk about anything especially something which puts you in a light, showing a sign of either weakness or insecurity or instability. You have to be that big tough guy that looks great all the time and I mean that-that doesn’t help people with mental health issues deal with it.
Masculinity expressed through the macho man ideal forms an obstacle that needs to be overcome to get help as suppressing health needs is not an effective strategy. Simultaneously, Alex conveys a disagreement with the macho attitude as the stigmatisation of male mental health difficulties prevents men from seeking help. Rather, seeking support or talking about emotions is not just necessary but something to be passed on. In a sense, there is an attempt to find a different way of being a man. Showing vulnerability compromises the ideal of the tough man and must be kept hidden, which maintains stigma and prevents men from openly discussing their mental health difficulties. Thus, adherence to masculine ideals impedes seeking help for mental health issues.

Tom: Guys all wearing this mask and it's totally different from how they are feeling inside... inside their emotions- they're screaming and try to get oot but [...] you-you hold this face, and everything is fine going outwardly and inwardly you're screaming 'just want to get out'. You're-you're holding all this stuff in. You don't want to open up and show it to the world. So so- it's what I call a mask, you're hiding yourself away from... the outside world.

Embedded is a reluctance to recognise vulnerability as it holds the power to destabilise the masculine ideal. Consequently, men must wear a mask to conceal true parts of themselves to keep safe from other people’s judgments. Thus, the masculine ideal – the mask - offers protection both from other people but also from psychological pain and provides a defence for men to keep themselves safe. Removing the mask would be risking societal acceptance but also means feeling something, perhaps for the first time, which can be scary.

For Lewis, it is important that gender expectations are changed societally, and boys are taught how to openly talk about emotions early on in life.

Lewis: because kids are up against it if they go home and their dads are saying 'stop being a wee pussy, stop being a woman' all that, all the derogatory terms, d'you know uh which stops people fae saying 'I'm feeling sad' or [...] 'I need help', d'you know. End that old 'men being men' and all that kindae thing [...] It's bullshit-it's bullshit, man. It's like 'people are dying'!

Expectations of what it means to be male is embedded in the language, reflecting that weakness and sensitivity is incompatible with hegemonic masculine ideals. When men use pejorative language to describe other men as unmanly by comparing them to subordinated women or gay men the ideal of the hard man, who holds back emotions is reinforced. Lewis links recent increases in male suicides in his local area to adherence to Western masculine ideals of stoicism and non-disclosure of mental ill-health. Across interviews were a push back against the traditional gender expectations especially regarding how emotional restrictions placed on men are unhelpful, unhealthy, and ultimately fatal.

3.1.3 Substances as enablers

A theme emerged around substances as a means to channelling emotions for men. Several participants spoke about how under the influence of substances, whether alcohol or drugs, it became easier to talk about their emotions.

Matt: alcohol is obviously it's-it's a little doorway into honesty for a lot of men uhm in in Britain.
James: The only times I would get onto the more intimate conversations would be down the pub when I was drunk, and they were drunk.

Processing of emotional experiences must be kept within societally approved settings for intimate conversations while under the influence. As alcohol constitutes a societally acceptable means to elicit emotions, the pub becomes a natural arena, the social institution, to display the same. With the intake of substances, the emotional guard may be lowered, and the mask taken off, allowing for emotional expression. The need to do so shows a real desire from these men to talk and connect.

Lewis: I spent years... saying I was fine, and I never spoke about anything unless I was under the influence of substances and I would be spouting my whole life story at people and anybody that wants to listen, and all that. But sober and free fae substances, I never spoke about anything.

When having to consciously hold emotions in when sober, being under the influence of substances is a way of freeing oneself up. As such, with the intake of substances comes a permission to let go. How Lewis describes speaking at people indicates both the significance and magnitude of the need to speak, and it being less of a conversation and more of one-sided release. Once the substances are out of the system again, he reverts to holding emotions in. In this way, the substances provide a temporary emotional relief.

For James, a change in his life provided him with an opportunity to have more intimate and emotional conversations without alcohol.

James: when my son was born I uhm became a stay-at-home father [...] that then meant that I was uhm spending lots of time with other adults uhm, you know, looking after kids but also just spending a lot of time sitting around drinking tea and uh [laughs] [...] and that then challenged that thing, like 'oh, I can have these more intimate conversations when I'm sober'.

In this new context where emotions can be expressed more freely, alcohol has been replaced by tea. There is a sense that being able to have intimate conversations feels both novel and positive. Furthermore, the change into the caring role of being a father may also bring about reflections on own experiences and how James wants to be as a dad. Reflecting on his men’s group participation, he explains how alcohol can be used to moderate difficult emotions temporarily while recognising that it suppresses feelings rather than process them.

James: "I feel bad, I might have a drink cos that will make me feel better" and that-and that's kind of part of the whole denial of those feeling. So, being with some people that uh, you know, uhm are welcoming of those difficult feelings just really helps with them uh... uhm creating connections rather than denying connections and uh suppressing them.

As substances alters a person’s sense of self, emotional expression under the influence becomes both inauthentic and an ineffective way of coping. Taking part in structures, such as a men’s group, where the expression of feelings is welcomed rather than denied allows emotional processing through connectedness. The men’s group provides a setting where men can allow themselves to be vulnerable without substances as the essence and purpose of the group is exactly that, an accepted structure for male emotional expression.
3.2 Locus of control

The superordinate theme of ‘Locus of control’ found evidence across all interviews and relates to how participants experienced a continuum of agency in their mental health recovery from being in control to being powerless. Evidence fell within four subthemes: 1) Clinical settings as power structures, 2) Time is precious, 3) Being listened to, and 4) Long-term support maintains mental health. Participants described receiving mental health care in clinical settings and participating in a men’s group as two opposites on a continuum of individual agency.

3.2.1 Clinical settings as power structures

When receiving care in formal health care settings participants described a power imbalance and lack of agency. Being in a men’s group, on the other hand, offered a structure with greater individual agency and a sense of equality between group members. For some participants, difficult experiences with professional health care services and the power imbalance in the doctor-patient relationship would impede on help-seeking for mental illness.

Craig: You had-you had your practitioner, and you couldn’t even speak to him, ken what I mean? [...] What they said was law, ken? They was gods to you. [...] they think they’re gods but they’re not.

Comparing doctors to gods place them in a position of being omnipotent, omniscient, otherworldly, and their words being indisputable. This leaves the patient in a position with limited control or influence over own treatment, as passive recipients of health care. Tom describes his experience of attending mental health courses following referral from his GP.

Tom: And it was all classes with a lot of people [...] to me how to describe it as like I was drowning, and they were describing the water. And all-all I wanted was a was a lifeboat to grab onto, if you know what I mean.

Feeling like drowning conveys a sense of being overwhelmed by the situation, feeling powerless and unable to navigate. The image feels cold and uncaring as the person is left drowning while others describe what he already knows about his difficulties, rather than offer a way out of the situation. If he feels like he is drowning, learning how to navigate in his current difficulties – or learning to swim - may be too big a task at that time. Perhaps what is needed at this point is to be saved by others. The responsibility is then put on the saver rather than the saved, which restricts personal agency. Before attending the men’s group, in his struggle with depression James described initial expectations of therapy.

James: I felt bad, and I wanted someone else to make me feel better. I didn't really know how to, uhm, how to go about that. Uh and I guess the only available narrative was this medical model narrative which- which doesn’t really- there's no agency in that uh.

The narrative of the medical model offers an understanding where there is a problem to be fixed and the patient passively receives a treatment ordained by a professional. James’ realisation that this was not how his mental
health difficulties would be resolved is both frustrating, as little effort or responsibility is required in the passive role of care-receiver, but also holds an understanding that within the medical model individual control is limited. However, in challenging the medical model, the responsibility for getting better shifts. The challenges of conceptualising mental health within the medical model were echoed by other participants.

_Hugh_: So, if you break your arm, you come in, you get a plaster cast, they check it, off with the plaster cast, bye-bye, away you go. I'm afraid life is not like that [...] and I think if we could get rid of that, feels to me it almost adds to the stigma.

Where experiences of mental health care within clinical settings for several participants restricted individual agency, the men’s group offered an alternative means of managing mental health with increased sense of control.

_James_: going to the doctors it's like a really- it's a medical problem uhm that there's something wrong with me uhm and I take some medication and it... it's gonna fix it. And uhm... whereas, when I think about the men's group, you know, there is nothing wrong with me [laughs]. I'm working fine [laughs]. This is with a group of other people who are also fine uhm. We are just living at this time in our lives and this time in the world and these are our responses to those experiences.

Contrasted against the medical model, the men’s group offer a new, empowering narrative wherein difficulties are normalised rather than pathologised. Within the realisation that there is nothing wrong lies a de-stigmatisation of mental health. Thus, there is a power in the group that allows members to see their own selves reflected in the other members and realise that their experiences and reactions are normal.

Similarly, several participants described the men’s group as sitting at the other end of the control-continuum with an equally balanced relationship between participants as opposed to clinical health care settings. This informal structure and setting of the men’s group puts less pressure on the group members.

_Simon_: it disnae matter who or what you are in the men's group; if there is an issue, you can talk about it.

_Matt_: I suppose you're more on even keel in the men's group.

_Craig_: Because you can be yourself [in the group]. [...] it's not a clinical surrounding, ken?

For some participants, the clinical health care settings posed a sense of threat and thus, inadvertently, reinforced the need to stay guarded and hold emotions in. The men’s group stands in contrast to that where participants can let their guards down and be themselves. In this sense, clinical settings and the men’s group become opposites.

3.2.2 Time is precious

When seeking mental health support, the availability of time varies greatly depending on the settings. Again, clinical settings and the men’s group were juxtaposed.
Simon: doctors are in a hurry all the time uhm they have ten minutes. So, to be able to tell your story, them to listen to it, analyse it and then find a solution in ten minutes, that—that’s a big ask for any professional […] but I mean in the men’s group sometimes it’s one person that covers the whole two hours. You know, that—that’s what we do. If one person needs to talk for two hours about whatever they are feeling or what their issues are then that’s fine.

The examples illustrate the difference between being pressured for time and the value in having enough time when managing mental health difficulties. Being given time to express personal problems can be a form of validation where issues are taken seriously and prioritised. Pressed for time, the ability to listen to another person may become compromised. Furthermore, experiencing severe time-restrictions may negatively impact individual agency whereas having enough time to express difficulties offers more agency when time as a controlling factor is reduced. Similarly, who controls time varies across the settings. In the doctor-patient relationship control of time lies solely with one part causing a relational power imbalance. In the men’s group power is more evenly distributed, and members allow each other time and space to talk.

Alex: all of us would benefit from the group if no guidance or advice or whatever was given, and we were just given time to chat [laughs] and-and offload.

There is a sense that having time to talk have intricate, universal value. Allowing another person enough time to speak about their issues conveys respect and appreciation of that person. Furthermore, giving a person space to talk increase the sense of being in control and being valued. Despite multiple negative experiences in professional health care settings, Craig describes feeling valued by his GP making time for him.

Craig: the doctor I had then she was ringing me every two weeks and coming round my house every two weeks to see how I was and everything. So, the doctor took her time, time out of her schedule to come round just to make sure I was alright and that, ken?

There is an appreciation that time is a commodity in short supply. As such, human beings can validate each other through giving each other time.

A strength of the men’s group structure is that without a definite end point the time pressure and thus the pressure to disclose difficulties is removed. Tom spoke about his re-entry to the men’s group following a period of suicidal ideation.

Tom: first couple of sessions I didn't really… talk […] I just sat and listened […] they were bouncing around and they were talking as well […] and they says [Tom], do you want to talk?” And I says 'nah, I dinnae want to talk just now’ and they let me be and […] uh in the third session I did… tell them why I was back […] And I was given that breathing space to do that in my [coughs] in my own time and I did do that and I just… I did break down a wee bit.

Without a time-pressure, the structure of the group allows for Tom to participate without having to contribute, which may add to feeling safe enough to eventually share when he felt ready. This structure may be difficult to replicate in more formal settings where treatments are generally time-limited.
3.2.3 Being listened to

A theme emerged from the data around the importance of being listened to. This theme developed as a natural extension of having enough time where being allowed time to speak about difficulties and feeling heard by others positively affected mental wellbeing. Feeling listened to seemed to happen on a continuum with settings as determinants once more placing professional health care and the men’s groups at opposite ends. In his contact with health care services, Craig describes experiences of not feeling heard regarding his health complaints.

Craig: Everything you are saying is just a figment of your imagination [...] In other words, [doctors] are making me out to be a hypochondriac, ken? Well, I've got the scars and everything else to prove what's wrong with me, ken?

Having to prove health needs through physical evidence on his body puts Craig in a position of being overlooked, having his experiences invalidated, and having to fight against a dismissal of his difficulties. Thus, not being listened to or having concerns taken seriously leaves him powerless. Trying to prove health care needs is an attempt of regaining a sense of control. Additionally, experiences of not being heard by professionals potentially recreates previous lessons learned regarding managing emotions by bottling them up. Feeling dismissed when trying to elicit health care may leave the men with an experience of a rejection of their health needs by professionals, which may increase the risk of them rejecting their own needs. Consequently, not being listened to may perpetuate mental health difficulties when psychologically painful experiences are dismissed or ignored.

Conversely, opening up and being vulnerable may be powerful and restorative in itself if the person is allowed time to speak and is listened to. Within the men’s group participants can be listened to in a space free of judgment.

Simon: it's something that's very important for somebody with mental health sues-issues that somebody actually listens to them and doesn't have an opinion.

Matt: there is this sort of shared experience and respect for not only speaking from the heart and uhm... uh... being vulnerable but also actually turning up and being a-a good listener for the others there as well.

Rather than being passive receivers of care, the men’s group offer a structure where members take on a dual role in both giving and receiving support. As such, they take an active role in their own as well as other people’s recovery. This aspect of reciprocation was emphasised by many participants as an important aspect of group engagement and was linked to positive feelings of self-worth when able to help and support others.

Alex: I suppose, it’s boosted [pause] my esteem a bit, in knowing that there are times when I can really help somebody else [...] by, you know, practically or saying something but I am also aware that just listening is-is the main thing.

Hugh: I'm helping them as well, cos they- we are always there for each other.
Tom: They give me feedback as tae... what they think I should do and give me suggestions and stuff like that, that's-that's what we do for each other, ken, we all bounce off each other.

Being listened to as well as listening to others and offer support enforces a sense of equality between members, where everyone has something to offer and contribute with. This reciprocation added to feelings of connectedness and camaraderie while reducing emotional isolation.

Through his work as a peer support worker with lived experience, Hugh describes how his interactions with other men left a powerful impression on him in terms of providing others with a sense of feeling listened to.

Hugh: some of the people I have supported, uhm, through the men's group and through another service uhm turned round and went 'I've seen professionals, but you are the first one that listened'.

There is a distinction made here between being seen by professionals and being listened to by a peer. Importantly, the ability to listen to someone may be tied into the time available. When short on time one may easily get pulled into offering solutions or trying to ‘fix’ and though this may feel like doing something for the other it risks leaving the person seeking support with the opposite experience, feeling unheard and unsupported.

Being a ‘listener’ rather than a ‘fixer’ puts the person listened to in greater control of their own situation. On the contrary, trying to fix others’ problems can be a way of exerting control over that person.

3.2.4 Long-term support maintains mental health

For almost all participants, the men’s group represented a stable structure that provided long-term support, which was regarded as invaluable and crucial to ongoing mental wellbeing.

Simon: I've been on courses, and I've had counselling in the past and, you know, there's an end date to that [...] after that you're on your own. [...] The men's group is... a platform for long term support, which nothing else gives.

The longevity of support inherent in the men’s group offers a unique, on-going structure to maintain mental wellbeing, which simultaneously provides safety in having a stable support system. Some of the men’s group had largely the same members for several years. The consistency and longevity of the group combined with the familiarity with group members may also allow for secure attachments to be formed between group members. For others, regular group attendance helped build resilience when facing life’s unpredictability.

Alex: it-it’s just that thought of knowing that once a week or once a fortnight when we get back to meeting together there is an opportunity to debrief life [...] it’s like a safety mechanism, you know you got that group and you got that- that sp-speaking time.

Hugh: Life keeps me coming to the group because curveballs continue to come at us all the time [...] Because, for example, someone in your family may [inaudible] die [...] and that could trigger all these previous uh traumas again. So, that's why I want to stick with the men’s group. So, if that happens uhm next time I want to be in as good place as I can be and uh try to keep enjoying life.
Using the men’s group is a future-proofing solution in the face of life’s unpredictability. The group offers a space to not only receive emotional support but also enjoy life among life’s challenges. Though the ongoing support may help build resilience for group members, there is an inherent understanding that mental health needs tended to and looked after regularly. Attending the group becomes a way of maintaining mental wellbeing by preventing a build-up that could lead to breakdown.

Tom: me personally, it’s more about uh ... prevention. It's stopping me from anything from building up and that's what I get- that's why I-I kept going and kept... coming back to it. [...] cos prevention is better than... the crash happening.

For Matt, the regularity of the men’s group has had a positive impact on his mental health.

Matt: But the regularity of the men's group I can honestly say that... that the impact on my mental health has been massive! You know, much more able to just cope with everyday life uhm... feel more confident in myself. Feel just more brave to do-to do things to- you know, uhm... [pause] yeah, I mean, God, it's-it's huge actually. I mean it's kind of more than therapy.

By using words such as ‘huge, massive, God’ Matt emphasises the magnitude of the impact attending the group has had. Confidence and bravery are values often associated with traditional masculine ideals, however, when applied to a context, such as the men’s group, the expectations linked to those values may take on a new meaning. Confidence and bravery may be linked to daring to show emotions thus offering an alternative version of masculinity to hegemonic norms.

3.3 Group experiences

The final superordinate theme related to participants’ overall experiences of being part of a men’s group. This superordinate theme had the most evidence across all interviews, which fell into four subthemes: 1) Safe space, 2) It’s okay to talk, 3) More than group therapy, and 4) Spaces for men.

3.3.1 Safe space

For many participants, the men’s groups constitute a space build on trust, that invites open conversations about thoughts and feelings without judgment or pressure. For some, having a confidential space to openly discuss issues and experiences was central to attending the men’s group.

James: it uhm provides a space for me to uhm [pause] talk about my feelings, talk about my experience [...] and to be heard and seen and valued with those experiences. Uhm and it provides a sense of community with-with others who are also doing that and uh makes me feel less lonely and isolated.

Simon: Uhm, there is no boundaries. There is no judgment, you know, we don't judge anybody at all and because it's confidential I mean, there are no other settings that you can have five or eight people or- talk about something and it doesn't go out that room.
The sense of community with other group members emphasises the importance of interpersonal connectedness; and the group offers a new way of relating to oneself and others. But being part of a structure where men are invited to speak openly and honestly about their emotional experiences comes with its own challenges.

*Tom:* we can talk in full confidence. And it's taken a while to get to that stage for us- I mean personally. It takes—it takes years for us tae... draw everything out and uh be trusting, if you know what I mean. You're going through a lifetime of not doing it. [...] I think, for me it's an acquired... it's acquired learning. You have tae learn how tae do it.

Open emotional discussions may go against previous learning regarding male emotional expression. There is an indication that first men must learn how to open up. The next step is to do it. As with any new learning experience, it takes time, which may have an implication for the effectiveness of time-constrained individual therapy with men.

For several participants, the men’s group offered them a space separate to their life in general where emotional conversations were welcomed.

*Alex:* having a... a protected time and space, I guess, out-with family where you could say anything, you know, could be brutally honest about how you were feeling without worrying that you're going to upset somebody or—or they start worrying about you, you know.

*Hugh:* [...] I’m feeling absolutely terrible, useless, worthless and all the rest of it. Do my parents need to know that? Does my sister need to know that? Does my son need to know that? They’ve got their own lives to lead. We are a family, and you will support them or whatever if there is a problem or whatever. But if you speak to them constantly about your mental health or for a long period of time, they—no one wants to hear as part of a family uhm seeing someone and hearing someone in a bad place, you know.

Compartmentalising of emotional conversations might be necessary if other settings out-with the men’s group do not allow for the same extent of emotional openness. Showing vulnerability may upset or burden other people, which is perceived as unacceptable. Traditional Western gender expectations might be enacted within some family systems whether overtly or subconsciously. While some of these men feel comfortable renegotiating masculinity within the group setting, this different way of being a man may not extend out-with the group context. For Craig, the men’s group provides a safe space to talk about his mental health, which would not be acceptable outside the men’s group.

*Craig:* with this having the men's group ... that we talk about things you can't talk to other people about, ken? Our mental issues, because if I said that to my pals, they would batter me and say 'you're—you're out of your mind'

The safety of the men’s group in discussing psychological pain may be limited to just that context for some members, and openness around mental health difficulties outside the group may be met with social rejection adding to stigmatisation.
The men’s group offers a place where the first step has been taken in sharing experiences; everyone is there because they are struggling psychologically in some way, which has a normalising effect.

*Lewis:* I think for men it’s hard enough to admit that you are struggling and feeling judged cos you are judging yourself, you know. So, if you come along to a community group and you got someone who’s already acknowledging that they’ve had issues and stuff like that ... it just breaks that barrier.

In the group everyone is on the same level and there for similar reason, which creates a safe space for group members. By taking part in a structure that challenge social norms surrounding masculine emotional expression, men can model new, more adaptable ways of coping that become more acceptable and easier to adopt when done within a group. Changing social norms in a group of people with shared experiences reduces self-stigma about mental illness. The group then provides a safe space where members can move along a continuum from being emotionally closed off to being more open.

### 3.3.2 It’s okay to talk

Being able to talk openly about their experiences with mental health in the men’s group was perceived as a positive experience by several participants.

*Alex:* you get that-that slot where you can just- just talk and- and talking is good.

*Craig:* The more I talk, the better it is for me, ken what I mean. Cos it’s like socialising, which I've not had for a year and five months now, ken.

Talking can also be a means of socialising and connecting with others and has a cumulative positive effect helping to break feelings of isolation. That talking is helpful goes against previous coping strategies of bottling up and becomes an empowering tool to manage emotions.

*Tom:* I'm not afraid tae speak [...] I find that if you hold stuff back it's no really beneficial to me. So-so I just try to I-I am just open and honest now and just saying 'this is where I am just now' [...] It-it's just having been... be able to talk and just freeing myself up from it. Not having this society for-forced upon me, just tae... be what society sees as being macho and no no talking about emotion.

Talking becomes a way of freeing oneself from society’s restricting conceptualisation of masculinity. As such, challenging masculine norms by talking openly about emotions becomes liberating. The journey through managing emotions by holding them in to being allowed to talk openly becomes a way to break with hegemonic masculinity forced upon the men. Based on his own experiences with mental illness and the positive effects of talking, Lewis, as a men’s group facilitator, encourages other men to start speaking openly about their experiences.

*Lewis:* So, what we want to actually try to get out to people, is that... do it quicker! Do it before you hit that rock bottom, d'you know. Start talking about things, start dealing with things, d'you know, cos for the substance misuse side everybody will say, 'yeah I know, but do you no have to
hit your own rock bottom?' and all that kindae thing, and I'm like that 'well, I'd have preferred to have heard somebody's story' and realise that I don't need to hit rock bottom. I can make thae changes now rather than going deeper into pain and suffering.

Lewis suggests men role-model to each other the positive effects of talking openly and sharing experiences. Hearing other people’s stories and being able to connect with others through shared experiences can empower others to take the first steps to positive changes for mental health management.

3.3.3 More than group therapy

Some participants experienced the men’s group as an anchor point. The settings provided members with a sounding board where the group’s reactions could help test the validity of members’ thoughts and experiences and thus support members to navigate through life’s difficulties.

Matt: the men's group is-is [...] a bit like a compass. [...] Yeah, it's a bit like a conscience, like having a conscience.

Comparing the men’s group to a compass suggests that participation provides a sense of direction in life, while supporting and empowering members to move forward. Comparing the group to a conscience implies that the group may help members make sense of right and wrong. As such, the group holds significant power and importance.

Similarly, Simon compared the group to a pillar, which gives an image of the group as a substantial structure and signifies the magnitude of its importance; the group becomes an immoveable and solid foundation for members to lean on when struggling.

In addition to providing members with a stable context for reflection, the less formal structure of the men’s group held opportunities for engagement and interactions between members where the focus was not solely on mental health support.

Alex: it’s having some-some men around who-who are now my friends as much as anything else uhm. Uh m-male friends have not been huge in my life generally speaking [...] And we have a lot of fun you know, we-we-we laugh and joke and take the mick out of each other and stuff as well as being serious.

Several men spoke of a lack of close connections to other men in their lives out-with the group. A possible consequence of keeping “the mask up” is that it may prevent people from building emotionally meaningful interpersonal connections. By showing their true and perhaps vulnerable selves, real connections and friendships can be built. Thus, the men’s group offers a ground for socialising and friendships to form and develop. Additionally, having a laugh was used in the groups to balance the heavier task of mental health support.

Hugh: I connected with them all very quickly and some of the topics that--[...]very very... dark uhm, but within that there was always something normal that happened, and we would have a
laugh. It's strange when you are talking about suicide, loss, and death [...] and you can have a laugh at the end of it.

Several participants described how friendships formed within the men’s group. For some the connectedness and friendship with other group members were not restricted or limited to the boundaries of the group.

*James:* we are a lot more like friends now. Uhm, and-and we do have, you know, we’ve become friends. We see each other individually outside of the group.

Both James, Simon and Hugh gave examples of how social events were arranged within their men’s groups. Such events included sports activities, meals out, sightseeing, or weekends away in the countryside. Participating in social events gave members an opportunity to engage with each other in different settings.

*Simon:* I think it it’s good to have a lighter side to men-mental health support as well as just uh the heavy-duty side of being able to be listened to and talk about serious subjects it’s be able to be in the same person’s company and just enjoy that company and enjoy what you are doing.

The flexible structure of the men’s group allows for the lines between mental health support and friendship to soften. As such, the men’s groups offer an alternative to the more formal, one-sided relationships in traditional health care settings. This flexibility may be a significant factor as to why the group holds such importance for its members. Feeling like a group of friends and participating in social events may also impact on both the sense of connectedness between group members but also the sense of commitment to the group. Though group engagement may predominantly be guided by a need for emotional support it also adds enjoyment to life perhaps unexpectedly. As such, the group becomes more than just a place to deal with emotional pain.

Some participants with lived experiences of suicidality reflected on the significant role the group played in their recovery from suicidal ideation or attempt.

*Tom:* I'm grateful to be here because I don't know if I would have been here if it wasn't for the group, y’know what I mean.

*Craig:* the men’s group has helped me- I'm not in that mood, 'ah, I'm gonna end me life', because I look forward to going back every week now, ken? [...] because... if I didn't join a group like that, I wouldn't be here talking to you, ken? That’s how serious it got with me

For these men the group has the power to add meaning to life and becomes a reason to stay alive.

### 3.3.4 Spaces for men

All participants spoke about the importance of being able to take part in a men-only project. Some spoke about a general lack of dedicated spaces for men like men’s groups or other gender-sensitised CBPs. Matt lamented the lack of opportunities for men to get together as they rely on each other for support.

*Matt:* I think men uhm... men need men and I and I think that uhm it's not very fashionable at the moment to say something like that. [...] but what I feel upset about is I feel kind of men-men
are left behind. There’s there’s often uhm a lot of talk about what men have done but not why men might have done it. Uhm... and I think that’s that’s a real problem.

The men’s group offers a space where men can use each other to help them make sense of their experiences and ways of being in the world. Matt raises the issue of men being blamed or scrutinised with little attention given to the reasons behind their actions. Though Matt does not expand on what men are left behind or by whom, there is a sense of a lack of curiosity or willingness from the wider society to challenge masculine standards and look for motivations for men’s behaviours. Perhaps because it is easier to blame that to try to understand.

Some participants spoke about having little opportunity in their lives to hear about other men’s internal worlds and emotional experiences and the men’s group offered a space for that. Sharing experiences brought about a sense of normalisation of own struggles.

James: But just in uh hearing other men talk about their struggles and their difficulties [...] just really makes it uhm... okay to feel the way I do. [...] all that societal stuff and that socialisation that doesn’t go away, so, uhm, you know, meeting as a group of men helps things- I wonder if that helps sort of counterpoint that a little bit.

A reason why Western male stereotypes of stoicism and holding emotions in continues to stand strong maybe because men do not regularly get opportunities to experience any differently. The men’s groups may offer the alternative to counter this male stereotype. Similarly, Matt reflects on the necessity of allowing oneself to be vulnerable in a group of other men.

Matt: there’s a necessity for vulnerability uhm... if you can be vulnerable with other men, that there is there is an incredible amount to gain from that. There’s an incredibly amount of courage to actually... go to the deep parts of yourself to be to be witnessed ultimately. It’s a very powerful thing and I had no idea that was the case.

Here Matt explains that there is a sense of empowerment in showing vulnerability. Displaying vulnerability for other people to see feels scary and goes against the defence offered within the ‘hard man’ role. Thus, putting down the defence becomes courageous and empowering.

Finally, several men spoke about how mixing the genders in a group setting may prevent some men from speaking openly about their experiences.

Lewis: [...] when you introduce women to a men’s group the focus is not on what they need to deal wi. The focus is on the women [...] the bravado and the... the chest comes out and all that kind of thing, d’you know, so, it changes the dynamic uhm and it puts people- puts men on the back foot that that they won’t share what they would have shared if it was just men.

The need to adhere to Western world hegemonic masculine ideals is enforced in the presence of women and for some men showing vulnerability in front of women is difficult, perhaps too exposing.
Simon: I think a lot of men find it difficult to talk about intimate subjects initially but even harder if there’s female company there. Uh, I don’t think they would talk about it at all.

Tom: no being able tae... show your emotions in front of a woman. [...] it’s going back to that macho thing, you no want to break down in front of women, if you know what I mean.

Discussing difficulties openly requires allowing oneself to be vulnerable, which can feel compromising. Therefore, there is a sense of safety in sticking to societally acceptable ideals of masculine behaviour even when this may risk personal wellbeing.

4. Discussion

This study explored subjective experiences of engagement with CBPs promoting men’s mental health. Participants, who all used men’s groups, were interviewed about their experiences and the data was analysed subsequently using IPA methodology. Three superordinate themes were identified: Managing Emotions as a Man, Locus of Control, and Group Experiences.

Several study participants reported that a learned masculine behaviour regarding emotions management was to hold emotions in, also referred to as stoicism in the literature (e.g., Martin, 2016). Adherence to traditional Western world masculine ideals that discourage disclosure of vulnerability was identified by participants as a barrier to seeking help for mental health; a finding echoed frequently within the existing literature (Addis & Mahalik, 2003; Cleary, 2012; Cleary, 2017; Courtenay, 2000; Rice, Aucote, Parker et al., 2017, Möller-Leimkühler, 2002). Research has found low mental health literacy in men, including the inability to recognise and articulate mental health symptoms (Rafal et al., 2018). A possible explanation for men’s low mental health literacy may be that if socialised to restrict emotions, they do not get to experience and discuss emotional difficulties, which could increase mental health awareness and understanding. As such, there may be a causal link between male emotional stoicism and low mental health literacy. Participating in men’s groups for emotional support may provide men with a setting and context to discuss emotive experiences, which may positively affect and develop mental health literacy.

Results of this study provide insights into how engaging with a men’s group for mental health support may offer a fundamentally different experience of managing emotions that stands in contrast to traditional Western world societal and cultural male gender expectation. From the interviews, it was evident that participants did not deem adherence to the prevailing, stereotypical male ideals of emotional stoicism relating to white, British, middle-aged men as a positive but rather as potentially having detrimental implications for mental health and wellbeing. Research has shown that men are willing to show and talk about emotions in specific contexts (Martin, 2016); evidence from this study points to men’s groups as one such context. Participants’ willingness to go against Western hegemonic masculine ideals and express emotions rather than holding them in can be viewed as a positive mental health behaviour that constitute a way of resisting dominant ideologies of masculinity (Foucault, [1978], in Martin, 2016). Rejecting stoicism in the face of emotional distress make up
a different form of masculinity and the men’s group provides the arena wherein what it means to be a man can be negotiated and re-invented. In a sense, male interactions within the group may offer a template for how to break down unhelpful masculine ideals with negative mental health implications. Ogrodniczuk and colleagues (2016) argue that initiatives that reframe masculinity by taking control of own health and wellbeing can be conceptualised as a way of showing strength. By inviting emotional conversation community-based men’s groups may provide a steppingstone to open the discussion about men’s mental health and offer a template of how to start challenging widely accepted but unhelpful traditionally Western world masculine ideals.

Within the theme of locus of control was a perception of varying degrees of individual agency depending on context. A possible inherent strength of the CBPs is the matter of individual agency they allow for. Participants frequently contrasted a lack of control in clinical settings with their sense of influence and individual control in the men’s groups. In formal health care settings mental illness was often conceptualised within a medical model, which left many participants feeling stigmatised and that something was fundamentally wrong with them. Conversely, in the men’s group their difficulties were normalised by others with similar experiences. For many, this validation brought about a sense of empowerment, which increased a sense of control over own recovery. Across the interviews there was a sense that negative experiences with the health care system meant that the men kept their guards up and held emotions in. In the men’s group they could lower their guards and allow themselves to be vulnerable.

The importance of personal agency has been found in similar studies. In Ballinger and colleagues’ (2008) study exploring men’s experiences of participating in Men’s Sheds, none of the interview participants saw themselves as recipients of a service, which may support masculine ideals of independence. Indeed, locus of control may be an important factor in how men seek out and use services. Men’s reticence to seeking help for mental health difficulties may be explained by a perception that receiving a service places one in a passive position, that may be incompatible with traditional Western masculine ideals of autonomy and self-reliance. Negative attitudes to professional health care by interview participants find support in existing research that point to men being less likely to seek help for mental or physical health issues if help-seeking is associated with loss of individual control or independence (Addis & Mahalik, 2003).

A relative strength of CBPs may relate to the opportunity for reciprocation. According to Addis & Mahalik (2003) the opportunities for reciprocation may increase the likelihood of men seeking help. The value of reciprocation was highlighted in the present study where several participants emphasised giving and receiving support as an important aspect of group participation. Some participants linked the opportunity to support others with feelings of self-worth. Furthermore, mutual support served to increase a sense of equality between group members associated with individual empowerment, which positively affected mood and wellbeing. Being able to reciprocate is conceptualised as a masculine strength in the Positive Psychology/Positive Masculinity model (Kiselica and Englar-Carlsson, 2010) and described as a male way of relating; men engage
in activities where they do something together. Furthermore, engaging in a reciprocal interaction may preserve masculine ideals of independence and self-reliance as the helping exchange is equally balanced. Moreover, Mankowski & Silvergleid (2000) argue that the reciprocity and non-hierarchical structure of male support groups help discourage competition and striving for achievement and status, which are often viewed as hegemonic masculine ideals.

Several participants lamented a general lack of close male relationships in their lives and group participation was viewed as a positive opportunity to form meaningful interpersonal relationships. Existing research has echoed similar perspectives with examples of men’s counselling groups where a primary aim of group participation became learning the initiation and maintenance of close emotional relationships with other men (Hetzel, Narton & Davenport, 1994).

All participants in the present study spoke about the men’s group as a safe space built on trust and without judgment, which served to normalise difficult experiences and strengthened connectedness between group members. Robertson and colleagues (2016) found that central to the development of a safe space in CBPs for men were factors such as a sense of trust, normalisations, and reduction of stigma. Normalisation of individual experiences through sharing one’s own story and hearing other men’s similar experiences contributed to a sense of safeness and increased connectedness, which has been emphasised in other research into all-male support group settings (Hetzel, et al., 1994). Interestingly, some men spoke about having a safe space to discuss their issues away from their families as to not burden them. This compartmentalising may inadvertently reinforce the ‘strong man ideal’ if men are only allowed by themselves or others to show vulnerability in specific contexts. The importance of a safe space is echoed in the existing literature.

Most participants also spoke about the importance of having a laugh in the group, which added to the sense of safety and comfort while balancing the sometimes-heavy task of emotional support. As such, having a laugh and making fun of each other served as a welcomed break, while strengthening connectedness between men’s group members. Humour has been found to have a therapeutic aspect as it naturally elevates mood, can strengthen abilities to cope and help alleviate stresses of everyday life through its relaxing effect (Oliffe, Ogrodniczuk, Bottorff, Hislop & Halpin, 2009; Williams, 2009). The use of humour has been found to be an important part of male interactions in health promoting men’s groups (Oliffe et al., 2009). In their study on the use of humour in prostate cancer support groups, Oliffe and colleagues (2009) found that humour was used to convey reassurance and decrease anxiety. Sharing a laugh also fostered group cohesion as it constituted a shared activity where collective laughter signalled camaraderie and a mutual understanding of group members’ experiences (Oliffe et al., 2009). As such, humour fosters social connectedness and can be used to establish solidarity with other men (Williams, 2008; Chapple & Ziebland, 2004). In Oliffe and colleagues’ study (2009) the use of humour was also found to provide a ‘time-out’ to manage discomfort or emotional vulnerability. This finds support in the current study as having a laugh was viewed by participants to balance the heavier
task of mental health support. As such, humour used in health promoting groups can offer a release from and dissipate intense emotions by creating distance between self and experienced difficulties (Chapple & Zeibland, 2004).

4.1 Strengths and limitations

A strength of this novel study relates to the generation of insights into the potential of CBPs for supporting men’s mental health. Most research on male specific CBPs target physical health and focus on activities. This study, however, focuses on the experiences of male support group engagement from the perspectives of group members. While previous research has investigated the benefits of community-based men’s groups quantitatively (Heisel, Moore, Flett, et al., 2020), less research has done the same using qualitative methodology. This study adds qualitative evidence to the existing knowledge base of what works in CBPs for men’s mental health. It has been suggested in the research (e.g., Oliffe et al., 2019) that men ‘connect by doing’ and that an activity focused aspect should be incorporated into CBP designs to increase chances of programme success and engagement. However, results from this research points to the fact that men also connect by talking and through supporting each other emotionally. Though several men’s groups incorporated a social aspect that included activities, this was not the main aspect that drove a sense of connectedness, rather, group participation was.

Though essential for an IPA study, a limitation regarding wider generalisability relate to the homogeneity of the sample; all participants were white, British men of similar age. Male mental health experiences may also be influenced by other factors such as race, ethnicity, social class, socioeconomic background, and educational level, which this study does not account for. Future research would benefit from samples reflecting greater diversity.

When speaking about why men-only initiatives were important to them some interview participants disclosed not feeling comfortable discussing emotional experiences in the presence of women. Is possible that those participants would have felt more comfortable talking to a male researcher than to the female researcher.

The study was carried out during a nation-wide lockdown due to the pandemic, Covid-19. Therefore, all interviews were conducted over video calls. While this assisted in the efficiency of arranging and conducting the interviews, some technical issues affected the process including occasional poor internet connections, which left some minor parts of the recordings inaudible and impossible to transcribe subsequently. However minor, incomplete interview transcriptions may compromise the reliability of the findings. Furthermore, some participants had family members present in their homes, while being interviewed, which might have affected what they felt comfortable disclosing. Future, post-pandemic studies would benefit from conducting interviews face-to-face in confidential spaces.
4.2 Recommendations

As part of the interview, participants were asked a final question relating to their views on changes needed for men to better engage with their mental health. Several participants pointed to mental health education in schools from an early age as crucial to increasing emotional understanding in boys and young men. This request from interview participants is in line with existing research recommendations. For example, Grace and colleagues (2018) point to inadequate mental health education as directly impacting on men’s emotional illiteracy, lack of mental health knowledge and vocabulary, which leave men ill-equipped to understand, respond to and discuss mental illness. Furthermore, participants regarded increased mental health understanding when taught as part of the school curriculum as essential to normalising and destigmatising mental illness allowing men to have more open emotional conversations. Importantly, mental health education on a wider societal level may help break with current Western world hegemonic masculinity that negatively affect men’s mental wellbeing and instead support the development of new masculine norms and ideals.

A shift towards greater societal education may already be at hand. Increasing attention is given to the promotion and awareness of mental health e.g., through public mental health awareness campaigns, televised awareness-raising advertisements, and celebrities such as the British princes, William and Harry, speaking out about mental health difficulties. This continued de-stigmatisation and normalisation of mental ill-health may help shift societal perceptions of the ‘normativeness’ of mental illness and consequently, promote help-seeking behaviours (Addis & Mahalik, 2003). Additionally, male-specific community-based initiatives and campaigns promoting male mental health, such as Campaign Against Living Miserably (CALM) (https://www.thecalmzone.net/) and Man-Up Against Suicide (http://www.manupagainstsuicide.ca/), may help change perceptions of men’s mental health and masculinity. The recent increasing number of open discussions around mental health and seeking help for mental illness has begun to reframe traditional male norms of courage and strength. CBPs promoting men’s mental health may play an important role in this development. Indeed, it has been suggested that male community-based support groups contribute to the development of both more positive and healthier forms of masculinity (Mankowski & Silvergleid, 2000). Possibly because of this recent change in narrative around men’s mental health, new research has pointed to a positive development in men’s mental wellbeing and help-seeking behaviours. A report by the mental health charity ‘Mind’ in partnership with English Football League (2020) established that men are now three times more likely to seek therapy as compared to 2009. Men’s willingness to see a GP if they are feeling low or worried has also increased significantly and is now equal to women (Mind, 2020). Taken together, this suggest that stigma around mental health is reducing societally.

Greater partnership-working and increased accessibility of services was highlighted by participants as important points for change. Suggestions were made to bring peer support workers and trained people with
lived experiences into GP surgery settings and increase the use of mental health nurses in health centres to improve accessibility while keeping costs down.

Lastly, future research should focus on adaptations to mental health delivery to better meet men’s mental health needs. Specifically, attention should be given to developing, promoting, and evaluating men’s e-health strategies (Ogrodniczuk et al., 2016). As the world saw an extensive move to digital platforms for communication during the pandemic, Covid-19 brought with it new insights into the feasibility and necessity of online presence, and it is highly likely that further web-based health initiatives will be rolled out in the future. Indeed, participants in the current study had all shifted from meeting in person to meeting online as an adaptation to the pandemic.

5. Conclusion

By focusing on community-based men’s groups with the primary aim of promoting men’s mental health, this study offers a useful contribution to the existing literature on men’s health otherwise dominated by research exploring physical health interventions. Using the methodology of Interpretative Phenomenological Analysis, the present study explored how members of community-based male support groups made sense of their experiences with mental health and group participation. All participants spoke positively of their experiences of group engagement. The key findings from this study related to 1) how traditional Western masculine ideals pertaining to stoicism and non-disclosure of emotional issues negatively affect men’s mental health and capacity for help-seeking, 2) that a sense of individual agency is important to mental health engagement, and this might be challenged within clinical health care settings, and 3) that CBPs that promote men’s mental health may offer compelling alternatives to conventional mental health care services.

The findings of this empirical study contribute knowledge to what white, British, middle-aged men value and need regarding mental health support, and how CBPs play a significant role in meeting these needs. As such, the findings are relevant to multiple audiences, including local authorities, government departments and health care service providers. Participants specifically pointed to increased focus on public mental health education starting at school level, which was understood as necessary to destigmatise mental health difficulties and support males of all ages to engage in mental health-based discussions. This request from interview participants is in line with existing research recommendations. Better partnership working between CBPs and professional health care providers such as the National Health Service (NHS) could mean that men seeking help for their mental health can be signposted to CBPs that effectively engage men with their health. This in turn may help decrease the growing burden on NHS, which could ultimately mean that more people would get help with their mental health difficulties sooner.
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Appendix 1. Manuscript Submission Guidelines for The Journal of Men’s Studies

Manuscript Submission Guidelines:

Submissions must be sent electronically to https://mc.manuscriptcentral.com/men.

Manuscript preparation.

The Journal of Men’s Studies publishes regular articles (7,500 to 8,500 words) and brief reports (2,500 to 3,000 words). Authors should prepare manuscripts according to the Publication Manual of the American Psychological Association (7th ed., 2019). Formatting instructions and instructions on the preparation of abstracts, text with designated headers (A-level through C-level), references, tables, and figures appear in the Manual. All copy must be double-spaced.

Abstract and keywords.

All manuscripts must include an abstract containing a maximum of 120 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References.

References should be listed in alphabetic order (also double-spaced). Each listed reference should be cited in the text, and each text citation should be listed in the References. Basic formats are as follows:

Journal article:


Article in an Internet-only journal:

Book:

Chapter in a book:

Dissertation:

Figures.
Graphic files are accepted if supplied as Tiff files (.tiff). High-quality printouts are needed for all figures. The minimum line weight for line art is 0.5 point for optimal printing.

Review Procedure.
The Journal of Men’s Studies uses a masked review process. Authors are asked to include all identifying information in the cover letter, including the manuscript title, the authors’ names, institutional affiliations, and e-mail addresses. The first page of the manuscript should include only the article’s title, abstract, and keywords. Footnotes containing information that would reveal the authors’ identity and/or affiliation should be removed. Every effort should be made to see that the manuscript itself contains no clues to the author’s identity.

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The Journal of Men’s Studies may accept submissions of papers that have been posted on pre-print servers; please alert the Editorial Office when submitting and include the DOI for the preprint in the designated field in the manuscript submission system. Authors should not post an updated version of their paper on the preprint server while it is being peer reviewed for possible publication in the journal. If the article is accepted for publication, the author may re-use their work according to the journal's author archiving policy.

If your paper is accepted, you must include a link on your preprint to the final version of your paper.
Appendix 2. Critical Appraisal Skills Programme Checklist 2018

CASP Checklist: 10 questions to help you make sense of a Qualitative research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA ’Users’ guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.

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### Section A: Are the results valid?

1. **Was there a clear statement of the aims of the research?**
   - Yes
   - Can’t Tell
   - No
   
   **HINT:** Consider
   - what was the goal of the research
   - why it was thought important
   - its relevance

### Comments:

2. **Is a qualitative methodology appropriate?**
   - Yes
   - Can’t Tell
   - No
   
   **HINT:** Consider
   - if the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
   - Is qualitative research the right methodology for addressing the research goal

### Comments:

### Is it worth continuing?

3. **Was the research design appropriate to address the aims of the research?**
   - Yes
   - Can’t Tell
   - No
   
   **HINT:** Consider
   - if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

### Comments:
4. Was the recruitment strategy appropriate to the aims of the research?

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<th>Yes</th>
<th>Can’t Tell</th>
<th>No</th>
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**HINT:** Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

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<th></th>
<th>Yes</th>
<th>Can’t Tell</th>
<th>No</th>
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**HINT:** Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:
6. Has the relationship between researcher and participants been adequately considered?

Yes
Can’t Tell
No

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes
Can’t Tell
No

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:
8. Was the data analysis sufficiently rigorous?  

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<th>Yes</th>
<th>Can’t Tell</th>
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**HINT:** Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

**Comments:**

---

9. Is there a clear statement of findings?  

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<th>Yes</th>
<th>Can’t Tell</th>
<th>No</th>
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**HINT:** Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher’s arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

**Comments:**
<table>
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<th>Section C: Will the results help locally?</th>
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<td>10. How valuable is the research?</td>
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HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature?
- If they identify new areas where research is necessary.
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used.

Comments:
PARTICIPANT CONSENT FORM

Study Title: Exploring Men’s Experiences of Engagement with Community-Based Projects Promoting Men’s Mental Health

1. I confirm that I have read and understood the Participant Information Sheet (version 3, 10/15/2021) for the above study.

2. I have been given the opportunity to consider the information provided, ask questions, and have had these questions answered to my satisfaction.

3. I understand that my participation is voluntary and that I can withdraw at any time without giving a reason and without my medical care or legal rights being affected.

4. I agree to my interview being video recorded for subsequent transcription and understand it will be deleted once transcribed and anonymised.

5. I understand that my anonymised data and interview transcript will be stored for a minimum of 5 years and may be used in future ethically approved research studies.

6. I agree to take part in the above study.
Worksheet 3.1 The Positive and Negative Affect Schedule (PANAS; Watson et al., 1988)

PANAS Questionnaire
This scale consists of a number of words that describe different feelings and emotions. Read each item and then list the number from the scale below next to each word. Indicate to what extent you feel this way right now, that is, at the present moment OR indicate the extent you have felt this way over the past week (circle the instructions you followed when taking this measure)

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<th>Very Slightly or Not at All</th>
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<td>Attentive</td>
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<td>Jittery</td>
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<td>19.</td>
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<td>20.</td>
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Scoring Instructions:
Positive Affect Score: Add the scores on items 1, 3, 5, 9, 10, 12, 14, 16, 17, and 19. Scores can range from 10 – 50, with higher scores representing higher levels of positive affect. Mean Score: Momentary = 29.7 ($SD = 7.9$); Weekly = 33.3 ($SD = 7.2$)

Negative Affect Score: Add the scores on items 2, 4, 6, 7, 8, 11, 13, 15, 18, and 20. Scores can range from 10 – 50, with lower scores representing lower levels of negative affect. Mean Score: Momentary = 14.8 ($SD = 5.4$); Weekly = 17.4 ($SD = 6.2$)

Copyright © 1988 by the American Psychological Association. Reproduced with permission. The official citation that should be used in referencing this material is Watson, D., Clark, I. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*(6), 1063-1070.
Appendix 5. Safe-keeping protocol

A qualitative study of how men with a history of mental health difficulties engage with community-based projects promoting men’s mental health

Mental health screening

Prior to starting the interview, a brief risk assessment will be carried out by the researcher to determine whether continuing with the interview is appropriate. The risk assessment will assess whether the interview participant is currently under the influence of drugs and/or alcohol. In case of a confirmatory response, the interview will be terminated and the reason for this will be explained to the participant.

The researcher will also assess whether there are any active risks to life at this stage by asking if the participant has made any plans to end their lives (using the formulation from the CORE-10). In case of any potential active risk to life, the interview will be terminated, and the participant will be encouraged to contact appropriate services i.e., own GP and/or Samaritans. Following the interview, participants will be provided with a debrief form (presented orally but can be sent over email on request) containing further contact details to relevant organisations.

If deemed appropriate to continue, the participant will be reminded that they can take a break from the interview if needed and that they may withdraw from the study at any point.

Throughout the interview process, the researcher will use their clinical judgment and skills from years of experience of working clinically with people with mental health difficulties to assess the participants well-being. If at any point during the interview the researcher is worried about the well-being of the participant, the participant will be offered to take a break and if the distress continues the interview will be terminated.

Mood assessment

Prior to commencing the interview, the participant completes the mood assessment Positive And Negative Affect Scale (PANAS).

Upon completion of the interview the researcher will repeat the PANAS. Furthermore, the researcher will engage the participant in a short mood-neutralising conversation e.g., relating to the weather, sports, or hobbies should the participant appear distressed.

Provide the participant with the debrief form.

Stop-study criteria
During the interview, using clinical judgment consider stop-study if the participant displays any of the following:

- Significant drop in mood
- Significant increase in distress
- Increase in aggression, threatening behaviour towards researcher (unlikely)

**Stop-study protocol**

- If the participant becomes distressed and continuing the interview may compromise their wellbeing: STOP THE INTERVIEW
- The researcher will empathetically check in with participant to assess the reason for becoming distressed
- The researcher provides the participant with input on how to manage distressed emotion e.g., by offering relaxation exercise e.g., breathing exercise, visualisation exercise or grounding exercise
- If the participant continues to feel distressed, the researcher will direct them to agencies sign-posted on the debrief form

In the unlikely event that the participant becomes distressed to a point where they feel suicidal, the researcher will draw up a safety plan with the participant and encourage the participant to contact their GP immediately.

**Keeping safe protocol**

This protocol is developed to ensure the researcher’s safety from any emotional distress that may arise during the interviews. A keeping safe protocol was deemed necessary as research participants may be vulnerable, have poor mental health or have experiences of suicidality and/or severe mental health difficulties given the nature and topic of the research.

Should the researcher become distressed following an interview, the following steps will be taken to ensure the safety and wellbeing of the researcher.

- Wherever possible, interviews will be arranged within normal working hours approximately 8.30am to 5.30pm. This timeframe will help prevent distressing interviews occurring out-with a normal workday where access to appropriate support e.g., supervision is limited or unavailable
- In case the researcher experiences mild to moderate distress following an interview, the researcher will ensure appropriate self-care activities i.e., relaxation exercises such as meditation, yoga, or distraction techniques
- In case the researcher experiences more severe levels of distress following an interview, she will contact the field supervisor for support. Should he not be available to answer the call, the researcher will follow up with a text stating the reason for the call and the supervisor will get back in touch as soon as possible thereafter
- In case of multiple interviews being carried out in one day, sufficient space should be allowed between interviews to ensure the researcher has enough time for self-care if needed
- If the researcher experiences distress following an interview to an extent where she feels unable to complete further interviews the same day, interviewees will be contacted to change the time and date of the interview

This protocol has been developed and agreed between the researcher and the field supervisor (RB).
Appendix 6. Interview schedule

Interview schedule

Initial question: Can you tell me about the community-based (third sector) project you use? How often do you attend? For how long have you been involved?

1. What happened that led you to make contact with the project?
   a. How did you find the project?
   b. What got you through the door/what encouraged you/made it easier for you to engage in this project?
   c. Can you tell me about your mental health before seeking out the project? How were you feeling at that time?

2. Can you tell me about how you use the project?
   a. What are you getting from using the project? Positive aspects?
   b. What does it mean to you to be involved in the project? Why is it important to you?
   c. What keeps you coming?
   d. How do you think your life would be if you did not use the project?
   e. What would you be doing if there was no project to come to?

3. What does it mean to you that the project is just for men?

4. How has using the project impacted on your understanding of your mental health?
   a. Does coming to the project make any difference to how you feel about yourself? To your mental health generally?

5. What is your experience of seeking professional help for your mental health e.g., through NHS?
   a. How does your experience of using professional help compare to using the project?

6. What do you think health care services such as the NHS could do differently to better help men engage their mental health?
   a. What would make it easier to engage with professional mental health services?

Thank you so much for participating in the study. I really appreciate you taking the time to do this interview. Is there anything you thought we would talk about that we haven’t talked about yet? What was it like doing this interview?

Finally, before we finish, I would like to tell you that following the interview I will send you an email with a debrief form, which has contact information for different services should you require any further support following the interview. The email will also include an invitation to discuss the results of the research at a later point. We invite all participants to look over the study results and provide any feedback or comments they may have. This is done to ensure a high quality of research.
Appendix 7: Participant Information Sheet

A qualitative study of how men with a history of mental health difficulties engage with community-based projects promoting men’s mental health

PARTICIPANT INFORMATION SHEET

You are being invited to take part in a research study exploring experiences of men with a history of mental health difficulties and their engagement with community-based services promoting men’s mental health awareness. Ditte Sorensen at the University of Edinburgh is leading this research. Before you decide to take part, it is important you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

WHAT IS THE PURPOSE OF THE STUDY?

In 2018 suicide rates increased for the third year in a row in Scotland, and suicide is now the leading cause of death in young Scottish men (15-24). Compared to women, men are more likely to end their own lives but are less likely to seek help. Different approaches to health care may be needed to make sure Scottish men receive the help they need. Community-based services promoting men’s mental health seem to engage especially middle-aged and elderly men well with their health, but more research is needed to find out how to better engage men more broadly. The present study seeks to get a better understanding of how men use such community-based services and how this contact may affect their health and wellbeing. The hope is that information from the study can be used in health care settings to better reach and engage men who struggle with their mental health.

WHY HAVE I BEEN INVITED TO TAKE PART?

You are invited to participate in this study because you are (identify as) male, are 16 years or older, have a history of mental health difficulties, and have experience of using community-based services focusing on men’s mental health.

DO I HAVE TO TAKE PART?

No – it is entirely up to you. If you do decide to take part, you are still free to withdraw at any time and without giving a reason. Please note down your participant number and provide this to the lead researcher if you seek to withdraw from the study at a later date. Deciding not to take part or withdrawing from the study will not affect your employment, use of the community-service, or your access to health care now or in the future.

WHAT WILL HAPPEN IF I DECIDE TO TAKE PART?

Before the interview, the researcher will tell you more about the research procedure and you will be asked to give your consent to participating in the study, this includes consenting to your interview being audio recorded. You will be asked to provide the researcher with your email address in order for them to send you a copy of the participant information sheet and consent form. Any identifiable information e.g. your name and email address will be kept confidential and stored separately from
anonymized data; only the researcher will have access to this information. Any identifiable information will be removed prior to data analysis. To ensure anonymity, you will be assigned a number linking your personal information with your contact details. A document will be used to link your information with your unique number, and this will be stored separately from the anonymized data. Only the researcher will have access to this information and all information will be kept confidential.

The interview will take place over video call at a time that is convenient to you. You can choose to turn your video off if you would like to. The location should be in a quiet, private area. This could be your own home or another location where you feel comfortable. The interview should take around 30 to 60 minutes to complete.

On the day of the interview you will be asked to give verbal consent to participating in the study. You will also be asked complete two questionnaires about your mental wellbeing and one questionnaire about your mood. As the interview will happen over video call, all forms will be read out to you and your answers will be noted down by the researcher. These questionnaires are used to make sure you are feeling okay at the time of the interview. You may not be able to participate in the study if your mood is very low, if you are actively suicidal, or if you are under the influence of drugs and/or alcohol. The interview will ask about your engagement with the community-based service, how using the service affects your health and wellbeing, and your experiences of seeking help for your mental health.

You can also take a break from the interview at any point if needed.

**WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?**

There are no direct benefits, but by sharing your experiences with us, you will be helping the University to better understand the needs of men in Scotland with a history of mental health difficulties. You might find the questions interesting, and the interview may be an opportunity for you to reflect on your own experiences.

**ARE THERE ANY POTENTIAL RISKS ASSOCIATED WITH TAKING PART?**

There are no significant risks associated with participation. However, some participants may find discussing personal experiences of mental health difficulties sensitive and potentially traumatic. If, during or following the interview, you feel distressed, you will initially be offered support by the main researcher e.g. by taking a break from the interview. In the unlikely event that the distress continues, the interview will be stopped, and the researcher will do relaxation exercises with you as described above. You will be encouraged to contact relevant support services such as counselling, Samaritans, Helpline etc if you need further support following the interview. You can also seek support through your GP. Please find relevant contact details below. At the end of the interview you will be given a debrief form with contact details for more organisations.

Samaritans 116 123
CALM 0800 58 58 58
Mind 0300 123 3393
PAPYRUS 0800 068 4141

If any information is shared during contact with the researcher that suggests that a child or adult is at significant risk of harm, the researcher has a duty to report this.

**WHAT IF I WANT TO WITHDRAW FROM THE STUDY?**
Agreeing to participate in this project does not oblige you to remain in the study nor have any further obligation to this study. If, at any stage, you no longer want to be part of the study, please inform the project administrator, Ditte Sorensen on email mensMHresearch@ed.ac.uk or by phone on xxxx. You should note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to your withdrawal and so you are advised to contact the research team at the earliest opportunity should you wish to withdraw from the study. On specific request we will destroy all your identifiable answers, but we will need to use the data collected prior to your withdrawal, and to maintain our records of your consenting participation.

**DATA PROTECTION AND CONFIDENTIALITY**

Your data will be processed in accordance with Data Protection Law. All information collected about you will be kept strictly confidential. The researcher is obliged to break confidentiality in case of any concerns regarding Adult or Child Protection. Unless they are anonymised in our records, your data will be referred to by a unique participant number rather than by name. If you consent to participating in the study, all interview recordings will be destroyed once they have been transcribed. Demographic information will be linked to your unique number code and stored separately from anonymized data. This will be anonymized prior to data analysis. Once analysed and written up, any identifiable information including demographics will be destroyed. Your data will only be viewed by the researcher/research team. All electronic data will be stored on a password-protected computer file and all paper records will be stored in a locked filing cabinet. Your consent recording will be kept separately from your responses in order to minimise risk and will be deleted from the password-protected drive upon publication of results i.e., in the form of a doctoral thesis.

The University of Edinburgh is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly.

Completely anonymised data including transcripts will be retained for 5 years on secure drives at the University of Edinburgh and may be used in future ethically approved research. After 5 years, the data will be securely disposed of.

**WHAT WILL HAPPEN WITH THE RESULTS OF THIS STUDY?**

The results of this study will be summarised and published in a doctoral thesis, articles, reports, and presentations. Quotes or key findings will always be made anonymous in any formal outputs unless we have your prior and explicit written permission to attribute them to you by name. With your consent, information may also be kept for future research. The findings of the study may be shared with relevant organisations in summary format with any identifiable information removed. A summary of the research project and its findings will be made available in an accessible format to you. You will be offered the opportunity to read over study findings/interview transcript to check whether you agree with findings. Should you wish to read over the findings, you will need to provide the researcher with an email address to send the document to. Your contact details (email address) and correspondence trail will be deleted after the findings have been sent to you.

**WHO IS ORGANISING AND FUNDING THE RESEARCH?**

This study has been organised by Ditte Holm Sørensen, Doctorate in Clinical Psychology and sponsored by the University of Edinburgh.

**WHO HAS REVIEWED THE STUDY?**
The study proposal has been reviewed by the School of Health in Social Science Ethics Committee.

**WHO CAN I CONTACT?**

If you have any further questions about the study, please contact the lead researcher, Ditte Holm Sorensen by email: mensMHresearch@ed.ac.uk, or telephone: xxxx

The study is supervised by Dr Ingrid Obsuth at the School of Health in Social Science, University of Edinburgh. Ingrid may be contacted on email ingrid.obsuth@ed.ac.uk. Tel: +44(0)131 651 3969.

The study is clinically supervised by Dr Richard Browne, NHS Lothian. Richard may be contacted on email richard.browne@nhslothian.scot.nhs.uk.

If you would like to speak to someone independent of the research about this research project please contact Dr Helen Griffiths Programme Director: Doctorate in Clinical Psychology, School of Health in Social Science, University of Edinburgh. You can contact Helen by email at Helen.Griffiths@ed.ac.uk. Tel: 0131 650 3482

If you wish to make a complaint about the study, please contact the Research Governance Team by email: cahss.res.ethics@ed.ac.uk. In your communication, please provide the study title and detail the nature of your complaint.

For general information about how we use your data go to:

https://www.ed.ac.uk/records-management/privacy-notice-research
Appendix 8. Follow-up Email

Dear [NAME],

Thank you very much for your time and interview participation on [DATE] as part of the study on men’s experiences of using community-based services promoting men’s mental health. I appreciate having gotten a chance to speak with you and hear about your experiences.

To ensure the quality of the research we invite all participants to look over the research findings and check whether they agree with our analysis of their response. We welcome participants’ comments and feedback on our analysis. It is entirely up to you whether or not you would want to do this. If you are interested in a summary of the research results once the research is complete, please get in touch to arrange this. Another meeting would then be set up to discuss and reflect on the themes identified from the data once data collection is completed. I would like to stress that looking over the research findings is voluntary.

If, following interview completion, for any reason you have concerns or second thoughts about your research participation, you can request for your information to be removed, until it has been typed up and included in the study findings. If you have any other questions or require further information, please feel free to raise this with the main researcher. If you wish to make a complaint about the study, please contact Dr Helen Griffiths using the contact details below. In your communication, please provide the study title and detail the nature of your complaint.

Once again, thank you very much for your help with this study. I wish you all the best for the future.

Kind regards,

Ditte

Contact information

If you have any further questions about the study, please contact the lead researcher, Ditte Holm Sorensen by email: mensMHresearch@ed.ac.uk, or telephone: [removed].

The study is supervised by Dr Ingrid Obsuth

School of Health in Social Sciences

University of Edinburgh

Tel: +44(0)131 651 3969

Email:

The study is clinically supervised by Dr Richard Browne

Clinical Psychologist

NHS Lothian
Email:

If you would like to speak to someone independent of the research about this research project please contact
Dr Helen Griffiths
Programme Director: Doctorate in Clinical Psychology
School of Health in Social Science
University of Edinburgh
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Tel: 0131 650 3482
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Appendix 9. Debrief Form

Debrief form

A qualitative study of men’s engagement with community-based services promoting men’s mental health

The present study aims to explore the experiences of men with a history of mental health difficulties and their engagement with community-based services focusing on mental health promotion. Thank you for your time and your participation.

During the interview, you were asked to answer some personal questions and invited to share your own experiences of mental health difficulties. We greatly value your contribution to the study, and we appreciate that talking about past experiences may be sensitive and potentially upsetting for some participants.

If the interview or any other aspect of the study has made you feel distressed and you would like to speak to someone about this, please contact your GP. You may also contact one of the following agencies for support:

- **Samaritans** is a 24-hours confidential phoneline offering emotional support for anyone who is struggling to cope. You can contact Samaritans on phone number 116 123, by texting 07725 90 90 90, or on email jo@samaritans.org
- **Breathing Space** is a confidential phoneline for anyone aged 16 or above, who experiences low mood, anxiety, or depression. Tel: 0800 83 85 87
- **Papyrus HOPELINEUK** is a helpline for people under 35 who struggle with suicidal feelings. Call Papyrus HOPELINEUK on 0800 068 4141 (weekdays 10am-10pm, weekends 2pm-10pm and bank holidays 2pm-10pm), email pat@papyrus-uk.org or text 07786 209 697.
- **Counselling Directory** helps connect people, who need emotional support, with a qualified counsellor or psychotherapist in their local area: https://www.counselling-directory.org.uk/
- **NHS 24** provides urgent health advice out of hours, when your GP practice is closed: call 111.
- **SOS Silence of Suicide** - works to eradicate the shame, stigma and silence around suicide and fragile mental health. Use the chat function online at https://sossilenceofsuicide.org/ or contact by phone on 0300 1020 505.
- **CALM – Campaign Against Men Living Miserably**: a leading movement against suicide in the UK. Use their web chat found on the website https://www.thecalmzone.net/ or phone 0800 58 58 58.
- **Mind** provides advice and support to empower anyone experiencing a mental health problem. They campaign to improve services, raise awareness and promote understanding. The website https://www.mind.org.uk/need-urgent-help/using-this-tool provides different tools for help such as crisis coping tools, emergency advice and a list of other helplines to contact.

Once again, thank you for your participation.

Ditte Holm Sorensen

Main researcher
Tel: [removed] Email: mensMHresearch@ed.ac.uk
Appendix 10. Example of transcript analysis

Note: Descriptive comments are marked in green, linguistic comments are marked in blue and conceptual comments are marked in red. Assigned codes are in bold.

It's for me it's an ongoing process (I: yeah), that's why I keep doing it (I: mh-hm). Cos life's no... like I say, everything else: you go to these courses, ten-week courses and you're meant to deal with that yourself and I don't think you really deal with it, if you got- like I says: everybody else they got family and they got kids and stuff like that. They'll go and deal with something else before they... sit (I: yeah) and help themselves (I: mh-hm). I'm talking about [inaudible] as well, ken (I: mh-hm), no-going and have fun, we'll get a nurse over and my mum [inaudible] ken, even when I was growing up (I: mh-hm) she put the kids in front of herself as well (I: yeah mh-hm). And that's why I'm [inaudible] and that's why I dunno mind doing this for my mum because again I realise over the years what she's done for me (I: mh-hm). That's what helps me do that for her. I dunno, have any... regrets about doing that because again it's a [inaudible] thing as well, when I first started doing it, people asked me 'you no working, you no working, you no working?' (I: mh-hm). And umm, it's-'I-I was starting to doubt myself, you know what I mean, just 'why am I go out there, why have I no got the working, why am I no able to work and care for my parents?' Again, that's a society thing as well (I: yeah) cos you no actually a different place doing some work (I: mh-hm), you're no working (I: mh-hm). And that's what that's the thing that really got me, ken. I say try to get back to normal (I: yeah)... what I everyone considers as normal (I: mh-hm) working, earning money and stuff like that (I: mh-hm). And that is [inaudible] things but a lot of doubts and that in my head (I: yeah) but now I'm perfectly clear in what I'm doing and why I'm doing it (I: mh-hm) and I just... but I just blocked because there's no... there... I dunno work full time, just do work for my friends and stuff like that but (I: mh-hm)... working full time... and earning for my mum or... and I'm better than any health care system, ken, people coming into the house or anything like that (I: mh-hm). And they realise I'm better for my mum (I: mh-hm) for getting her through it than people coming in once a day (I: yeah) and the staff like that and that's getting my mind set fixed as well (I: mh-hm). Cos my mum doesn't work by a clock (I: mh-hm) either, ken. Her health goes up and down (I: yeah) and it changes day by day and poorer, better... and I can't work: do a work life around her (I: mh-hm). Either work full time and get somebody into to look after my mum or put her into care (I: mh-hm). That's something I dunno want to do (I: yeah) and so I've had to realise over the years that's one thing [inaudible]. You just make that choice and be clear about it and no have any... doubts about it myself and why I'm doing it (I: mh-hm) and letting other people... determine what I do (I: mh-hm) you know, what I've done I'm doing is wrong and they can't understand it, that's their problem (I: mh-hm). As I said about my life being a total change from (I: yeah) what it used to be before I was a carer (I: mh-hm, mh-hm). It's a total change (I: yeah, sounds like it). Again, the men's group have been there over the years to help me deal with that (I: mh-hm)... and not beat myself up for not doing work in society because as if I was being... normal (I: mh-hm).

So, it seems like the group has... the support you've gotten through the group has helped with kind of making sense of this life transition (I: mh-hm) from one kind of living to a very different kind of living umm... and I guess as well what you are saying is that people can have a lot of... people out with the group so society um... can have a lot of judgments or questions about you know why are you doing? Why are you giving this up? Or 'Why are you not working?' (I: mh-hm) umm whereas...
Appendix 1: Ethics application and approval

**SECTION 1: Introduction**

This is a:
- New application for ethical approval - first submission
- A resubmission following reviewers' comments
- A resubmission with requested amendments

Please select your School:
- School of Health in Social Science

Please select your subject area:
- CIASS
- Clinical Psychology
- Nursing Studies

It is each researcher's responsibility to check whether their project requires Sponsorship, Caldicott Approval, R&D approval, and/or IRAS. [Visit the relevant website](https://www.ed.ac.uk/health/research/ethics/sponsorship-and-governance).

If the project requires any of these, these need to be secured prior to submitting this application.

Please tick the relevant box before proceeding:
- I have checked and this project does not require Sponsorship, Caldicott, R&D and/or IRAS approval

**My project requires Sponsorship**
- Sponsorship letter attached

**My project requires Caldicott approval**
- Caldicott approval letter e-mail attached

**My project requires R&D approval**
- R&D approval letter e-mail attached

**My project requires IRAS approval**
- IRAS approval letter e-mail attached

**External Research Ethics Approval**

Does your research project require the approval of any other institution and/or ethics committee, nationally or internationally?

Please state the name of the review body and the current status of your application (for example, submitted, approved, deferred, or rejected)? Please include any known submission/approval timelines.
SECTION 2: Your project details

2.1 Project details

Your name: Ditte Helen Sorensen

Please enter your project title: Help-seeking behaviours in men with a history of suicidality: a qualitative study of men’s engagement with community-based services promoting male mental health.

Proposed Project Start Date: autumn 2020
Proposed Project End Date: 01.05.2021

Q1. Are you a member of staff or a student?
☐ Staff member
☐ Student

Supplementary questions for staff members only:
List the names and institutions of any Co-Investigators working with you on the project.

Supplementary questions for students only:
Truman Clinical Psychologist

Please provide your course title or programme name
Doctorate in Clinical Psychology

Who is your supervisor?
Joanna Osmka

Q2. Please indicate any external ethical guidance your project has to adhere to. For example, the British Psychological Society (BPS), the British Academy, the British Association of Sport and Exercise Sciences (BASES)

Q3. Will you be collecting or generating any new data (including autoethnographic writings)?
☐ Yes
☐ No

Q4. Will you be extracting, re-coding or using existing data that contains sensitive information (i.e., identifiable information)?
☐ Yes
☐ No

If the answers to both Q3 and Q4 are ‘no’ you are not required to complete:
Section 4: Potential risks to participants and researchers
Section 5: Participants and data subjects
Section 6: Participant or data subject information and consent
2.3 Security-Sensitive Material

Q5. Does your research project fit into any of the following security-sensitive categories?

☐ Your research project is commissioned by the military.
☐ Your research project is commissioned under an EU security cell.
☐ Your research project involves the acquisition of security clearances.
☐ Your research project concerns groups which may be construed as terrorist or extremist.

If you answer "yes" to any of the questions above you must complete Section 8 Security Sensitive Material. You must answer all questions in the section.

2.4 Good Conduct in Collaborative Research

Q6. Will your research project involve collaborative work?

☐ Yes
☐ No

Selecting "Yes" to this question means you must complete Section 10 "Good conduct in collaborative research" later in the form. You must answer all questions in the section.

2.5 Project Funding

Q7. Is funding required for your research project? (To be completed by staff only)

Please indicate how the project will be financially supported.

2.6 Knowledge Exchange and Impact

Q8. Will there be any knowledge exchange and impact activities associated with this project? (To be completed by staff only)

2.7 Consultancy Potential
SECTION 3 Description of the research

Q10: Please use the box below to describe your research, including a background summary, rationale, research questions and hypotheses, methodology, procedures. If you have identified ethical considerations that are not addressed in other parts of the form, please outline and discuss them here.

Project Summary:
With an increase in suicide rates in 2013 for the third year in a row, it is now the leading cause of death among young Scottish men (Stewart, 2017). Though men are more likely to suicide, compared to women they are less likely to seek help (Maddocks et al., 2013). Traditional gender roles that value independence and stoicism in the face of adversity may maintain stigma around men’s mental health, and help-seeking can be viewed as shameful and a sign of weakness (Jordan & Chvislinder, 2002; Rice et al., 2017; Davy, 2017; Office et al., 2012). Non-disclosure of mental health issues constitutes another barrier to help-seeking (Donaldson et al., 2000; Maddocks et al., 2010). Barriers to help-seeking in young men, which reduce symptom recognition (Maddocks & Wroblewski, 2006; Gregor et al., 2018; Office et al., 2019). Young men, especially, are reluctant to seek help for emotional issues and tend to discontinue help from health services around the time of suicide (Rice et al., 2017). Furthermore, the highest levels of stigma toward male depression and suicide can be found in the age group (Maddocks & Wroblewski, 2016). Non-engagement with health care services and increases in suicide rates among young Scottish men raise the question of whether different approaches to treatment and interventions are needed for reaching young male suicides (Rice et al., 2015). Research findings indicate a need for the development and evaluation of gender-specific psychotherapeutic interventions to improve male help-seeking (Rice et al., 2018).

The role of community-based services focusing on the promotion of men’s mental health

The 2000s have seen an increase in community-based services focusing on promoting men’s mental wellbeing (Office et al., 2020). Such as Warwickshire men’s SHARE project, Men’s Shed, Andy’s Men’s Club and Brothers in Arms. Research has found that factors that promote help-seeking behaviours in men include informal settings, community-based services, and interventions promoting social interactions e.g. sports or activities (Maddocks et al., 2013; Gregor et al., 2018). The least formal settings of the community-based spaces compared to traditional health care services promote opportunities for social contact, emotional support, and activity-focused programmes, which increase the likelihood of engaging men with their health (Office et al., 2019). Evaluations of such health-promoting community-based programmes have found that regular attendance increases both physical and mental health (Office et al., 2020). This study aims to explore the experiences of young men’s engagement with such services and how this contact may affect their capacity for help-seeking. The hope is that the study will generate important learning points that may be applied to health care settings more widely to better reach and engage this at-risk group. Furthermore, the study seeks to add empirical evidence to increase the understanding of what engages men with their health (Office et al., 2019).

Participants

(Under 18s at Male)

History of suicidal or mental health difficulties
Use of community-based service promoting men’s health
At 16-20 years
Ability to take part in 20-40 min interview

Research questions and hypotheses

How are young men with a history of suicidal or mental health difficulties engaging with community-based services focusing on men’s mental health?

What are their experiences of their contact with these services?

Are their experiences of their contact with these services?

What is the function of sharing their lived experiences of suicidal or mental health difficulties in a non-therapeutic setting?

Methodology

Structured, semi-structured, qualitative interviews will be conducted using interpretative phenomenological analysis (IPA), which aims to explore individual experiences of significant life events through detailed personal accounts to gain a better understanding of what it was like for the person to live through a particular situation (Vannucci, 2006; Smith, 2008, 2009). IPA will be used to investigate how participants make sense of their experiences of mental illness and engagement with community-based services aimed at promoting men’s health. IPA has been used in other research related to the present e.g. to explore the role of self-stigma in suicidality among young men (Kamruzzaman, 2013) and to examine the meaning of suicide attempts in young men with first episode psychosis (Stewart et al., 2016).
Upon completion of the interview the researcher will engage the participant in a short mood-monitoring conversation to assess for changes in mood states.

Following interviews, all participants will be provided with a debriefing form orally over the phone, which includes information on relevant aspects to contact should they experience any emotional distress that requires help. This debriefing form can be sent to participants on request. Furthermore, the PANAS will be repeated post-interview to detect any noticeable changes in mood states.

Data handling
Data will be collected through individual semi-structured interviews conducted over video calls to ensure the health and safety of both interviewee and researcher, given the current health risk posed by the pandemic. To ensure accurate transcription for data analysis, interviews will be conducted and recorded using Microsoft Teams as per the university’s recommendation. Upon completion, interviews will be downloaded to Dropbox and transcribed verbatim. To ensure participant anonymity, any identifiable information will be removed prior to analysis. Identifiable participant information, to which only the researcher has access, will be stored securely on password-protected devices (Transcripts).

Identifiable information such as contact details, quasi-identifiers, background information, and audio recordings will be stored separately from any anonymized data. Recordings will be uploaded to Dropbox immediately after interviews. The recordings will be deleted from the Teams following upload. Once transcribed, the audio recordings will be deleted from Dropbox and the transcriptions will be stored securely.

Participants will be made aware of this through the participant information sheet and consent form.

Consent
Prior to the commencement of data collection, the researcher will ensure participants are fully informed about the research content and procedure. Informed consent will be obtained verbally, and participants will be made aware that participation is voluntary and that they may withdraw from the study at any time. All forms will be administered orally and participants’ responses to the consent questions will be noted down. These forms will be provided to the unique participant number described above and stored separately from any identifiable information.

Participants will be informed of confidentiality including limits to this, such as Adult or Child Protection issues. Following data collection, participants will be debriefed on the expected outcomes of the research. Furthermore, it will be inferred that the researcher maintains complete confidentiality regarding any identifiable information about them throughout the study process.

References


SECTION 4: Potential risks to participants and researchers

Q11. Is your research project likely or possible to induce any psychological stress or discomfort in the participants or others, indirectly associated with the research?

☐ Yes
☐ No

If “yes” state the types of risk and what measures will be taken to deal with such problems.

Q12. Does your research project require any physically-invasive or potentially physically harmful procedures?

☐ Yes
☐ No

If “yes” give details and outline procedures to be put in place to deal with potential problems.

Q13. Does your research project require the use of privacy-invasive technology, such as CCTV, biometrics, facial recognition, vehicle tracking software?

☐ Yes
☐ No

If “yes” – Give details and outline procedures to be put in place to deal with potential problems.

Q14. Does your research project involve the investigation of any illegal behaviors or activities?

☐ Yes
☐ No

If “yes” – Give details of any illegal behavior or activities you may investigate.

Q15. Is it possible that your research project will lead to awareness or the disclosure of information about child abuse or neglect?

☐ Yes
☐ No

If “yes” – Explain what information will be disclosed and why.

Q16. Is it likely that dissemination of research findings or data could adversely affect participants or others indirectly associated with the research?

☐ Yes
☐ No

If “yes” – Describe the potential risk for participants/data subjects of this use of the data. Outline any steps that will be taken to protect participants.

Q17. Could participation in this research adversely affect participants and others associated with the research in any other way?

☐ Yes
☐ No

If “yes” – Describe the possible adverse effects and the procedures to be put in place to protect against them.

Q18. Is this research expected to benefit the participants, directly or indirectly?

☐ Yes
☐ No

If “yes” – Give details of how this research is expected to benefit the participants.

Sharing their personal experiences will help to better understand the needs of young men in Scotland with a history of substance abuse and their use of community-based services. The study aims to generate knowledge that can be applied to health care settings more widely to better reach and engage this at-risk group. There are no personal benefits in taking part such as vouchers or monetary payments. However, participants might find the question interesting and the interview may be an opportunity for them to reflect on their experiences.

Q19. Will the true purpose of the research be concealed from the participants/data subjects?

☐ Yes
☐ No

If “yes” – Explain what information will be concealed and why.
Q20. Will participants/data subjects be debriefed at the conclusion of the study?

☐ Yes  ☐ No

If “no” – Why will participants/data subjects not be debriefed?

Q21. At any stage in this research could researchers’ safety be compromised, or could the research induce emotional distress in the researchers?

☐ Yes  ☐ No

If “yes” – Give details and outline procedures to be put in place to deal with potential problems.

The researcher might be emotionally affected by upsetting accounts of participants’ experiences of suitability during interviews. A keepsafe protocol for the researcher will be developed jointly with the field supervisor, which may include access to supervision immediately following a distressing interview.

Please tick to confirm you agree with the following:

I will adhere to School guidance on risk assessment and health and safety and will seek advice on project and travel insurance prior to project commencement.

☐ I agree  ☐ I do not agree  ☐ Not applicable

SECTION 7: Participants and data subjects

Q22. How many participants or data subjects are expected to be included in your research project?

This study will aim to recruit 4-10 interview participants.

Q23. What criteria will be used in deciding on the inclusion and exclusion of participants/data subjects in your research project?

Inclusion criteria:
- Identity at stake
- History of suitability or mental health issues
- 16-25 years of age (should recruitment prove difficult, the age range may be extended to allow for more data collection)
- User of community-based service promoting mental health
- Ability to participate in 90-120 minute interview

Exclusion criteria:
- Under 18 years
- MCI or older
- Activity withdrawal
- Active psychotic
- Substance misuse that may impact ability to participate in interview
- (Identify as) Female or non-binary
- Non-English speakers

Q24. Are any of the participants or data subjects likely to be under 16 years of age?

☐ Yes  ☐ No

If “yes” – Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q25. Are any of the participants or data subjects likely to be children in the care of a Local Authority?

☐ Yes  ☐ No

If “yes” – Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q26. Are any of the participants or data subjects likely to be known to have additional support needs?

☐ Yes  ☐ No

If “yes” – Explain and describe the measures that will be used to protect and/or inform participants/data subjects.
Q27. In the case of participants with additional support needs, will arrangements be made to ensure informed consent?

☐ Yes
☐ No

If “yes” - What arrangements will be made?

If “no” - Please explain why not

Q28. Are any of the participants or data subjects likely to be physically or mentally ill?

☐ Yes
☐ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

As described above under Q11, the researcher will use a short assessment of participation suitability to determine mental health status using a standardized mental health questionnaire. This assessment will also focus on the exclusion criteria listed above and any potential participant deemed as actively suicidal or actively psychotic will be excluded from the study and supported to relevant services for support.

Q29. Are any of the participants or data subjects likely to be vulnerable or likely exposed to harms in other ways?

☐ Yes
☐ No

If “yes” - Explain and describe the nature of the vulnerability and the measures that will be used to protect and/or inform participants/data subjects.

Poor mental health or risk of suicidality. Regarding measures to protect participants please see section 4, Q11.

Q30. Are any of the participants or data subjects likely to be unable to communicate in the language in which the research is conducted?

☐ Yes
☐ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q31. Are any of the participants or data subjects likely to be in a relationship (i.e., professional, student-teacher, other dependent relationship) with the researchers?

☐ Yes

Q32. Are any of the participants or data subjects likely to have difficulty in reading and/or comprehending any printed material distributed as part of the study?

☐ Yes
☐ No

If “yes” - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q33. Describe how the sample will be recruited.

First path of recruitment will be through Melbourne Men’s SHARE project as agreed with John Murphy, Team Leader. If not enough participants can be recruited through the first path, recruitment will be expanded to similar community-based services based in Scotland. If recruitment objectives have not been achieved through the primary sources, other churches and organisations focusing on men’s mental health will be approached. Social media platforms, such as Twitter and Facebook, may be used for recruitment tagging both organisations and keywords relevant to the research topic.

Q34. Will participants receive any financial or other material benefits as a result of participation?

☐ Yes
☐ No

If “yes” - What benefits will be offered to participants and why?
Section 5: Participant or data subject information and consent

Q15. Will written consent be obtained from all participants or data subjects?
☐ Yes
☐ No

If "yes" – attach participant information sheet and consent form.
If "no" – explain why not and how consent is obtained (e.g. orally), and/or if consent cannot or should not be used for some reason, please provide a clear and rationale for this.

Q16. Have you made arrangements to tell participants what information you will hold about them and for how long?
☐ Yes
☐ No

If "yes" – what arrangements have been made?
This information is outlined in the participant information sheet.

Q17. Have you made arrangements to tell participants whether you will disclose the information to other organisations?
☐ Yes
☐ No

If "yes" – what arrangements have been made?
No personal information, only in summary format or as all.

Q18. Have you made arrangements to tell participants whether you will combine that information with other data?
☐ Yes
☐ No

If "yes" – what arrangements have been made?

Q19. In the case of children participating in the research, will the consent or assent of parents be obtained?
☐ Yes
☐ No

If "yes" – explain how this consent or assent will be obtained.

Q20. Will the consent or assent of children participating in the research be obtained?
☐ Yes
☐ No

If "yes" – explain how this consent or assent will be obtained.

Q21. In the case of participants who are not proficient in the language in which the research is conducted, will arrangements be made to ensure informed consent?
☐ Yes
☐ No

If "yes" – what arrangements will be made?

Q22. Does the activity involve using cookies or tracking individual’s activity on a website or the Internet in general?
☐ Yes
☐ No

If "yes" – describe the arrangements you have put in place to obtain informed consent for the use of these tools.
SECTION 7. Confidentiality and handling of data

Q43. What information about participants/data subjects will you collect and/or use?

Data collected through interviews will be personal, individual accounts of participants’ experiences mental health and use of community-based services promoting mental health. The following demographic information will be collected:

Gender
Age

Q44. Will you collect or use NHS data?

☐ Yes
☐ No
If “yes” – what NHS data will you collect or use?

Q45. What training will staff who have access to the data receive on their responsibilities for its safe handling? Have all staff who have access completed the mandatory data protection training on the self-enrolment page of [Learn]?

The researcher will complete mandatory data protection training on [Learn] prior to commencement of research study.

Q46. Will the information include special categories of personal data (health data, data relating to race or ethnicity, to political opinions or religious beliefs, trade union membership, criminal convictions, sexual orientations, genetic data and biometric data)?

☐ Yes
☐ No
If “yes” – Explain what safeguards e.g. technical or organisational you have in place, including any detailed procedures if this requires special and/or external processes, storage and analysis.

If you answered “no” to this question, please skip Q56 and continue answering the rest of the questions.

Q47. Please indicate how your research is in the public interest:

☐ Your research is proportionate
☐ Your research is subject to a governance framework
☐ Research Ethics Committee (REC) review (does not have to be a European REC)
☐ Peer review from a funder
☐ Confidentiality Advisory Group (CAG) recommendation for support in England and Wales or support by the Public Benefit and Privacy Panel (PBPP) for Health and Social Care in Scotland
☐ Other
Q48. It is essential that you identify, and list all risks to the privacy of research participants. You will then need to consider the likelihood of the risks actually manifesting and the severity of harm if the risks actually manifest.

<table>
<thead>
<tr>
<th>Risk details</th>
<th>Likelihood of risk manifesting</th>
<th>Severity of harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifiable due to data linkage</td>
<td>Remote</td>
<td>None</td>
</tr>
<tr>
<td>Identifiable due to low participant numbers</td>
<td>Possible</td>
<td>None</td>
</tr>
<tr>
<td>Identifiable due to geographical location</td>
<td>Probable</td>
<td>Significant</td>
</tr>
<tr>
<td>Identifiable due to transfer of data</td>
<td>Significant</td>
<td>None</td>
</tr>
<tr>
<td>Identifiable due to access of data</td>
<td>Likely</td>
<td>None</td>
</tr>
<tr>
<td>Data that will be processed as appropriate</td>
<td>Certain</td>
<td>Significant</td>
</tr>
</tbody>
</table>

Please use this box to record any other risks and the likelihood of them occurring, along with the severity of harm.

Please identify measures you could take to reduce or eliminate risks identified as possible significant or probable severe.

To minimize the risk of identifying participants due to geographical location of low numbers, all personal identifiers will be removed and anonymization will be ensured prior to publication. Furthermore, quotes will be selected carefully to protect anonymity.

Q49. Will information containing personal, identifiable data be transferred to, shared with, supported by, or otherwise available to third parties outside the University?

☐ Yes  ☐ No

If “yes” - Please explain why this necessary and how the transfer of the information will be made secure. If the third party is based outside the European Economic Area please obtain guidance from the Data Protection Officer.

Q51. Will feedback of findings be given to your research project participants or data subjects?

☐ Yes  ☐ No

If “yes” - How and when will this feedback be provided?

A summary of the research project and its findings will be made available in an accessible format to the study participants. Participants will be offered the opportunity to read over study findings interview transcript to check whether they agree with findings.

If “no” - Please provide rationale for this

Q52. How do you intend to use disseminate the results of your research project?

This research is to be written up in the format of a review paper and will include a systematic review of the relevant literature, which together will be submitted to the Doctorate in Clinical Psychology course at the University of Edinburgh.

The systematic review and research project will be presented for submission to a relevant academic journal, to make the findings of the research available to a wider audience. The researcher will discuss and identify relevant academic journals for research submission with both the clinical and academic supervision. Suitable journals may be the British Journal of Clinical Psychology, the Journal of Mental Health. The article will follow the relevant journal’s submission guidelines. Furthermore, the study findings may be presented to community-based services and to the health board, where the research was conducted. Finally, a summary of the research project and its findings may also be made available in an accessible format to the study participants.

Interviews will be conducted over Microsoft Teams from the researcher’s own house (from alone). Identifiable participant information, to which only the researcher has access, will be stored securely on password protected device, but the
SECTION 1: Security-sensitive material

The Terrorism Act (2006) outlaws the dissemination of records, statements and other documents that can be interpreted as promoting or endorsing terrorist acts.

Q23. Does your research involve the storage on a computer of any such records, statements or other documents?

☐ Yes
☐ No
If "yes" - Please tick "Yes" to indicate that you agree to store all documents on that file store

Q24. Might your research involve the electronic transmission (for example, as an email attachment) of such records or statements?

☐ Yes
☐ No
If "yes" - Please tick "Yes" to indicate that you agree not to transmit electronically to any third party documents stored in the file store

Q25. Will your research involve visits to websites that might be associated with extremist, racist, or terrorist content?

☐ Yes
☐ No
If "yes" - You are advised that such sites may be subject to surveillance by the police. Accessing these sites from University IP addresses might lead to police enquiries. Please acknowledge that you understand this risk by ticking "Yes"

☐ Yes
☐ No
By submitting to the ethics process, you accept that your School Research Ethics Officer and the convenor of the University’s Compliance Group will have access to a list of titles of documents (but not the contents of documents) in your document store. Please acknowledge that you accept this by ticking "Yes"

Please confirm that you have contacted your School Research Ethics Officer to discuss security-sensitive material by ticking "Yes"

☐ Yes, I have contacted my School’s Research Ethics Officer
☐ No, I have not contacted my School’s Research Ethics Officer
Section 19: Good conduct in collaborative research

Q57. Does your project involve working collaboratively with other academic partners?

☐ Yes
☐ No

If "yes" - Is there a formal agreement in place regarding a collaborative relationship with the academic partner(s)?

☐ Yes
☐ No

If "no" - Please explain why there is no formal agreement in place.

Q58. Does your project involve working collaboratively with other non-academic partners?

☐ Yes
☐ No

If "yes" - Is there a formal agreement in place regarding a collaborative relationship with the non-academic partner(s)?

☐ Yes
☐ No

If "no" - Please explain why there is no formal agreement in place.

Q59. Does your project involve employing local field assistants (including guides/interpreters)?

☐ Yes
☐ No

If "yes" - Is there a formal agreement in place regarding the employment of local field assistants (including guides and translators)?

☐ Yes
☐ No

If "no" - Please explain why there is no formal agreement in place.

Q60. Will cars be taken to ensure that all individuals involved in implementing the research adhere to the ethical and research integrity standards set by the University of Edinburgh?

☐ Yes
Section 11: Good conduct in publication practice

In publication and authorship, as in all other aspects of research, researchers are expected to follow the University’s guidance on integrity. By ticking yes, you confirm that full consideration of the items described in this section will be addressed as applicable.

☐ Yes
☐ No

Subsequent to submission of this form, both the applicant and their supervisor should review any alterations in the proposed methodology of the project. If this change to methodology results in a change to any answer on this form, then a re-assertion to the Ethics advisory panel is required.

The principal investigator is responsible for ensuring compliance with any additional ethical requirements that might apply, and for compliance with any additional requirements for review by external bodies.

All forms should be submitted in electronic format. Digital signatures or scanned in signatures are acceptable. The applicant should keep a copy of all forms for inclusion in their dossier.

Date Helen Stevens
Applicant’s Name
Applicant's Signature
Date signed

Ingrid Clancy (sic)
Ingrid Clancy

*Supervisor’s Signature
Supervisor’s Name
Date

*NOTE to Supervisor: Ethical review will be based only on the information contained in this form. If uncertainties exist, check list in italics wording of ‘No’ answers, you are taking responsibility, on behalf of the RHE and LSE, that the research proposal truly poses no ethical risks.

ISSUES ARISING FROM THE PROPOSAL

1 Not required for staff applications
The applicant should respond to these comments in section below.

Inclusion/Exclusion criteria:

The inclusion criteria are not clear whether "lack of community engagement service" is one of the requirements of the study, while this is stated in the information sheet. This criterion appears to be related to all relevant documents.

The inclusion criteria should include "low-risk" participants, i.e., low risk of harm or suicide.

Inclusion criteria should include ability to take part in a 15-60min interview.

Methods:

It was not clear how potential participants will view the information sheet and consent form. Will they receive a copy of those documents via email? If this is the case, then the researcher will have collected identifiable information regarding name and email address. This should be communicated to participants as part of the consent process.

The document should be signed by participants, i.e., low risk of harm or suicide.

The consent to collect information should be obtained verbally or in written form. If written consent will be required, then it is not clear who will be involved in obtaining the consent. If verbal consent will be obtained, there are no details in the application explaining how this will be done and what will be done if the participant is unable to provide written consent. If only verbal consent will be required, it is clear that this is sufficient for the study and how much information should be collected and stored.

These details were not explained in the application.

The fact that participants may be excluded due to substances should be communicated to participants at the time of first intake. This should be reflected in the study protocol.

Protection of participants:

Researchers should clarify access to all relevant documents that participation in the study will be kept confidential. The researcher supports the study is anonymous in the application, but this is not the case as participants will be identifiable to the researcher.

In relation to welfare, it is recommended that participants are informed for conducting part and part movement of mood. However, it is not clear whether the researcher or the researcher's access for identifying those who may be experiencing persistent distress or low mood after the interview. Add this information to the study protocol.

The researchers have indicated that management of mood and distress during interviews will involve the use of relaxation techniques and other distress tolerance methods. However, some of these methods may be contraindicated for the participant and potentially harmful (i.e., how does the interviewer know which technique will work with the participant?). It is recommended that as part of the keeping safe protocol, that the researcher includes steps to ensure that potential distress tolerance technique may be appropriate for each individual participant prior to the start of the interview. All relevant documents, including the information sheet, should reflect this where appropriate.

The researcher is advised to add a contextual mood induction conversation (e.g., weather, mood, etc.) prior to the end of the interview to ensure that the interview does not finish having discussed a distressing topic like experiences of suicide.

Options for the participant to stop and take a break from the interview or withdraw from the study should be provided to the participants as well. The information sheet should include details that findings from the study could be shared with others, as indicated by the application (answer to Q17).

Data storage:

How will the transcribed manuscripts be anonymized? Will a unique code be generated? Will pseudonymization be used so that identified consent can still be matched to recorded interviews if needed? These details will be required and explained to participants. Participants should be made aware how their personal information (name, informed consent, email address) will be stored separately to the interviews.

Participant information sheet - be clear about consent in this study or verbal? Or outline consent procedure this will be online.

Researchers should ensure they are informed in a quiet private place at home.

Be specific about which information you will use.

In the unlikely event that violence occurs - outline how this will be managed, i.e., break or stop interview, etc.

Stringent measures throughout that ensure separate consent will be recorded for the interview and being audio-recorded. Suggest rephrasing this or removing.

Make sure what will happen to demographic information that is not anonymous.

Any circumstances where confidentiality will be broken should be clarified here.

Put legenda's title (also do this for the dataset).

Detail - add details of how the participant can access summary report of study findings.

Consent:

Add in statement that the transcripts may be used in future research studies.

Other:

Specify in the process, that participation in the study will be confidential (not anonymous).

Please ensure that the study will be conducted in accordance with ethical guidelines as well. E.g., EPS.
AMENDMENTS: REQUEST FOR APPROVAL

Subsequent to receipt of ethical approval I the applicant would like to request the following amendment(s) to my original proposal:

- Removal of the age specifier (16-29) to allow for all male above 18 years to participate in the study with the aim to recruit more broadly.
- Remove the suicidality specifier and make the research more inclusive in terms of any mental health difficulty people may have experienced. This is done to facilitate recruitment.

Signatures:
Date: 10/01/2021

CONCLUSION TO ETHICAL REVIEW OF AMENDMENT

The applicant’s response to our request for further clarification or amendments has now satisfied the requirements for ethical practice and the application has favorable opinion from Clinical Psychology.

Signature:

Position: Lecturer in Applied Psychology/Ethics and Integrity Lead
Date: 13.01.21

Acronyms / Terms Used
- NHS: National Health Service
- SHSS: School of Health in Social Science
- IRAS: Integrated Research Applications System

Section: The SHSS is divided into Sections or subject areas, these are: Nursing Studies, Clinical Psychology, C-PASS.
Ethics Administrators

Nursing Studies: nursing@ed.ac.uk

Counselling, Psychotherapy and Applied Social Science: CPASS.ethics@ed.ac.uk

Clinical Psychology: Submitting.Ethics@ed.ac.uk

MA in Health, Science and Society: 
Full thesis references

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