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Understanding the Factors which Facilitate the Engagement of Men in Psychological Therapy

by

Isabelle Louise Cullis

Thesis for the degree of Doctor of Clinical Psychology

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Abstract

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Understanding the Factors which Facilitate the Engagement of Men in Psychological Therapy

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Isabelle Louise Cullis

In the UK, suicide continues to be the leading cause of death in men under 45 and research has consistently shown that men are less likely than women to seek professional help for mental health problems (National Statistics, 2018; Seidler et al., 2016). Endorsement of traditional views of masculinity, problems identifying emotional difficulties and externalised expressions of distress (e.g. substance misuse, violence etc.) have been identified as barriers to psychological help-seeking in men (Mansfield et al., 2003; Perlick & Manning, 2007). A systematic review identified that increased Mental Health Literacy and conformity to masculinity are predictors of help-seeking in men. Demographic factors such as race and education have also been found to influence this process.

The current study aimed to assess viewpoints held by men on what factors would be important to them when considering engaging in therapy and whether viewpoints differed depending on demographic factors (e.g. age, ethnicity, sexuality, religion). Forty-five statements were developed from a scoping review by Seidler et al. (2018) providing recommendations for factors that would be important to consider when engaging men in psychological therapy. Forty-seven men who had not previously accessed psychological therapy completed a Q-sort by ranking the statements relating to therapy in accordance with their perceived relative importance.

Q-methodology uses a by-person factor analysis to identify shared and different viewpoints within the sample (Watts & Stenner, 2014). The data analysis was completed

in two stages: 1a) analysis and interpretation of factors from Group One (those who had considered psychological therapy), 1b) analysis and interpretation of factors from Group Two (those who had not considered psychological therapy) and 2) a second-order factor analysis combining factors from both groups to understand common and differing viewpoints across both groups. Second-order analysis revealed a three-factor solution that accounted for 45% of the total variance: Factor A 'The Context of Therapy', Factor B 'Gendered Therapy and a Relaxed Approach' and Factor C 'The Individuals Experience'. Viewpoints can be understood within the context of previous literature, theories and findings. The dominant viewpoint described men placing value in feeling accepted, supported and safe within psychological therapy, through understanding the process (expectations and treatment goals) and through the relationship with the therapist. Future research would benefit from establishing whether the findings from this study could be used to support men to understand therapy and what to expect in order to promote more positive attitudes towards, and consequently engagement in, psychological therapy.

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Research Thesis: Declaration of Authorship

Print name: Isabelle Cullis

Title of thesis: Understanding the Factors which Facilitate the Engagement of Men in Psychological Therapy

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before

Signature: .... Date:..........................

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Chapter 1: Predictors of Help-seeking for Mental Health Problems in Men: A Systematic Review of Literature

1.1 Introduction

Male deaths accounted for three quarters of UK deaths by suicide in 2018 and statistics have shown suicide is the highest killer in men under the age of 45 (Office for National Statistics, 2018). In 2012 the UK government declared young and middle-aged men as a priority high-risk group in their strategy for reducing suicide in England (Department of Health, 2012). Furthermore, men over the age of 75 have higher rates of suicide than women. The factors associated with suicide are complex, however untreated depression and mental health problems with prolonged experiences of suicidal thoughts and feelings have been associated with suicide attempts (Mental Health Foundation, 2019).

Despite these figures, men have repeatedly been found to be half as likely to seek help for mental health problems from a GP or mental health professional than women (Addis & Mahalik, 2003). Many studies have investigated the differences between men and women in relation to help-seeking for mental health problems (Kessler, Brown & Broman, 1981). National Statistics from the UK estimate that only 9% of men have accessed help for a mental health concern compared to 15% of women (Mental Health Foundation, 2019). Furthermore, research has repeatedly found men have less positive attitudes towards help-seeking than women due to a sense of shame, perceived and internalised stigma around asking for help (House et al., 2018; Padesky & Hammen, 1981). These findings have been consistent across men of different ages, cultures, nationalities and sexualities (Ishikawa et al., 2010; Lynch et al., 2018; Pitt & Fox, 2009). Early intervention for mental health problems has been shown to be vital in order to improve someone's life chances and reduce healthcare costs (Mental Health Foundation, 2019).

1.1.1. The process of help-seeking

Cornally and McGarthy (2011) found help-seeking behaviour to be a complex decision-making process involving a series of cognitive and behavioural steps initiated by a problem that is inhibiting a person's ability to function in some way. Help-seeking theories suggest that this process is dictated by different variables such as the type of difficulty somebody has, as well as the type of help they are seeking (Rosenstock, 1974). Psychological help-seeking is defined as an attempt by an individual to seek help from trained mental health professionals so as to be able to solve their emotional, social, interpersonal and/or other psychological concerns/issues (Leong & Zachar, 1999).

The process of help-seeking has been studied and numerous theories have emerged that can be helpful when trying to understand the factors involved in help-seeking for mental health problems. The Health Belief Model (HBM) is a social cognition model in health psychology that suggests health related behaviours are dependent on three factors: existence of health concern (otherwise described as motivation), perceived threat and belief that the chosen behaviour will reduce the perceived threat (Rosenstock, 1974). Rosenstock, Stretcher and Becker (1988) suggested that despite its evidence base, a key component that was missing from the HBM was the idea of 'self-efficacy' meaning a person's ability to believe that they can make the behaviour change. Although locus of control is incorporated within the other variables of the model, Rosenstock et al. believed it important to include self-efficacy as a separate independent variable. Bandura (1977), Rosenstock et al. and other theorists believed self-efficacy and locus of control to have distinct differences as self-efficacy is situation specific and therefore you need both when considering making specific health behaviour changes (Ajzen, 2002).

Similarly to the HBM, the theory of planned behaviour has been applied to different populations to explain and understand help-seeking behaviour. Ajzen (1991) developed the theory of planned behaviour (TBP) from his theory of reasoned action (TRA; Ajzen & Fishbein, 1980). The TBP suggests that behaviour is the result of a combination of a number of different constructs including attitude toward the behaviour, subjective norms surrounding individuals and perceived behavioural control or a person's belief in their ability to be able to conduct the behaviour (Ajzen, 1991). Subjective norms refer to beliefs that an influential person or group of people will approve or support a behaviour or belief

(e.g. cultural norms,). Subjective norms are often determined by social pressure from others for an individual to behave in a particular way. The TBP posits that behavioural commitment can be predicted by these

aforementioned antecedent variables and therefore suggests that there are particular factors that may predict help-seeking behaviours in men.

1.1.2 Different types of help-seeking

Help-seeking for health difficulties can take many different forms and can be sought from various sources. The purpose of this review is to examine the literature around psychological help-seeking which has been described in two main forms: formal and informal. Formal help-seeking can also be described as professional help-seeking and describes the process of seeking assistance through professionals or organisations who have a recognised role in providing appropriate, professional support, advice or treatment relevant to the problem. The role of a General Practitioner (GP) has previously been identified as significantly important in seeking help for mental health problems (Perkins et al., 2010). The GP is often the first port of call for someone seeking support for a mental health problem and statistics have shown that one in three GP appointments are for mental health problems (Joint Commissioning Panel for Mental Health, 2015)

Informal help-seeking through friends and family rather than professional sources has been found to be viewed more favourably by men (Oliver et al., 2005). Evidence has suggested that the social network plays a key role in the help-seeking process for men. For example, Vogel, Wade, Wester, Larsen & Hackler (2007) found those who sought help to have been prompted 74-78% of the time by their partner or a family member. Furthermore, Cusack, Deane, Wilson, and Ciarrochi (2006) found that 59% of men were influenced by an intimate partner to seek help for mental health problems. Findings by the organisation Relate (2014) revealed that more men reported having no friends (11%) than women (7%) and additionally more women rated their friendships as good (81%) than men (73%) suggesting less satisfaction by men in their friendships. These findings may suggest that some men are less well supported socially and emphasise the need for further research in this area in order to support services to improve their accessibility to men.

1.1.3 Barriers to help-seeking for men

When considering help-seeking by men, research has suggested there are many factors that may make it difficult for men to seek help for mental health problems.

1.1.3.1 Social Construction of Masculinity

Many studies have identified masculinity as a key barrier for mental health help-seeking in men (Vogel & Heath, 2016). Theorists in male psychology view 'masculinity' to be a social construct. According to social constructionism men will be differently socialised into masculine gender roles depending on their contextual factors and values such as culture, heritage and family (Lindsey, 2015). Addis and Mahalik (2003) suggested that masculine ideology and gender role conflict have a significant impact on help-seeking behaviour in men. In a systematic review by Seidler, Dawes, Rice, Oliffe & Dhillon (2016) nine qualitative papers of the 37 included papers referred to masculinity inhibiting the process of help-seeking and described men seeking help only when the severity of their symptoms had increased and they felt unable to manage on their own or were encouraged to access help by external sources.

According to Aizen's theory of planned behaviour (1991) subjective norms are a crucial construct in the process of a behaviour suggesting that help-seeking behaviours may be determined by the perceived social pressure from others and their motivation to comply with other people's views of help-seeking. Given the aforementioned statistics around men's likelihood to access help for mental health problems and attitudes towards help-seeking it is likely that these norms may influence the process of help-seeking in men (Addis & Mahalik, 2003).

1.1.3.2 Problem Identification

Furthermore, there have been sex differences identified in recognising emotional distress and mental health problems which may act as a barrier to help-seeking (Yokopenic et al., 1983). Men have been found to be less likely to be able to identify mental health problems they have than women (Kessler et al., 1981). Findings have also suggested that there may also be gender differences in expression of distress which may

be explained through the Social Learning Theory and the idea of modelling (Bandura, 1977). Alexithymia refers to a person's inability to identify or verbally describe his or her feelings and has been found to be present in higher rates in men than women (Levant et al., 2009; Lewis et al., 2008; Zaidel & Kaplan, 2007).

Additionally, stereotypes appear to have an impact on a person's perception of men and women's emotions which is likely to impact on the help-seeking process. For example, women are perceived to express less anger and aggression than men despite empirical data not supporting this (Fabes & Martin, 1991). Findings have indicated gender differences in symptoms of depression with aggression and anger more likely to be present in men with depression than women (Winkler et al., 2005). Sixteen qualitative papers from the review by Seidler et al. (2016) described symptoms of depression going undetected in men by existing diagnostic tools due to their expression of distress appearing atypical.

1.1.3.3 Perceptions of substance misuse

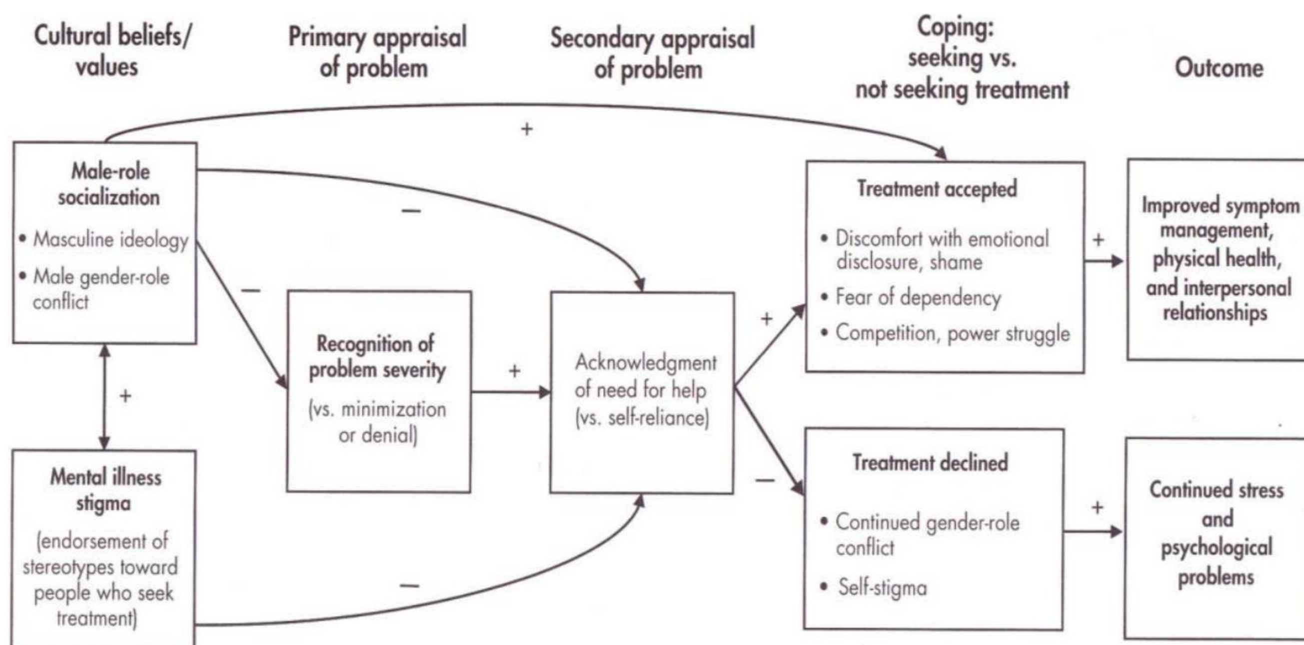
Research has shown higher prevalence of substance misuse problems and aggression amongst men (Mental Health Foundation, 2016; Mustafa et al., 2013). Substance misuse behaviours have been shown to be negatively perceived by mental health professionals as a result of difficulty in understanding what could be deemed a self-destructive behaviour (Foster & Onyeukwu, 2003). Substance use could be described as a means of coping with emotional distress however, if it is perceived differently it is likely to impact on the process of help-seeking (Singleton et al., 2003).

1.1.4 Models of Male Help-Seeking

Addis and Mahalik (2003) developed a model of men's help-seeking from research that uses social psychological theory and the masculine gender role socialisation paradigm with social constructionism and feminist analyses of masculinity. The model suggests a relationship between male gender socialisation and the process of constructing masculinity within specific help-seeking contexts. Addis and Mahalik identified 5 basic social psychological processes that may moderate this relationship: 1) perceptions of the normativeness of problems, which describes the degree to which an

individual believes the problem they are experiencing to be 'normal' or experienced by others; 2) the perceived ego centrality of problems, which describes the belief an individual has that the problem is a central part of themselves; 3) characteristics of potential helpers; 4) characteristics of the social groups to which individual men belong, for example whether other men within their social network share their problems and 5) perceived loss of control, which describes how much men believe accessing help will remove their sense of control over the situation. Addis and Mahalik described their model as a starting point for comprehending how men both react to and create meaning of masculinity as they contemplate whether to seek help for their concerns.

The Model of Male Help-Seeking (MMHS) was proposed by Perlick and Manning (2007). The MMHS was developed based on research on gender differences and role socialisation in help-seeking behaviours and was influenced by Lazarus and Folkman's (1991) model of stress and coping. According to the model of stress and coping, an individual's ability to cope is influenced by their assessment of the severity of the problem or stress and their perceptions of their ability to cope with it. The MMHS builds upon Lazarus' model by considering how cultural beliefs and values about traditional masculine ideology and stigma around mental illness influence the appraisal of the problem and subsequently the likelihood of seeking help (see Figure 1). The MMHS describes coping to be dependent on men's perception of the severity of the difficulty and their belief about their ability to manage the difficulty. Gender role conflict and conformity to masculine norms has been found to impact upon attitudes towards



psychological help-seeking (Levant et al., 2009). The MMHS suggests that this masculine ideology such as ideas of emotional restriction and gender role conflict, influences the primary appraisal or men's ability to understand severity of the problem. The secondary appraisal of the problem is also influenced by these factors for example through ideas of self-reliance along with stigma around mental illness. Whilst these models provide a useful understanding of male help-seeking processes there is a lack of empirical evidence supporting them.

Figure 1. The Model of Male Help-Seeking

1.1.5 Intersectionality

It is possible that predictors of help-seeking for mental health problems in men may vary across men of different demographics such as age, culture, ethnicity, religion and sexuality. Intersectionality has been defined as 'the interconnected nature of social categorisation such as class, race and gender, regarded as creating overlapping and interdependent systems of discrimination or disadvantage; a theoretical approach based on such a premise' (Oxford Dictionary, n.d.). Intersectionality considers individual's overlapping identities and experiences in order to help understand the complexity of prejudices they might face. Within the population of men evidence suggests that some men are more likely to seek help than others. For example, research has shown that White British men are more likely to receive mental health treatment (13.3%) when compared to men from BAME groups (7%), and those from black ethnic minority groups (6.2%) are least likely to receive treatment (Mental Health Foundation, 2019). An examination of the factors associated with help-seeking and predictors of help-seeking would support a vital understanding into why and how some men are able access help for their mental health problems. This understanding is crucial to enable further research into these predictors and ways of developing services in order to better meet the needs of those struggling to access or ask for help.

1.1.6 The Current Review

Despite the development of male help-seeking models by Addis and Mahalik (2003) and Perlik and Manning (2007) there is a lack of evidence supporting them. Furthermore,

previous reviews and research to date has mainly focused on investigating the barriers to help-seeking for men, with some research exploring the factors that may mitigate these barriers (Nam et al., 2010; Rothì & Leavey, 2006). Seidler et al. (2016) examined the role of masculinity in help-seeking for depression and other existing reviews have addressed the factors associated with delays in help-seeking by men (Yousaf et al., 2015). This review identified a variety of barriers to help-seeking the most prominent of which were disinclination to express emotions or concerns about health, embarrassment, anxiety and fear, and poor communication with health-care professionals. However, there is still limited understanding of predictors of help-seeking for mental health in men. Exploring the process of help-seeking for mental health difficulties in men is essential in order for psychologists and mental health practitioners to better understand the role of services in supporting people to access help. A better understanding of predictors of help-seeking for mental health problems in men would allow for identification of specific factors that could be targeted and improved through specially designed health promotion campaigns or interventions.

The current review aims to synthesise existing research into professional help-seeking for mental health in men. The MMSH and existing theories presented within the introduction of this review would expect the review to reveal masculine and gender role socialisation, stigma, problem recognition and identification of need for help to be predictors of psychological help-seeking in men (Addis & Mahalik, 2003; Levant et al., 2009; Perlick & Manning, 2007). Alongside this previous evidence suggests social support and other demographic factors to also be predictors (Pederson & Vogel, 2007; Vogel et al., 2007). The review will draw upon existing work examining barriers to help-seeking and provide important evidence to help us better understand previous theories and models of male help-seeking. However, it will be the first review to examine predictors and men's experiences of facilitators of professional help-seeking for mental health problems by asking: What are the predictors of help-seeking for mental health problems in men?

1.2 Method

1.2.1 Information sources and search terms.

The following five databases relevant to psychological research were searched during October 2019: PsychInfo, PsychARTICLES, Web of Science, Cochrane Library and

Medline. It is possible that published papers are subject to publication bias and therefore, to reduce the impact of this, a grey literature search of theses and dissertations was also conducted using Proquest a database of dissertations from the UK and Ireland.

Search terms were derived through a process of scoping searches, examining previous systematic reviews and review of terms with supervisors and a University Librarian. Scoping searches revealed systematic reviews examining barriers to help-seeking but no current systematic reviews examining predictors of professional help-seeking for mental health in men. The search terms used to identify studies for the review can be seen in Table 1. The syntax was appropriately adapted for each database. Initial searches including further terms for 'mental health' including a variety of diagnoses (low mood, psychosis, schizophrenia, bipolar, suicide) revealed no further papers and therefore these terms were removed. The searches were conducted by two independent researchers to ensure validity and reliability of the search terms.

Table 1. Search terms used on each database

	Search terms
Help-seeking	help* N2 seek*
AND	
Men	(m?n OR male*)
AND	
Mental Health	(mental N1 (health OR well-being)) OR "mood disorder*" OR "psychological well-being" OR depress* OR anxi* OR "emotion* distress")

1.2.2 Eligibility Criteria.

Following study identification, papers were examined against pre-determined inclusion/exclusion criteria that were based upon scoping searches and were deemed to facilitate the answering of the research question.

Inclusion criteria:

1. Empirical papers that identified at least one predictor of help-seeking (e.g. psychological, social or demographic) in men
2. Papers on mental health

3. Papers using qualitative or quantitative methodologies

Exclusion criteria:

1. Papers on physical health
2. Theoretical papers on help-seeking
3. Conference posters, abstracts, book reviews, systematic reviews, meta-analyses and book chapters
4. Papers with men under the age of 18
5. Papers that did not analyse data from men and women separately
6. Papers that investigated factors or barriers that reduce help-seeking without directly addressing help-seeking factors
7. Papers that include specialist groups of men where help-seeking might be different (e.g. prison populations)

1.2.3 Study selection.

Following initial searches, studies were screened, and duplicates were removed. A hand search of previously identified relevant studies and their reference lists using a snowballing citation method provided a further 15 studies. The snowballing method involves searching reference lists of included papers to identify further papers that meet inclusion criteria. This method has been found to help identify high quality articles that may be in obscure locations (Greenhalgh & Peacock, 2005). The records were then screened for eligibility using the title and abstract. A total of 47 articles were examined by full text and 18 were included in the final review. Despite contacting the author, one thesis was not able to be accessed due to external restrictions and therefore was excluded (Douglass, 2008).

1.2.4 Data Extraction.

Information was extracted from all 18 studies in line with the review question. Due to the heterogeneous nature of the studies a narrative approach to synthesising findings was adopted (Greenhalgh et al., 2005). The review included papers of both qualitative and quantitative nature and therefore data was extracted from these separately. Qualitative data was used to provide context to information collected regarding predictors from the quantitative papers. For the ten quantitative studies the information extracted included:

research aims, sample population, study design, outcome measures and key outcomes/findings. For the eight qualitative studies the information extracted included: research aims, sample populations, procedure, key outcomes/themes identified. A summary of the included quantitative studies can be seen in Table 3 and qualitative studies in Table 4.

1.2.5 Quality Assessment.

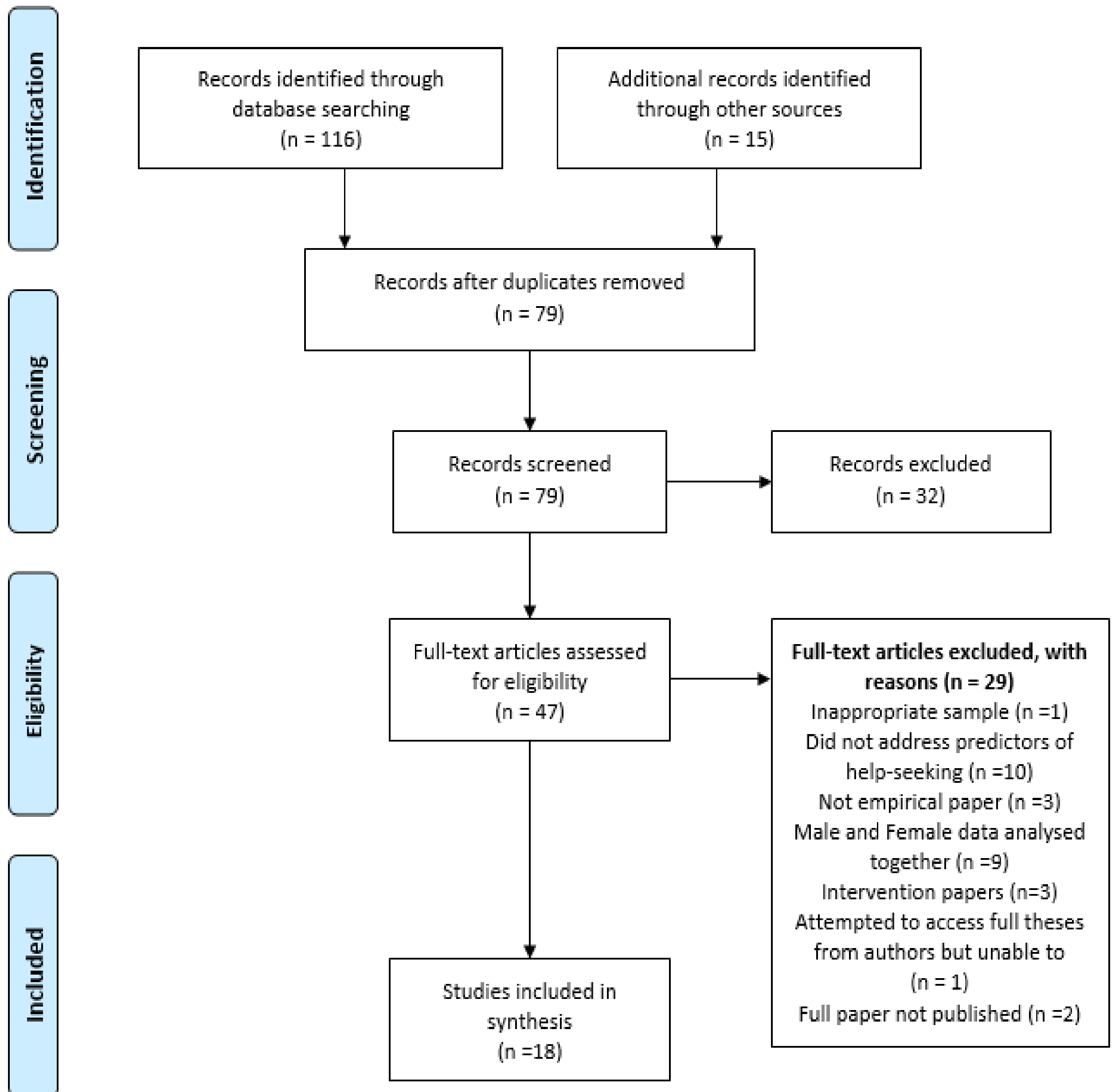
The quality and methodological rigour of the included studies was assessed using the QualSyst quality tool (Kmet et al., 2004). The tool includes assessments for both quantitative and qualitative research studies and allows for assessment of a large range of study designs. Studies are rated according to a set of standards and were rated by two independent researchers to improve validity of scoring. There are 14 standards for quantitative studies that include: research objective, design, method of subject selection, outcome measures, sample size, analytic methods, results and conclusions. As interventional studies were not included in this review standards five, six and seven were not used. For qualitative studies there are 10 standards that include: research objective, design, context, sampling strategy, data collection methods, analysis, conclusions and reflexivity. Scoring ranges from 0-2, where 2 represents the standard being met, 1 being partially met and 0 representing the standard not being met. A total mean score is calculated for each paper by summing the total score across the relevant items (excluding scores of items omitted) and dividing by the total possible score (number of items included) producing a percentage score that can be compared against other study scores.

1.3 Results

1.3.1 Study Characteristics

Following screening, a total of 18 studies were included in the review (see Figure 2). Of these 18, 10 were quantitative studies and eight were qualitative. The published studies included in the review were published between 1996 and 2019 with 16 of them being published within the last decade.

Figure 2. PRISMA Flow Diagram



The majority of the studies were conducted in the United States (67%) and the UK (17%). All of the studies took place in developed countries and most took place in university towns or cities. The majority of the studies included in the review used a cross-sectional design with only two incorporating a longitudinal design. Furthermore, 12 of the studies were published within peer reviewed journals and the remaining six studies were published theses. Of the 18 papers included, 16 of them were published since 2000 and the oldest paper was published in 1996. A summary of the study characteristics is included in Table 2 and full details of the included studies can be seen in Table 3 and 4.

Table 2. Study Characteristics

Study	Date Conducted	Study Location	Type of Study
Abrams	2016	USA	Quantitative
Blazina & Watkins	1996	USA	Quantitative
Call & Shafer	2018	USA	Quantitative
Cole	2013	USA	Quantitative
Coleman	2019	USA	Qualitative
Cramer, Horwood, Payne, Araya, Lester & Salisbury	2014	UK	Qualitative
DeBate, Gatto & Rafal	2018	USA	Quantitative
Fisk	2013	UK	Qualitative
Harding & Fox	2015	Australia	Qualitative
Johnson, Oliffe, Kelly, Galdas & Ogrodniczuk	2012	USA	Qualitative
Mahalik & Dagirmanjian	2019	USA	Qualitative
Parent, Hammer, Bradstreet, Schwartz & Jobe	2018	USA	Quantitative
Rafal, Gatto & DeBate	2018	USA	Quantitative
Simonsen	1999	USA	Quantitative
Sullivan, Camic & Brown	2015	UK	Quantitative
Tang, Oliffe, Galdas, Phinney & Han	2014	Canada	Qualitative
Vogel, Heimerdinger-Edwards, Hammer & Hubbard	2011	USA	Quantitative
Wirback, Forsell, Larsson, Engström & Edhborg	2018	Sweden	Qualitative

1.3.2 Participant characteristics.

Collectively, 14582 participants are included in the current review, 148 participants from qualitative studies with a mean sample size of 18.5 (range from 6- 38) and 14434 from quantitative studies with a mean sample size of 1642.9 (range 117- 4825). Only six of the studies included a clinical sample all of which were qualitative (n= 98), with the remaining studies utilising participants from a non-clinical population (n=14484) four of

which used student populations (Blazina & Watkins, 1996; Cole, 2013; DeBate et al., 2018; Rafal et al., 2018) Twelve of the studies relied upon self-selecting recruitment strategies, non-clinical samples of which were recruited from the general population through advertisements (Abrams, 2016; Johnson et al., 2012; Mahalik & Dagirmanjian, 2019; Sullivan et al., 2015; Vogel et al., 2011), community organisations (Simonsen, 1999) or national surveys (Call & Shafer, 2018; Parent et al., 2018). Participants' ages ranged between 18 and 79 years old, and of the 12 studies that reported specific ages of their samples the mean age was 31.8 years.

Table 3. Quantitative Studies

Study	Aim	Sample	Study design	Key Outcome measures	Key Outcomes/Findings	Quality Assessment
Abrams (2016)	To examine the relationship between alexithymia, public stigma, gender role socialization, help-seeking attitudes, and their collective influences on help-seeking intentions for depression among men	Non-clinical sample N= 190 Age (M= 33.8, SD = 9.97)	Cross-sectional Regression analyses	The Normative Male Alexithymia Scale (NMA) (Levant et al., 2004) The Male Role Norms Inventory-Short Form (MRNI-SF) (Levant, et al., 2013) The Attitudes Toward Seeking Professional Psychological Help Scale-Short Form, (ATSPPH-SF; Fischer & Farina, 1995) The Perceptions of Stigmatization by Others for Seeking Psychological Help (PSOSH, Vogel, Wade & Ascherman, 2009	Three predictors (ATSPPH, MRN &NMA) explained 49% of the variance $F(3,167) = 52.573$, $p < .000$, $R2 = .486$ ATSPPH ($\beta = .752$, $p < .000$) was the strongest predictor of men's willingness to seek help for depression Followed by MRN ($\beta = .148$, $p < .05$). Normative Male Alexithymia (NMA) did not predict men's willingness to seek help for depression ($\beta = -.002$) The Perceptions of Stigmatization by Others for Seeking Psychological Help (PSOSH) was excluded due to insignificant correlation	77.27
Blazina & Watkins (1996)	To examine the effects of gender role conflict on college men's scores of psychological well-being, substance usage and attitudes towards psychological help-seeking	Non-clinical student sample N= 148 Age range 18-55 (M =23.25, SD= 3.23)	Cross-sectional Regression analyses	Gender Role Conflict Scale (O'Neil et al. 1986) The Attitudes Toward Seeking Professional Psychological Help Scale-Short Form, (ATSPPH-SF; Fischer & Farina, 1995)	GRC variables as predictors were significant $F(4, 143)= 6.6$, $p< .0001$, $R2= .156$ and accounted for 15.6% of the ASPPH variable Success, Power and Competition variable $\beta = -.20$, $F(4, 143)= 9$, $p < .05$) and Restricted Emotionality variable were significant $\beta = -.27$, $F(4, 143)= 9$, $p < .002$)	72.73

Call & Shafer (2018)	To understand how help-seeking behaviours in men who exhibit male typical symptoms of depression differ from men with more traditional symptoms and whether this influences who men seek help from	Non-clinical sample N = 2382 Age 30- 55	Longitudinal Logistic regression	**Dependent variables:** Past help-seeking behaviours for depression Past help-seeking behaviours for mental health concern (not depression) Past help-seeking behaviours for mental health concern and depression Categorical variable: help provider **Independent variables:** 1. An index of traditional DSM criteria for depression 2. index of male-typical symptoms of depression.	Traditional symptoms increased the odds of seeking help for depression for all men. Male-typical symptoms did not increase the odds of seeking help for depression or another mental health concern. Both traditional and male-typical symptoms increased the odds of initially seeking help from a medical provider, and men with male-typical symptoms had an overall higher likelihood of seeking help from a medical provider	100
Cole (2013)	To examine the moderating effects of hope and psychological well-being on the relationship between adherence to traditional masculine norms and attitudes toward help-seeking	Non-clinical student sample N= 366 Age 18- 40 (M = 20.24, SD = 2.813)	Cross-sectional Multiple Regression Analysis	Conformity to Masculine Norms Inventory-46 (CMNI-46; Parent & Moradi, 2009) Gender Role Conflict Scale (GRCS; O'Neil et al., 1986) Potential Responses to Depressive Symptoms (PRDS) Hope Scale-Revised (HSR) Psychological Well-Being-54 (PWB-54)	Gender role conflict and conformity to masculine norms predict attitudes about psychological help-seeking behaviours when depressed Conformity to masculine norms predicts decreased willingness to engage in help-seeking when depressed (p<.05) Conformity to masculine norms predicts decreased willingness to engage in help-seeking from professionals (p< .005) Gender role conflict predicts decreased willingness to engage in professional help-seeking (p< .005)	90.91

DeBate, Gatto & Rafal (2018)	To examine the relationships between Mental Health Literacy (MHL), mental health attitudes, subjective norms about mental health treatment, and stigma on intention to seek help from mental health services in a large sample of male students in the United States	Non-clinical student sample N= 1242 Age (M= 25.21, SD= 7.07)	Cross-sectional Multiple Regression Analysis Mediation	Multicomponent MHL Likert-type Scale Attitudes Toward Seeking Help Likert type scale Self-stigma of Seeking Help (SSOSH) Intention of Seeking Counselling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975)	Information (Mental Health Literacy) and Motivation are predictors for Behavioural skills (help-seeking) Stigma is significant mediator for relationship	90.91
Parent, Hammer, Bradstreet, Schwartz & Jobe (2018)	To undertake an intersectional analysis of men's mental health help-seeking behaviours using data collected from a national data set.	Non-clinical sample N= 4825 Ages 20- 59 (M= 39.59, SE= 0.26)	Cross-sectional Multiple Regression Analysis	PHQ-9 Help-seeking: "During the past 12 months, have you seen or talked to a mental health professional such as a psychologist, psychiatrist, psychiatric nurse, or clinical social worker about your health?"	Age, sexuality, race, income, relationship status and severity of depression symptoms as predictor of help-seeking Varying within intersections	95.45
Rafal, Gatto, DeBate (2018)	To assess MHL, psychosocial determinants, and help-seeking intention among a large sample of male US college students.	Non-clinical student sample N= 1,242 Age M= 25.21, SD= 7.07	Cross-sectional Analysis of Variance	MHL was assessed using a modified version of the 26-item multi-component scale Modified version of the Self-Stigma of Seeking Help (SSOSH) scale Attitudes Toward Seeking Help scale Subjective Norms Scale Intention of Seeking Counselling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975)	Race, Major classification and Mental Health Literacy as predictors of professional help-seeking	77.27
Simonsen (1999)	To determine if male gender role conflict plays a role in gay men's psychological dysfunction and help-seeking behaviours	Non-clinical sample N= 117 Age M= 37	Cross-sectional Multiple Regression Analysis	Personal Data Questionnaire Gender Role Conflict Scale (GRCS; O'Neil et al., 1986) Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH)	Gender role conflict scale identified Restricted Emotionality (RE), Restricted Affection (RA) Between Men (as predictors of attitudes towards help-seeking. RA was	81.82

					significant β= -.337, F(4, 109)= -2.64, p < .010)	
Sullivan, Camic & Brown (2015)	To determine, using a large-scale survey design, whether adherence to masculine norms, emotional expressiveness, and intimacy in close relationships were associated with UK men's attitudes towards seeking professional psychological help.	Non-clinical sample N= 581 Age > 18	Cross-sectional Regression analysis	The Fear of Intimacy Scale (FIS; Descutner & Thelen, 1991) The Normative Male Alexithymia Scale (NMAS; Levant et al., 2006) The Male Role Attitudes Scale (MRAS; Pleck, Freya,&Leighton, 1994) Attitudes towards Seeking Professional Psychological Help Scale – Short Form	Three predictors: Masculine ideologies, Alexithymia, Fear of Intimacy accounted for 12% of variance. Education level (β= .096) identified as predictor of attitudes towards help-seeking	100
Vogel, Heimerdinger-Edwards, Hammer & Hubbard (2011)	To understand the relationships between conformity to dominant masculine gender roles, self-stigma, and attitudes toward seeking counseling for men from diverse racial/ ethnic and sexual orientation backgrounds.	Non-clinical sample N= 4773 Age 18-79 (M= 32.9, SD= 12.2)	Cross-sectional Structural Equation Modelling	Conformity to Masculinity Norms Inventory (CMNI-22; Mahalik et al., 2003) Self-Stigma of Seeking Help scale (SSOSH; Vogel et al., 2006) Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPHS-SF; Fischer & Farina, 1995) Center for Epidemiological Studies Depression scale (CES-D; Radloff, 1977)	Endorsement of masculine norms identified as predictor of less favourable attitudes towards help-seeking Stigma as mediator between masculine norms and attitudes towards seeking help	95.45

Table 4. Qualitative Studies

Study	Aim	Sample	Procedure	Analysis	Key themes identified	Quality Assessment
Coleman (2019)	To explore and describe the experiences of African American men with depression as it relates to help-seeking	Clinical sample N =6 Age 18- 65 (M= 36.2)	Semi-structured interviews Phenomenological study	Thematic analysis	Understanding that talking with a therapist can be very helpful A support system or safety net will help a person get through it	90
Cramer, Horwood, Payne, Araya, Lester & Salisbury (2014)	To establish if men do attend therapeutic/support groups for depression, the types of group they attend, the reasons why they attend them and the advantages and disadvantages of groups.	Clinical sample N =38 Interviews n=17 Group attendees n= 30 Age 18- 70s	Semi-structured interviews Group Observations	Thematic analysis	Isolation and the social benefits of groups The value of groups and strategies for attracting men Accessing support and the role of health professionals	80
Fisk (2013)	To contribute to the understanding of: 1. the pathways into mental health services for male service users 2. the resources that men employ prior to accessing mental health services 3. how men overcome barriers to helpseeking in order to access mental health services	Clinical sample N =11 Ages 38-48 (M= 42.7)	Semi-structured interviews	Grounded Theory	Stigma and Endorsement of Masculinity Scripts Self Management Acknowledgement of Difference from self and others combined with reaching a threshold of concern about symptoms by self and others Acknowledgment That Difference Concerns Mental State Cognitive Evaluation of Risks of Not Addressing Mental State	100
Harding & Fox (2015)	To identify the enablers men engage to facilitate mental health help-seeking with reciprocity and social norms of help-seeking informing this study	Clinical sample N= 9 Aged 23-65	Semi-structured interviews	Thematic Analysis	Precipitating Event Significant person Online Resources Social Norms Mental Illness Definition -	80

					Stereotypes Mental Illness Treatment - Stereotype	
Johnson, Oliffe, Kelly, Galdas & Ogrodniczuk (2012)	To determine how participants' reproduced or reconstructed the dominant discourse of men's help-seeking for depression and to determine if there were alternative ways in which they framed their help-seeking.	Non-clinical/Clinical sample N= 38 Aged 24-50	Semi-structured interviews	Discourse analysis.	Desperation	75
Mahalik & Dagirmanjian (2019)	To give voice to men employed in physical labour using a Consensual Qualitative Research methodology to explore their constructions of help-seeking when feeling depressed or sad.	Non-clinical sample N= 12 Age 21-70 (M= 40.92)	Semi-structured interviews	CQR Methodology	Experiences of Safety and Relief Conditions That Reduce Threat and Stigma	100
Tang, Oliffe, Galdas, Phinney & Han (2014)	To describe the connections between masculinities and college men's depression-related help-seeking.	Clinical sample N= 21 Age 19- 25 (M= 22.3)	Semi-structured interviews	Inductively derived themes	Redefining strength.	50
Wirback, Forsell, Larsson, Engström & Edhborg (2018)	To describe young, urban, Swedish men's experiences of depression and help-seeking. How ideal masculinity influences the experience of depression and help-seeking.	Clinical sample N= 13 Age 21-32 (M= 27.5)	Semi-structured interviews	Interpretive Content Analysis	Struggling with everyday life Negotiating norms of ideal masculinity	100

1.3.3 Measures

Overall, the measures included varied across the studies suggesting an inconsistency of factors identified as potential predictors for professional help-seeking in men. There was also a reliance on self-report measures within the quantitative studies and therefore participant responses may have been influenced by social desirability bias. Despite the variety of measures used each appeared to be based on previous literature and theoretically driven.

1.3.3.1 Measures of help-seeking

The included studies varied in measurement of help-seeking; seven of the qualitative studies included clinical samples of men who had already sought help for mental health problems and therefore were retrospectively reflecting on this experience for researchers to establish possible facilitators. Whereas, only three of the quantitative papers examined help-seeking behaviour and the remaining eight papers (seven quantitative, one qualitative) measured attitudes towards help-seeking and intention to seek help as opposed to actual help-seeking behaviour.

Seven of the ten quantitative studies utilised the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF; Fischer & Farina, 1995). The ATSPPH-SF has been found to have strong internal consistency and test-retest reliability (Elhai et al., 2008). Intentions to seek psychological help were measured differently. One paper used the Intention of Seeking Counselling Inventory (ISCI; Cash et al., 1975), another paper developed a questionnaire called the Potential Responses to Depressive Symptoms (PRDS; Mahalik & Rochlen, 2006) and other papers simply asked men to report on their help-seeking behaviour as categorical data (e.g. which help provider they would chose).

1.3.3.2 Measures of mood and mental health difficulties

Some of the studies included measures of mood. These were the Patient Health Questionnaire 9 (PHQ-9; Kroenke et al., 2001) and the Centre for Epidemiological Studies Depression scale (CES-D; Radloff, 1977). Both scales have been validated with both clinical

and non-clinical populations and are commonly used within primary care and mental health services across the UK (Gilbody et al., 2007; Zich et al., 1990).

1.3.3.3 Measures of masculinity

Seven of the included studies used scales that assessed factors related to masculinity: the Conformity to Masculinity Norms Inventory (CMNI-22; Mahalik et al., 200), the Normative Male Alexithymia Scale (NMAS; Levant et al., 2006), the Male Role Attitudes Scale (MRAS; Pleck et al., 1994), the Male Role Norms Inventory-Short Form (MRNI-SF; Levant et al., 2013) and Gender Role Conflict Scale (O'Neil et al., 1986) all of which have been found to have good reliability and validity (Good & Mintz, 1990; Hammer et al., 2018; Levant et al., 2006, 2010, 2013; O'Neil et al., 1986).

1.3.4 Synthesis of Findings

Most of the studies used exploratory, cross sectional designs. The quantitative studies were conducted with non-clinical populations using regression analyses and reported largely heterogeneous findings. One of these studies used structural equation modelling to identify interactions. The lack of studies employing behavioural measures such as observational measures of help-seeking used in studies by Berger et al., (2013) or data collected from mental health services (e.g. primary care consultation, discussion with GP) suggests a lack of experimental and methodological rigour in addressing the research question. Drawing conclusions on causality and establishing predictors for help-seeking in men is a challenge based on current literature due to the heterogeneity of methods, the lack of methodological rigour and variety of factors that appear to be involved.

1.3.4.1 Predictors of Help-seeking

There were a large number of different factors considered within the studies and the findings vary across each study making it difficult to draw any clear conclusions. Due to the heterogeneity in the results from the quantitative studies, in the following sections the qualitative data has been used to help draw upon the quantitative findings and facilitate further understanding of the results. There was a notable difference across the quantitative studies in their assessment of predictors of help-seeking. Some of the studies examined predictors and facilitators of attitudes towards seeking professional

psychological help and intentions to seek professional psychological help (Abrams, 2016; Blazina & Watkins, 1996; Cole, 2013; DeBate et al., 2018; Rafal et al., 2018; Sullivan et al., 2015; Vogel et al., 2011) whilst others examined professional psychological help-seeking behaviours (Call & Shafer, 2018; Parent et al., 2018; Simonsen, 1999).

1.3.4.1.1 Attitudes Towards Seeking Help

Four of the included studies revealed that positive attitudes towards help-seeking may be a significant predictor of professional help-seeking behaviour. In psychological terms, attitude has been defined as a psychological construct of emotional and cognitive entities that relate to a particular individual, object, group etc. Attitudes are formed from previous experiences and influence our cognitions, feelings and behaviours (Allport, 1935). The study by Abrams (2016) found attitudes towards seeking professional psychological help to be the strongest significant predictor of men's willingness to seek help for depression.

Motivation and attitudes have been found to very closely related and interdependent, both processes involving cognitions (Peak, 1955). DeBate et al. (2018) found that motivation (alongside information) was a significant predictor of help-seeking behaviours suggesting that positive cognitions towards help-seeking are a key aspect of predicting behaviour. Qualitative findings from Tang et al. (2014) support this finding as 'Redefining Strength' or reframing help-seeking as a strong (and therefore positive) thing was recognised as a key theme and predictor within depression related help-seeking in college men. Additionally, in the study by Coleman (2019) 'understanding that talking with a therapist can be helpful' was identified as a shared sub-theme amongst African American men with depression when examining the factors that led to their help-seeking.

In contrast to the above findings, 'desperation', 'struggling with everyday life', 'acknowledgement of reaching a threshold of concern about symptoms by self and others' and 'cognitive evaluation of risks of not addressing mental state' were also identified as key themes within qualitative studies included in the review, suggesting that cognitions associated with lack of choice, loss of agency and need for emergency help are also associated with predictors and facilitators for professional help-seeking (Fisk, 2013; Johnson et al., 2012; Wirback et al., 2018). Three men described experiencing a 'cognitive

shift' and a reappraisal of psychological therapy within the context of other methods not proving to be successful (Fisk, 2013). This finding from Fisk suggests that there is a reappraisal process between desperation or reaching a threshold of concern and considering psychological therapy to be a helpful possibility:

"! was grappling with it for ages. I just got to the point where I was like it's okay to ask for a bit of help ...l was like fine ... I don't feel weak but I do feel unable to change whatever is going wrong here... I don't have enough understanding of what it is, but I can't get past that so I need... I don't know, by that point I just thought yeah help is fine. It doesn't have to reflect badly on me. it doesn't have to be the source of judgment, whereas I think early on I was judging myself' (pp. 141- 142).

1.3.4.1.2 Factors Associated with Masculinity

Many of the papers included in the review examined the relationship between factors (that have been previously found to be) associated with masculinity and professional help-seeking. Conformity to male and gender role norms were found to be a significant predictor of attitudes towards professional help-seeking and decreased willingness to engage in professional help-seeking in 5 of the quantitative studies (Abrams, 2016; Blazina & Watkins, 1996; Cole, 2013; Simonsen, 1999; Vogel et al., 2011). Gender role conflict has been described as resulting from a process of gender re-evaluation, whereby men have questioned their feelings and thoughts about socialised masculine roles. These questions have included how gender-role definitions may have restricted or affected men and conflicts have resulted when trying to integrate new gender-role definitions into their lives (O'Neil, 1982).

Blazina and Watkins (1996) and Simonsen (1999) found that specific aspects of the gender role conflict scale were more significant than others. Both studies found the 'Restricted Emotionality' (RE) variable to be significant. The RE variable is the degree to which men are taught to avoid verbally expressing their feelings to other men to avoid appearing weak (Wester et al., 2012). In contrast, Blazina and Watkins also found the 'Success, Power and Competition' (SPC) variable to be significant with a sample of college men. The SPC variable is the degree to which men are socialised to focus on personal achievement through competitive efforts. Simonsen however, found 'Restricted Affection

Between Men' (RABM) variable to be significant within a sample of gay men. The RABM variable is how men are socialised to have difficulties expressing their care and concern for other men. This difference in findings suggests that conformity to gender roles or specific aspects of the gender role that facilitate help-seeking may differ amongst men of differing sexualities. This was described by one participant who identified himself as being a gay man in the study by Fisk (2013):

'I think probably if I was straight, if I was a father of two, I would have to get on with things and soldier on more. I think perhaps, and this is sound sexual orientation-ist ... that I'm a lot more aware of myself, not just mentally but physically and all those sorts of things' (p. 126)

For most of the men interviewed within the study by Fisk (2013) the constructs of 'stigma and endorsement of masculinity scripts' were identified as common processes which influenced the men's decisions to seek psychological help. Furthermore, Wirback et al. (2018) found that 'negotiating norms of ideal masculinity' was a common key theme amongst young Swedish men describing their help-seeking experiences for depression:

'I might well find it a little difficult to express feelings and things like that sometimes, yes. I know that it is, it feels a little hard, er, I've become better lately actually, to accept that one can feel bad' (p. 412)

There were similar findings amongst papers that examined Male Alexithymia; Sullivan et al. (2015) found alexithymia to be a significant predictor of men's attitudes towards seeking professional psychological help. Abrams (2016) found this to be related to men's willingness to seek help for depression; however, this was not found to be a significant predictor. Previous findings suggested that gendered manifestations of depressive symptoms may play an important role in why some men do not seek help for mental health issues (Martin et al., 2013). Call and Shafer (2018) found that both traditional and male-typical symptoms (somatic symptoms, feeling irritable or angry) were found to increase the odds of initially seeking help from a medical provider, and men with male-typical symptoms had an overall higher likelihood of seeking help from a medical provider. These findings suggest that acknowledgement of male related symptoms for mental health problems by men and by those around them (friends, family, healthcare

professionals) may influence predictors and facilitators of professional psychological help-seeking.

1.3.4.1.3 Mental Health Literacy

The studies by DeBate et al. (2018) and Rafal et al. (2018) examined Mental Health Literacy (MHL) and help-seeking intentions amongst US college students. The studies used the same sample and found MHL to be a significant predictor of help-seeking intentions. Fisk (2013) found a common theme amongst men concerning acknowledgment of difference in mental state from self and others as a predictor of help-seeking. Similarly, the men included in the study by Harding and Fox (2015) described the role of a significant person in supporting men to acknowledge mental health problems:

'Yeah, she definitely initiated it and I thought it was the only way of fixing it or bringing it all out.... From there it led to me seeing him [current psychologist]' (p 455)

Additionally, access to online resources was described by men as effective in reinforcing the decisions to seek psychological help but that access to resources is difficult as one man described having *'no clue where to start'* (Harding & Fox, 2015). These findings taken together with the findings about alexithymia suggest that there may be an important link between acknowledgement of a mental health problem and access to information in predicting help-seeking behaviour in men and that other people surrounding men may play a role in this too. Cramer et al. (2014) found men described the role of health professionals as facilitating psychological help-seeking in men. Some of the men described their GP to have prevented further help-seeking by not allowing them enough time and others described them as helpful as they listened, gave the men adequate time to talk and provided them with information and support.

1.3.4.1.4 Demographic Factors

Many of the studies examined demographic factors as predictors of psychological help-seeking behaviour. Age, sexuality, ethnicity and race, education, income and relationship status were found to be predictors, but findings were inconsistent across papers.

Parent et al. (2018) found age, sexuality, race and income to be predictors of help-seeking with help-seeking behaviours most prevalent amongst older men, white men and non-heterosexual men. Rafal et al. (2018) also found race to be a significant predictor of help-seeking intentions amongst US college men however, their findings suggested that white graduate students had lower intention to seek help for difficulties with self and others than Asian students. In contrast, Sullivan et al. (2015) did not find age, sexuality, ethnicity and race, and income to be significant predictors of psychological help-seeking in UK men. However, they did find education to be a significant predictor, a finding that was supported by Call and Shafer (2018) who found men with 16 or more years of education were more likely to seek help for depression or another mental health concern. Rafal et al. (2018) found that major classification (STEM (Science, technology, engineering and maths) or Non-STEM) was also a significant predictor of help-seeking intentions of college men. The variation in these findings suggest that predictors and facilitators of professional psychological help-seeking in men may vary across intersections of men and research examining this is required to understand this further.

Cramer et al. (2014) identified a shared experience of 'isolation and the social benefits of groups' as well as 'the value of groups and strategies for attracting men' as facilitators of psychological help-seeking in men. Men described finding it difficult to speak to friends and family about their difficulties. These findings suggest that the sharing of experiences with others in support groups reduces stigma. Other studies found men to describe social support from friends and family to be facilitators of psychological help-seeking (Coleman, 2019). Parent et al. (2018) found relationship status to be a predictor of psychological help-seeking in men; participants who were not married or living with a partner were more likely to seek help than those who were married or living with a partner. Given there are varying findings across the papers it is difficult to draw clear conclusions on demographic factors that predict help-seeking.

1.3.5 Mediating and Moderating Factors

In the study by DeBate et al. (2018) stigma was found to be a significant mediating factor between information (mental health literacy), motivation and behaviour skills (intention to seek help). This provided an explanation for the weak positive relationships found between information, motivation, and behavioural skills. Furthermore, in the study

by Vogel et al. (2011) stigma was again found to be a significant mediator between conformity to dominant masculine gender roles and attitudes towards seeking professional help. The significance of stigma as a mediator was found to vary across different races and sexualities. Cole's (2013) study examined hope and psychological well-being as moderators for the relationship between masculine ideology and help-seeking behaviours and found results were in the predicted direction however this result was not significant.

1.3.6 Quality assessment

All 18 studies were assessed using QualSyst quality tool (Kmet et al., 2004). The measure was selected for the current review due to its inclusion of both qualitative and quantitative study assessment and ability to be clearly and easily applied (Kmet et al., 2004). Overall scores ranged from 50% to 100% however, 17 out of 18 papers scored above 70%. The range in scores indicates variation in the overall quality of the studies that may represent varying standards in the field. The qualitative studies scored between 50% and 100%. Of those papers that scored below 100% common concerns related to lack of information regarding data collection methods and whether verification procedures were used to establish credibility of the study. Furthermore, only 3 of the 8 studies included information on reflexivity.

The quantitative studies scored between 72.73% and 100%. Of those papers that scored below 100% common concerns related to; the method of subject selection (many papers included a student population sample), papers not controlling for possible confounding variables for multiple comparisons, and a lack of estimates of variance for main results. Kmet et al. (2004) identified a conservative inclusion cut-off score of 75% however, all the studies were retained in the current review to prevent loss of potentially useful data. The ratings for each individual study can be seen in Table 3 and 4.

1.4 Discussion

1.4.1 Main Findings

The findings of the review provide important understanding of the complexity of the process of seeking professional psychological help by men and the difficulty of understanding specific predictors within this process. The findings suggested that increased MHL and conformity to masculine gender roles can predict attitudes towards help-seeking supporting previous literature that suggests that mental health literacy, attitudes towards help-seeking, and factors associated with masculinity are integral parts of this process (Perlick & Manning, 2007). Furthermore, the review illustrates the variety of demographic factors that may contribute to this process. The current review supported previous findings suggesting that demographic factors such as race, education and relationship status may influence the process of psychological help-seeking for men with those with higher education, of white race and not in a relationship being more likely to seek help. These findings varied across papers and therefore we cannot draw any definite conclusions. Some of the studies included within this review have sought to explore this with specific groups of men but further empirical research with a more diverse sample of men seems essential. Furthermore, the majority of studies included in the review were cross-sectional and therefore we are unable to explain causality. Therefore, further research is required to understand the multitude of contributing factors and to establish direction of causality within them.

1.4.2 How do findings fit with previously published research

One of the studies included in the review by Cole (2013) aimed to map the results onto Perlick and Manning's (2007) Model of Male Help-Seeking to ascertain if the model is an accurate representation of this process. Contradictory to the theory, Cole found there were no significant indirect effects of male gender role socialisation or mental illness stigma on decisions to seek help. However, multiple direct effects suggest that important interactions exist between conformity to masculine norms, gender role conflict, attitudes toward professional psychological help-seeking, self-stigma of help-seeking, identification of depressive symptoms, and potential responses to depressive

symptoms. The current review supported these findings and therefore provides some support for the MMHS. The main findings from the current review support the first three stages of the MMHS suggesting that factors associated with masculinity (e.g. gender role conflict, male gender norms) and mental health literacy (e.g. recognition of the problem, alexithymia) combined with an acknowledgement of needing help will lead to professional help-seeking by men. There were significant findings around the role of stigma within this process. The study by DeBate et al. (2018) found stigma to be a significant mediating factor between information (mental health literacy), motivation and behaviour skills (intention to seek help). Furthermore, Vogel et al. (2011) found stigma was a significant mediator between conformity to dominant masculine gender roles and attitudes towards seeking professional help. Further research is needed to understand the role of stigma. The qualitative findings from the current review allow for helpful narration of the process of professional help-seeking in men. When applied to the MMSH the themes support this as an accurate representation of this process.

The MMSH does not make any reference to demographic factors and their role within the process of help-seeking. Previous research has suggested that demographic factors may have an influence on an individual's views of masculine ideology and the current review's findings support previous suggestions that different demographic factors can predict men's likelihood to seek help. These findings have been inconsistent across the research but suggest an additional complexity not considered within the MMHS. Previous findings have shown that men of black or Asian ethnicities seek help at lower rates than white men, a finding that was consistent with the findings in this review (Chandra et al., 2009; Constantine et al., 1997; Shin, 2002). It also seems that education appear to play an important role in predicting help-seeking in men with higher levels of education being associated with high likelihood to seek professional help. Given existing research and findings of the review, the MMHS could be improved upon by incorporating these factors (MHL and education) into the theory.

The review identified that relationship status may have some influence on the process of professional help-seeking for mental health in men. Previous research has suggested that female partners within heterosexual relationships may play an important role in supporting men with their mental health problems. This support has been found to both facilitate the process of professional help-seeking and potentially mitigate the need

for professional help as the support within this relationship fulfils that need (Cusack et al., 2004; Mahalik & Rochlen, 2006b; Rooney et al., 2020). Furthermore, there were inconsistencies in the role of the GP within this process. This suggests that there may be a need to include the role of external factors such as other people (e.g. GP or partner) within the process for professional help-seeking for mental health in men.

1.4.3 Strengths and limitations of the included studies

1.4.3.1 Methodology

The quality assessment suggested strong methodological rigour within most of the included studies. The lack of longitudinal data is a notable limitation of the included studies. Cross-sectional research is cost-effective and easy to conduct which may be why it was the most common methodology. Previous research has suggested that the process of help-seeking for men is likely to be complex and involve multiple factors. Although with cross-sectional design it is possible to measure and assess various factors, it is also possible to miss confounding variables as previous literature has suggested a complex interaction of many variables. Many of the quantitative studies used multiple linear regression analysis to assess whether confounding was present, however it is possible that this analysis may oversimplify what is in fact a complex process in which covariates and response variables do not exist in such a linear relationship. According to the transtheoretical model, the process of change is often not a straightforward cyclical process and that individuals may experience regression back to earlier stages of the model (Prochaska et al., 1992). Therefore, it is arguable that a linear understanding of psychological help-seeking in men may be too reductionist in understanding an evidently complex process.

1.4.3.2 Sample

The majority of studies utilised a non-clinical sample which may be reflective of difficulties in recruiting male participants who have sought professional help. Stigma of mental illness has been identified as a barrier to research participation within men (Woodall et al., 2010). The qualitative papers included mainly used clinical samples and

allow for a richer understanding of the process of help-seeking in men that can help to narrate the quantitative findings though it is difficult to generalise these findings. Due to the high proportion of studies utilising a self-selecting recruitment strategy and the presence of student samples it is important to take caution when considering the generalisability of the findings as sampling bias may have influenced the responses.

1.4.3.4 Measures

It is possible that the use of self-report measures within the studies may have been because they are easy to administer, however they are subject to reporting error. Given that previous research has suggested that stigma around mental health is a particular barrier for men it is possible that the men taking part within this research were subject to social acceptability bias (Vogel et al., 2014). However, Short et al. (2009) found that when comparing self-reported use of healthcare in comparison to administrative data men were more likely than women to report their healthcare use accurately. Including a measure of social desirability bias in future research may help to understand this better.

Many of the studies used the same measures for factors such as attitudes towards help-seeking, alexithymia and gender role conflict, which allows for direct comparison of the findings across papers. The studies appeared to have a good theoretical grounding and factors selected to measure were based on previous findings. However, there were a large variety of factors and constructs considered across the research which meant that the findings were difficult to synthesise and draw any clear conclusions on the predictors of help-seeking. Despite the variety of findings, the conclusions drawn from the review support previous findings and provide some further evidence for aspects of the Model of Male Help-Seeking (Perlick & Manning, 2007).

Most of the research in this area is focused on barriers to help-seeking, which is helpful in giving us a better understanding into why men are not able to access psychological help as much as women. However, further understanding is required into understanding the factors that promote professional help-seeking in order to ensure that health promotion campaigns focus on developing these factors within men.

1.4.4 Strengths and limitations of the review process

Despite various adaptations and initial scoping, the search strategy revealed a very small number of papers. However, extensive scoping and pilot searching was undertaken and supplementation of the electronic search results by hand searching and searching of reference lists suggests that all relevant research was included. This process may have reduced the systematic nature of the review and thus impacts replication potential. It is possible that the inclusion and exclusion criteria may have contributed to the small number of papers included in the review. However, a clear rationale based on previous reviews, research and findings was considered during the development of the review process and this would not have affected the initial number of papers identified by the search strategy. Despite the high suicide rates suggesting there is a definite need to understand reluctance to seek help within men it is an under researched area and it is possible that the low numbers of papers revealed from searches are as a result of this (Sullivan et al., 2015). There were a number of studies excluded due to the inclusion of women within samples and therefore, as there was no statistical breakdown between men and women this potentially helpful data was not included for review. A strength of the current review is the identification of further research needed within this area to develop a comprehensive understanding of psychological help-seeking in men.

One of the strengths of the current review is that all the papers included were published in the last 25 years. This suggests that the review reflects an up to date understanding of the topic and that the need for research within men's mental health has developed in recent years. The limited number of papers revealed by the initial search highlights the lack of empirical research in this area and the importance of developing a better understanding of the process of help-seeking for mental health problems in men in order to inform and improve interventions to improve access to services for men (see section 1.4.5 below). The lack of longitudinal studies was a weakness within this review as when considering the research question, it is difficult to infer causality from cross-sectional studies and so many of the factors identified as predictors may be part of a more complex process of varying interacting or facilitative factors. Intervention papers were not included in the review as it was believed they would not answer the review question because interventions would likely impact or influence possible predictors of help-seeking however, it is possible that some data was missed as a result of not including

these papers. Furthermore, some of the theses included were not published in peer reviewed journals which may have an impact on the validity and methodological rigour of these particular studies. However, this was not reflected within the quality assessment. A strength of including unpublished work is that conclusions are less likely to be subject to publication bias.

The use of a quality assessment tool was a strength in the current review as some reviews do not include them despite researchers considering them to be integral to the process. The process of quality assessment has been debated amongst researchers as some believe it is impossible to gain a consensus on agreed principles to judge the quality (Seehra et al., 2016). The use of two independent researchers strengthened the assessment however, the process of agreeing on a consensus rating may have been subject to bias. Furthermore, there were some limitations identified with the QualSyst tool as it does not ask about all methodological aspects of a study such as the lack of comment on theoretically driven hypotheses (Kmet et al., 2004). Although the QualSyst tool allowed for an evaluation of the quality of studies employing varying methodologies, the current review could be improved by incorporating these missing aspects into quality review.

1.4.5 Implications

The findings from the review have important clinical and research implications as well as possible implications for wider society. Given that there is growing evidence to suggest that there are many barriers for men to overcome before seeking help, developing an understanding of the predictors and facilitators of psychological help-seeking alongside an understanding of barriers is essential for clinical, theoretical, research and societal development.

The current findings suggest that more could be done to support men to engage in psychological support. Some services within the UK have begun campaigns for men and built, adapted and co-produced 'male-friendly' services. However, these efforts appear to be being undertaken largely by third sector organisations such as Samaritans and The Movember Foundation as opposed to the NHS where any 'male specific' services tend to be focused around fathers and paternal post- natal depression (Banks, 2001). The findings

from the review suggest that there are particular groups of men that are more likely to seek help than others and therefore, services, campaigns and research needs to be targeted to support those who are less likely.

Prochaska and DiClemente's (1984) transtheoretical model of change has widely been applied within addiction services to describe the process of cessation of drug or alcohol use. According to the model, individuals progress through five stages when considering and making behavioural changes: precontemplation is when the individual is not aware of the need for change and is not considering change, contemplation is when the individual is aware of any need for change and is considering change, preparation is when the individual is intent on taking action to change behaviour, action is when the individual is engaging in active change and maintenance when the change is sustained. When considering the transtheoretical model of change within the context of psychological help-seeking in men, the findings suggesting factors associated with masculinity (such as male alexithymia), MHL and attitudes towards help-seeking are predictors of help-seeking suggest that interventions to promote help-seeking in men may need to be targeted at the pre-contemplation stage (Prochaska & DiClemente). Interventions that aim to normalise and promote positive attitudes towards help-seeking, use psychoeducation to improve understanding and MHL in the general population of men (precontemplation) may inhibit any delays in help-seeking.

Further research around predictors and facilitators of help-seeking in men is essential to develop the efficacy of the MMHS model. The findings identified in this review around factors associated with masculinity (stigma and gender role conflict) and problem recognition (alexithymia) support the MMHS model. However, the review also identified mental health literacy and race, education level and relationship status may also be predictors of attitudes towards help-seeking and help-seeking behaviours. The findings from the review suggests that existing theoretical models may have missed important factors and further research into understanding of the interaction of these factors is needed.

The variability in the studies around help-seeking and whether researchers examined attitudes towards help-seeking, intentions to seek help, and help-seeking behaviour is important to note. Abrams (2016) identified that attitudes towards seeking professional psychological help were a significant predictor of help-seeking intentions.

This finding supports models of help-seeking such as the HBM, and suggests that cognition is key in predicting behaviour, and suggests that understanding of the help-seeking process needs to include and illustrate the process of factors that predict attitudes towards professional help-seeking in men as well as factors that predict help-seeking behaviour.

To date, a large proportion of the research within this area has focused on the negative impact of masculinity and very few studies have explored the positive aspects of masculinity and how they might be fostered to promote help-seeking behaviour. Understanding these factors could inform strength focused health promotion and preventative work. Positive psychologists and Systemic therapists believe that using strengths-based approaches can foster resilience and well-being in individuals (Magyar-Moe, 2009; Seligman & Csikszentmihalyi, 2000). The Positive Psychology/Positive Masculinity framework (PPPM) was developed by Kiselica and Englar-Carlson (2010) and encourages researchers and clinicians to explore the positive aspects and strengths of male gender roles in support of positive psychology approaches. This approach can allow for development of different social constructions of masculinity that are built on strengths (Magyar-Moe, 2009; Schell, 1994).

A social constructionist understanding of masculinity can help explain this further, as findings support the idea that dominant gender discourses men encounter through society may be associated with negative health behaviours for example 'boys don't cry' may prevent men from showing emotions (Berger et al., 1995). This suggests the need for important societal changes in the way we consider 'masculinity' and difficulties in the way masculine discourses are "shaped and constrained by social structure" (Fairclough, 2013). Arguably, if men do not view seeking psychological help as a possibility then they will never pass through to the 'contemplation' stage of the transtheoretical model. An active process of providing an alternative discourse can challenge certain aspects of hegemonic masculinity and potentially promote more helpful health behaviours (Stibbe, 2004).

The findings of this review highlight the lack of empirical research and inconsistency of findings around predictors of psychological help-seeking in men. It appears that this is a difficult area in which to conduct research, given that the findings of the review suggest that intersectionality and social factors may impact upon the process of help-seeking making it complex. The review suggests future research should address the

methodological limitations of the currently published findings for example by including longitudinal methods with more complex analysis of the factors involved within the process. Further research in this area using wider populations of men and including more diverse samples of men would provide a better understanding of how demographic factors might influence this.

1.4.6 Conclusions

The current review aimed to synthesise current research into what the predictors of help-seeking for mental health problems in men are. Many of the findings support previous research and aspects of the Male Model of Help-Seeking and other help-seeking models. However, there was some inconsistency in these findings and suggests a more complex process that may be influenced by other factors such as culture. The review was useful in identifying gaps in the literature and may also be used to guide the design of future research.

Chapter 2: Understanding the Factors which Facilitate the Engagement of Men in Psychological Therapy: A Q-sort Study

2.1 Introduction

2.1.1 Men's Mental Health

In 2018 in the UK, men accounted for three-quarters of suicide deaths (4,903 men compared to 1,604 women). The recent increase in UK suicide deaths appears to be as a result of suicides in men in particular: rates of suicide in women remaining relatively consistent across recent years (17.2 deaths per 100,000 males in 2018 vs. 15.5 deaths per 100,000 males in 2017). Suicide continues to be the leading cause of death in men aged 20-49 with males aged 45-49 years having the highest rate of age-specific suicide (Mental Health Foundation, 2019; Office for National Statistics, 2018)

Despite staggering gender differences in suicide rates, National Statistics from 2014 have shown women in the UK are more likely to show symptoms of anxiety or depression (22.5%) than men (16.8%). Additionally, all types of common mental health problems were more prevalent in women (Health and Social Care Information Centre, 2015). Men account for 95% of the prison population and 87% of rough sleepers, have higher rates of hazardous drinking and are more likely to be dependent on illegal drugs than women(4.3%; Home Office, 2012). Findings imply males may externalise psychological distress differently to females (Department of Education, 2013; Harris et al., 2016; Rose & Pevalin, 2013; The Movember Foundation, 2015). For example, findings have suggested that men are more likely than women to use drugs or alcohol in response to distress (Cleary, 2012; Samaritans, 2012).

2.1.2 Help-Seeking in Men

Despite figures indicating males experience difficulties with mental health, findings have consistently shown that men are less likely than women to seek professional help for mental health difficulties (17% of men compared to 29% of women) - a finding that

may be unrepresentative due to male underreporting (Mental Health Foundation, 2016; 2019; Seidler et al., 2018). Within mental health, a narrative has been identified around men being resistant to seek help (Möller-Leimkühler, 2002), with men reporting less access to social and emotional support from friends and family (Boreham et al., 2002).

Externalised distress and symptoms displayed by men may not be recognised by family, friends or professionals if they are not in line with traditional symptoms, or symptoms in diagnostic manuals (e.g. anger and substance abuse; Hammer & Vogel, 2010; Logan et al., 2008; Jackson & King, 2004; Kessler & Wang, 2008). Some expressions of distress may be perceived to be more socially acceptable than others and the use of violence or involvement with illegal drugs is likely to lead to castigation over support (Addis, 2008). This may also be influenced by other factors such as socio-economic status and race (Kemper, 1992; Seale & Charteris-Black, 2008). This suggests that expression of emotions is highly gendered and gender differences in expressive behaviour may explain why higher rates of psychological distress are reported in women, when compared to men, but higher rates of suicide for men (Gunnell et al., 2002).

Men's experiences of mental health difficulties have been found to be constrained by gender-specific social norms, with higher levels of psychological distress and less willingness to seek help being linked to more traditional male norms (Addis, 2008; Berger et al., 2013; Sweeting et al., 2014). Social Constructionism and the Social Learning paradigm argue that gender roles and masculinity are constructed by society, culture and upbringing (Bandura & Walters, 1966; Lindsey, 2015; Pleck, 1981). Dominant or hegemonic Western masculinity norms have encouraged emotional stoicism and self-reliance and discouraged disclosure of emotional vulnerability (Addis & Cohane, 2005). Discrepancies between men's perception of need and their help-seeking behaviour may explain gender differences in help-seeking (Möller-Leimkühler, 2002). Interviews with 52 Irish men who had attempted suicide revealed high levels of emotional pain with difficulties experienced in understanding their symptoms of distress and further difficulty in disclosing this. Findings suggested that constructions of masculinity within their context and social environment played a crucial role in their decisions to attempt suicide over seeking help (Cleary, 2012). Research has suggested that societal gender role attitudes are evolving, becoming increasingly egalitarian, though findings have suggested these

changes have been more significant for women than men (Möller-Leimkühler, 2002; Sweeting, et al., 2014).

2.1.3 Predictors of Help-Seeking

Men's emotional development is thought to be importantly linked to their attitudes towards seeking help (Levant, 1990). Furthermore, adherence to masculine norms has been found to be associated with less willingness to seek professional help in men (Addis & Mahalik, 2003; Berger et al., 2013). In accordance with social constructionism and the social learning paradigm, emotional development and gender norms are influenced by contextual factors such as family and culture (Bandura & Walters, 1966; Lindsey, 2015). Certain demographic factors including race, education and relationship status have been found to influence psychological help-seeking, though findings are inconclusive (see Chapter One; Call & Shafer, 2018; Rafal et al., 2018). Men have been found to be more likely to seek help from someone with whom they are familiar and where they feel they will not lose control; 74-78% of men who had sought help were prompted by their partner or a family member (Oliver et al., 2005; Vogel et al., 2007). Men have been shown to consider seeking help as a loss of control suggesting that improving feelings of agency may promote help-seeking behaviour (Möller-Leimkühler, 2002).

Positive attitudes towards help-seeking are a significant predictor of professional help-seeking behaviour in men (Abrams, 2016). Alongside endorsement of masculine norms, increased Mental Health Literacy and information are two predictors of improving attitudes towards, and expectations of psychological help-seeking (DeBate et al., 2018; Perlick & Manning, 2007). Research has suggested that as attitudes are less central to a person's identity, they may be more amenable to change through psychoeducation and information than gender roles (Leong & Zachar, 1999). For example, attitudes and fear related to treatment have been found to be more adjustable than factors related to gender identity (Deane & Todd, 1996). A better understanding of what men expect and want from therapy would enable the development of information that could promote feelings of agency and more positive attitudes toward psychological help-seeking (Addis & Mahalik, 2003).

Social psychologists suggest help-seeking to be a complex process, involving those seeking help, providers, the type of help needed and the context in which the help is

sought (Wills & DePaulo, 1991). Services in the UK are attempting to meet the needs of a diverse group of men. Mental health services within the UK are facing increasing demand whilst experiencing increasing financial pressure, furthered by the impact of austerity policies (Cummins, 2018). Services and Psychological therapists need to consider aspects of individual identities and the influence of interlocking social stratifications of experiences such as class, race, sexual orientation and age etc. and how these impact on attitudes towards and access to psychological therapy (McCall, 2005).

Services based around traditional models of mental healthcare rely on individuals initiating help-seeking and disclosure of personal information and emotion (Morison et al., 2014). The literature presented thus far would suggest that this model would therefore pose challenges to men. NHS mental health services have a responsibility to improve their accessibility to promote help-seeking in men. More recently, third sector organisations have campaigned to tackle stigmas surrounding male mental health difficulties and increase awareness of psychological services that can help. Specialist services such as Campaign Against Living Miserably (CALM) and Men's Minds Matter, as well as campaigns by the Samaritans (2012) and The Movember Foundation (2015) have attempted to increase awareness and normalise men's experiences. However, there is a lack of empirical evidence identifying men's perceptions of these and what factors might support men to engage in psychological services (McKelley & Rochlen, 2010; Rochlen & Hoyer, 2005). Additionally, there is a paucity of exploratory research with non help-seeking men aiming to understand what might improve their attitudes towards seeking help and therefore, subsequent help-seeking behaviour (Abrams, 2016; DeBate et al., 2018).

Previous findings have identified that service users who have been previously labelled as 'hard to engage' were more likely to engage in services that were responsive to their priorities (Davies et al., 2014). Service user involvement within NHS mental health services is encouraged by service commissioners and has been found to be a useful part of service design and development as well promoting wider societal change (Noorani, 2013). Evidence of what men's priorities would be if they were to consider accessing psychological therapy appears to be missing from the current literature. A better understanding of this would be crucial for the development of meaningful and accessible services (Steen et al., 2011).

A recently published scoping review by Seidler et al.(2018) has provided a summary of recommendations for services on how to engage men in psychological treatment. The recommendations can be divided into four main themes: being aware of gender socialisation; reflecting on the impact of gender for both clinician and client; clarifying structure building rapport and a collaborative relationship; and tailoring language. Statistics show the current main concern is getting men to begin engaging with help and services whereas the recommendations from Seidler et al. focus primarily on factors that would work to retain men in therapy rather than initially engage (The Movember Foundation, 2015). Whilst the review helpfully synthesises current findings the recommendations are aimed at psychological therapists and Seidler et al. acknowledged the need for these recommendations to be examined by men.

The research and findings presented suggest that the process of help-seeking for mental health difficulties for men is multifaceted. The findings that suggest attitudes towards psychological help-seeking in men are influenced by Mental Health Literacy and information suggests the need for further examination of interventions utilising these factors. Understanding what factors would be important to men if they were considering engaging in psychological therapy could help inform these interventions and provide insight into views of men which are currently lacking. The existing literature does not include views of men who have not engaged in therapy, understanding of which could have important implications for service promotion, design and delivery.

2.1.4 Aims & Objectives

The current study aims to address gaps in the literature by assessing viewpoints held by men on what factors would be important to them if considering engaging in therapy. These objectives were therefore achieved by asking a group of men who had not previously engaged in psychological therapy to participate in a sorting task; ranking statements relating to psychological therapy based on their perceived level of importance. The study utilised Q-Methodology which allows examination of a diverse group of participant's viewpoints relative to the subject matter in order to establish the common viewpoint. In order to reduce the impact of possible gender role expectations (given the researcher's gender) and influence of social desirability bias, the current study used an online format (Joinson, 1999)

The study aimed to explore this by asking: a) What factors are important for men when considering engaging in psychological treatment b) Do factors of importance change amongst different age cohorts, ethnicities, religious beliefs and sexualities? The study aimed to gain viewpoints of men on the recommendations identified by Seidler et al., (2018) in order to further understanding of existing findings and theories and identify possible areas for service improvement.

2.2 Method

2.2.1 Design: Q-Methodology

The study used Q-sort methodology to understand what factors would be important to men if they were to engage in psychological therapy. The methodology is a way of systematically and qualitatively establishing points of view of a sample of people on a topic of interest (Brown, 1980). The Q-sort task requires participants to rank and judge statements (relating to the topic of interest) in relation to other items. The methodology was chosen for the study to enable the researcher to understand how men relate to interconnected features of a complex topic and to allow for examining similarities between individual perspectives. The methodology combines both quantitative and qualitative analysis by providing empirically rigorous statistics that support the perspectives that are interpreted.

2.2.2 Ethical Information

The study received full Ethical Approval from the University of Southampton Ethics Committee (16/10/2019 Appendix A). The study used a non-clinical sample and therefore, did not require ethical approval from the NHS Ethics Committee.

Participants in the study were given information outlining the study and asked to consent before taking part (see Appendix B). Participants were informed that participation was anonymous and were made aware of their right to withdraw from the study. Following participation, participants received a debrief statement and contact details for researchers should they want to ask further questions (see Appendix C). The debrief information included signposting information to mental health services and

websites for support. Participants were offered the opportunity to enter a prize-draw for an Amazon voucher for participation.

2.2.3 Participants sampling strategy and recruitment

Q-methodology states that the right participants for the study will be a function of the research question being asked (Watts & Stenner, 2014). The group of interest in this study was males aged 18 and over who had not previously sought psychological help. Participants interested in men's mental health research were recruited to take part in the Q-sort online from social media websites Twitter and Facebook (see Appendix F). The study was also publicised by a charity called MQ Mental Health Research through their website. MQ are a mental health research charity promoting the importance of participating in mental health research and publicise studies to support recruitment for researchers. Q methodology places value in sample diversity and therefore, participants can be theoretically sampled based on factors of interest (e.g. demographic) to ensure the group is unbiased and balanced. Therefore, aiming to recruit participants who do not have access to the internet, posters were placed in local sport centres, working men's clubs and pubs. Posters gave men the opportunity to take part in the study face-to-face at Southampton University (see Appendix G). Participants were given information about the study before being asked to consent and were offered the opportunity to enter a prize draw for a £200 Amazon voucher.

2.2.3.1 Inclusion/exclusion criteria and sample size

Participants were purposively recruited if they were aged 18 and above and had not previously accessed any psychological therapy. Q- methodology only requires half the number of participants as there are items in the Q-set (Watts & Stenner, 2014). Men who had previously sought psychological help from services were excluded from the study as it was believed that their viewpoints would be influenced by their own experiences of psychological support. Consenting participants were first asked to complete a brief screening questionnaire; those that met inclusion criteria were then able to take part in the Q-sort.

2.2.3 Procedure

The study procedure had four phases: developing the Q-set, piloting, sampling and participant recruitment and data collection and analysis.

2.2.3.1 Developing the Q-set

The first phase for Q-methodology is to develop a list of statements (Q-set) for the sorting task. Q-methodology generally utilises a Q-set of statements that are heterogeneous in content and refer to a single subject matter. The statements are intended to broadly represent a population 'concourse', meaning communications surrounding a topic of interest (Stephenson, 1953). The process of developing the Q-set normally involves identifying opinions about a topic through semi-structured interviews or scoping of current literature resulting in a pool of statements that represent the research question (Stainton Rogers, 1995). An initial literature search for this study identified a scoping review conducted by Seidler et al. (2018) into engaging men in psychological treatment. The review revealed four key themes: being aware of gender socialisation, clarifying structure, building rapport and a collaborative relationship, tailoring language. Each theme covered a series of recommendations for psychological therapists and noted the need for these recommendations to be reviewed by a sample of men. Therefore, it was decided that this list would form the basis of the Q-set. The recommendations were adapted into statements, duplicates removed, and language modified so it was concise and accessible. This process was reviewed by the research team and a draft Q-set developed.

2.2.3.2 Piloting

Three male participants were recruited through social media to complete the Q-sort face-to-face with the draft Q-set as part of a pilot process (see Appendix D). Q-methodologists recommend the use of piloting in order to refine Q-sets and technical language and jargon are avoided (Watts & Stenner, 2014). These participants completed the Q-sort (as per below procedure) and gave feedback on the statements, the draft matrix and whether they felt any items were missing. Participant feedback suggested some of the statements were repetitive and the language needed adapting in order to be

better understood by participants. Participants helped the researcher to remove or combine statements that were similar and reword some of the statements e.g. 'unconditional positive regard' was changed to 'accepting and supportive'. Following feedback, the final Q-set was developed and contained 45 statements (see Appendix E). Participants in the pilot stage were offered a £10 Amazon voucher for their participation.

2.2.3.4 Data collection and measures

Eligible participants were asked to complete a pre-sorting demographic questionnaire (see Appendix H) before being redirected to FlashQ software, a commonly used online software for Q-sort tasks (Hackert & Braehler, 2007). Following the sorting task, participants were asked to complete a post-sorting questionnaire (see Appendix I).

2.2.3.4.1 Demographic Questionnaire

The demographic questionnaire asked participants for information on age, ethnicity, sexuality, education level and employment status. Participants were also asked whether they had considered accessing psychological treatment before with answers given by participants selecting either 'yes' or 'no' (see Appendix J and Table 5). Answers were given in free-text boxes to allow for richer data and to remove any possibility of researchers providing delimiting responses (Watts & Stenner, 2014).

2.2.3.4.2 Sorting Distribution Matrix

Q methodology requires researches to provide participants with a sorting distribution matrix in which to sort their items. Participants are asked to organise the statements into the pre-determined grid where they must allocate a statement to every available space (see Figure 6). A forced-choice distribution matrix was chosen for this study due to it being the most convenient and practical means of facilitating the participant's ranking process (Brown, 1980). Brown suggested that a steeper distribution matrix (where more items can be placed within the central area of the matrix) is a better choice for a less knowledgeable participant group, allowing fewer decisions and feelings of indifference due to larger numbers of items being placed in the distribution's centre. As the sample were not deemed to have expert knowledge of psychological therapy it

was decided a steeper distribution matrix would be more appropriate than a shallow one (allowing for a wider range and placement of items; see Figure 5).

Least Agree | Most Agree

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6

Figure 3. Example of a shallow or more flattened Q-sorting distribution for 45 sample items

A sorting matrix was designed to fit the 45 statements in the Q set (see Appendix E), where items are measured on an 9-point scale of relative agreement from -4 to 4 (see Figure 6). Each row in the distribution matrix from a Q-sort will contain the perspective of a participant. Conducting a factor analysis based on the Q-sorts will result in identification of groups of participants with shared viewpoints (Watts & Stenner, 2014).

Least Agree | Most Agree

-4	-3	-2	-1	0	1	2	3	4

Figure 4. Q-sorting distribution for 45 sample items

2.2.3.4.3 FlashQ

FlashQ is a user-friendly application for performing a Q-sort online that employs a physical 'drag and drop' sorting method and was chosen for the study based on its ecological validity (Hackert & Braehler, 2007). FlashQ presents the participants with brief information about the rationale for the study before asking participants to read through the 45 statement cards (cards appeared one-by-one in random order). Participants were

asked to sort cards based on their view on the research question: 'what factors would be important to men who are thinking about engaging in therapy?'. Participants were first asked to sort the statements into three piles: a pile for statements they disagreed with/agreed with least, a pile for cards they agreed with/agreed with most, and a pile for the rest. Participants were then presented with a distribution matrix (see Figure 5) and asked to sort the cards (according to how much they agreed with the statements) by dragging the statements into available matrix slots.

2.2.3.4.4 Post-sorting Questionnaire

The final stage of data collection involved a post-sorting questionnaire made up of open-ended questions (see Appendix I). The questionnaire aims to gather information on why participants have sorted items in the way they have and discover why particular items were considered meaningful and salient (Watts & Stenner, 2012). The questions asked participants why they agreed or disagreed most with the statements they had placed below "+4" or "-4" on the distribution matrix. Furthermore, participants were asked if there were additional items that should have been included in the Q-sort (e.g. other statements relating to improving access to psychological therapy to men) and for any further comments.

2.2.4 Data analysis

Analysis in Q-methodology utilises a by-person factor analysis, employing the participants as the variables for the study (Watts & Stenner, 2014). Factors are then interpreted based on this analysis and qualitative data collected during the Q-sort. This abductive process examining previous findings allows for generation of new hypotheses that can then be investigated further. The data analysis was completed in two stages: 1a) analysis and interpretation of factors from Group One (those who had considered psychological therapy), 1b) analysis and interpretation of factors from Group Two (those who had not considered psychological therapy) and 2) a second-order factor analysis combining factors from both groups to understand common and differing viewpoints across both groups.

The analysis of Q-data uses a form of factor analysis that aims to identify shared viewpoints in the sample. The Q-sort distribution matrices are inter-correlated into a correlational matrix by which factors can be extracted. Patterns of similarity in the correlation matrix and therefore, shared participant viewpoints, are identified by factor analysis (Watts & Stenner, 2014). PQMethod (version 2.35, Schmolck & Atkinson, 2015) computer software was used to analyse the data. Participant Q-sorts data was entered into the programme, inter-corelated and analysed for factors. Factors were extracted to determine the smallest number, accounting for the largest study variance. Principal Component Analysis (PCA) was decided to be the best method of analysis for factor extraction as it allows for the best possible mathematical solution, allowing the researcher to evaluate ideas developed in previous studies by making use of statistical methods (Watts & Stenner, 2014). PCA first takes the Q-sort data and computes and outputs Eigenvalues (and corresponding percentage figures). Factors were extracted if they had Eigenvalues >1.00 and if the cross-product of the two highest factor loadings exceeded twice the standard error in accordance with Kaiser-Guttman criterion and Humphrey's rule (Schmolck & Atkinson, 2015; Watts & Stenner, 2014). Q-sorts are considered confounded if they load significantly onto more than one factor and are therefore not included in the analysis (Brown, 1980).

Once the factors are extracted, they are rotated through Varimax rotation. Factor estimates are developed from weighted average scores of all the Q-sorts that load significantly onto a given factor. Q-sorts with higher loadings contribute proportionally more to the final factor estimate and are therefore considered to be more representative of the factor's viewpoint. Factor arrays are then developed from weighted averages and reveal where items are ranked in an overall viewpoint. Factor arrays are presented in the same format as the distribution matrix and provide an illustration of the best possible estimate of the relevant factor. These form the basis of the factor interpretation and allow researchers to examine patterns and differences between factors (Watts & Stenner, 2014)

2.2.3.6.1 First-Order Analysis

The first stage required analysis of the data from the two groups Q-sorts to understand the viewpoints of those who have considered therapy and those who have not. Factors from the first stage of the analysis provides the data for the second-order

factor analysis which allows better understanding of the similarities and differences between the two groups. The second-order analysis was the main focus of the study and therefore, only a brief description of results of the first-order analysis is included.

2.2.3.6.2 Second-Order Analysis

The second stage of the data analysis uses the factor arrays from the extracted and rotated factors in the first-order analysis to examine shared viewpoints between the two groups. The first-order factors are used as variates and analysed with PQMethod software (Schmolck & Atkinson, 2015). Each factor is described in the results section and information from the demographic and post-sorting questionnaires has been used to further understand and clarify viewpoints. Statement rankings are included in parentheses, for example (22: +3) indicates that item 22 was ranked in the +3 column. Statements that were distinguishing or ranked in a significantly different way than in other factors are marked with an asterisk. Distinguishing statements support interpretation as they identify difference between viewpoints. Consensus statements are items that participants have ranked similarly and therefore represent shared viewpoints across factors. Participants were asked to provide a rationale for ranking the highest (+4) and lowest (-4) items and therefore, quotes are included to help further understand viewpoints. Pseudonyms have been used to help identification of different participants.

2.3 Results

2.3.1 Participants

A sample of 47 men took part in the online Q-sort. Unfortunately, no participants responded to the posters and all participants included were recruited online through social media and the MQ website. In order to establish the main viewpoints of the target population, Q-sort methodology requires twice as many items in the Q-set (list of statements) as there are in the P set (participant group) and does not require a large sample size. Additionally, the analysis method is a by-person approach to factor analysis, where participants become the variables and high number of variables are not desirable (Watts & Stenner, 2005). Therefore, due to the high number of participants recruited for the study the sample was divided into two groups (see Table 5). This method has been

useful within previous Q studies and has been deemed an acceptable approach within Q-methodology (Barker et al., 2019; Wong et al., 2004). After examining the data collected during the pre-sorting questionnaire it was decided that participants would be divided into two groups based on those who reported they had considered accessing therapy Group One (n= 24) and those who reported they had not Group Two (n= 23). The data yielded two groups that were felt to be the most appropriate split for the analysis.

Table 5. Participant Demographic Information

Characteristic	Group One n (%)	Group Two n (%)
Age		
18- 24	4 (16.7%)	1 (4.3%)
25- 34	12 (50%)	9 (39%)
35- 44	6 (25%)	2 (8.7%)
45- 54	0 (0%)	2 (8.7%)
55- 64	1 (4.2%)	8 (34.8%)
65-70	1 (4.2%)	1 (4.3%)
Ethnicity		
Asian	2 (8.3%)	1 (4.3%)
Black British	1 (4.2%)	3 (13%)
Mixed Race	1 (4.2%)	0 (0%)
White British	17 (70.7%)	18 (78%)
White German	1 (4.2%)	1 (4.3%)
White Italian	1 (4.2%)	0 (0%)
White Polish	1 (4.2%)	0 (0%)
Sexuality		
Asexual	1 (4.2%)	0 (0%)
Bisexual	1 (4.2%)	0 (0%)
Gay	4 (16.7%)	2 (8.7%)
Heterosexual	18 (75%)	21 (91%)
Religion		
Buddhist	2 (8.3%)	0 (0%)
Christian	3 (12.5%)	10 (43.5%)
Hindu	1 (4.2%)	1 (4.3%)
Muslim	1 (4.2%)	1 (4.3%)
No Religion	17 (70.8%)	11 (47.8%)
Level of Education		
GCSE	3 (12.5%)	2 (8.7%)
College	4 (16.7%)	3 (13%)
Apprenticeship	3 (12.5%)	0 (0%)
Undergraduate Degree	10 (41.7%)	12 (50%)
Postgraduate Degree	4 (16.7%)	6 (25%)
Employment Status		
Employed	15 (62.5%)	16 (69.6%)
Retired	1(4.2%)	3 (13%)
Self-Employed	2 (8.3%)	2 (8.7%)
Student	2 (8.3%)	1 (4.3%)
Unemployed	4 (16.7%)	1 (4.3%

2.3.2 First-order Analysis

2.3.2.1 Principal Component Analysis Results: Group One – Considered Therapy

Three factors were identified, rotated, and extracted, accounting for 45% of the Group One study variance. The three factors were made up of 15 Q-sorts: Factor One: Feeling accepted and in control was made up of seven sorts; and Factors Two: Emotional support and an individual approach and Three: Honesty and expectations were each made up of four sorts. The four remaining Q-sorts were confounded, and two did not pass extraction criteria and therefore were not included (see Appendix J).

Analysis of Group One factors revealed two consensus statements: 12. The therapist provides a clear plan for treatment that works towards the client's goals (+2) and 27. The therapist avoids challenging traditional male behaviours such as awkwardness or difficulty expressing emotions (-4). Statement 27 was ranked very low across all Group One participants, with 15 of the 24 participants placing this statement at -4 (least agree). It is therefore clear that men in this group disagreed with this statement. Furthermore, 11 of the participants agreed that the therapist using gestures and body language within their communication was not an important factor placing this at -4 (least agreed with). In contrast, participants appeared to agree across the three factors that an important aspect of psychological therapy would be to have a clear plan provided by the therapist that incorporates and works towards client goals. Statement 37 describing confidentiality within the relationship was deemed an important factor by the participants with 11 of them placing it at +3 and four placing it at +2. The factors developed by the Group One analysis are shown in Table 6.

Table 6. Group One Factors

Participant Information	Factor Summary
Factor 1:	
• Comprised of 7 Q-sorts • Accounts for 20% of the variance • Average age 32.1 (range = 21-58) • 7 White British, 1 Mixed Race • 5 Heterosexual, 2 Gay • 5 Employed, 1 Self Employed, 1 Student	• Feeling accepted and in control • This group placed importance on items relating to the therapist being accepting and supportive of the client (23: +4) • These participants believed it important that clients know what to expect in treatment and feel stronger and more in control throughout treatment (35: +4) • This group ranked several items relating to the therapist considering gender and masculinity significantly lower than other factors such as role of being a man and the pressure (9: -3) and strengths of being a man (28: -3) and the therapist recognises their own gender (11: -2).
Factor 2:	
• Comprised of 4 Q-sorts • Accounts for 10% of the variance • Average age 26.8 (range = 18-33) • 2 White British, 1 Asian • All Heterosexual • 3 Employed, 1 Unemployed	• Emotional support and an individual approach • Participants placed value in some items relating to the therapist considering individual men's experiences of masculinity such as how upbringing may have influenced their experiences of being a man (1: +4) and how different men might describe masculinity (3: +2) • There was importance placed in being accepted by the therapist (29: +4) and the therapist supporting the client emotionally (32: +3) whilst considering emotions like discomfort or shame (5: +4) • Participants also placed value in the therapist using appropriate humour (42: +3) and informal conversation (14: +3) • This group placed less value in the structure of therapy (13: -3) and expectations of roles (17: -4)
Factor 3:	
• Comprised of 4 Q-sorts • Accounts for 15% of the variance • Average age 36 (range = 19-47) • 1 White British, 1 White Irish, 1 White Polish, 1 Asian • 2 Heterosexual, 1 Asexual, 1 Bisexual • All Employed	• Honesty and expectations • Participants placed importance in the therapist being honest (25: +4) and helping the client to feel their experiences are understandable (24: +3) as well as on the client looking after themselves (20: +3) • They also valued having clear expectations of treatment (18: +4) and the therapist/client roles (17: +3) as well as working towards small goals (14: +4) • Participants did not feel that style of communication such as informal conversation (44: -4), brief and specific communication (43: -3) or positive and action focused language (39: -3) would be important. • The group also placed less value in the therapist considering emotions like rage, guilt (7: -2) discomfort or shame (5: -2)

2.3.2.2 Principal Component Analysis Results: Group Two

Four factors were rotated and extracted following the same procedure and collectively accounted for 53% of Group Two variance. The four factors were drawn from 16 Q-sorts: Factor Four: Trust and progress was made up of eight sorts, Factors Five: Individual experiences and working hard and Six: Strengths and being a man were made up of three sorts and Factor Seven: Equality in the relationship and a clear plan for treatment was made up of two sorts. Six sorts were confounded, and one did not pass extraction criteria and therefore were not included (see Appendix J).

Analysis of Group Two revealed 14 of the 23 participants agreed on the ranking of statement 33. The relationship with the therapist will be collaborative (0). Suggesting that participants in this group believed a collaborative relationship would be important but not vital. Furthermore, all participants ranked statement 27, describing the therapist challenging traditional male behaviours, very low with eight of the participants agreeing this statement was least important -4 and the other eight agreeing this statement should be placed at -3. Participants generally did not believe that having an equal and reciprocal relationship with the therapist would be important with 14 ranking this statement lower down the distribution matrix. The therapist accepting and supporting the client (not judging the client) was deemed to be an important factor with 13 of the participants ranking it high. Conversely, three of the participants seemed to disagree that this would be important, placing the statement lower at -3. All participants believed that the therapist discussing the reasons for treatment and what happens in therapy was an important factor, although five participants believed it to be the most important (+4) whereas, 11 believed it to be important but not vital (+1). Table 7 outlines the factors that were developed from the Group Two analysis.

Table 7. Group Two Factors

Participant Information	Factor Summary
Factor 4:	
• Comprised of 8 Q-sorts • Accounts for 19% of the variance • Average age 50 (range = 28-62) • 7 White British, 1 White Anglo Saxon • 7 Heterosexual, 1 Bisexual • 4 Employed, 2 Self-Employed, 2 Retired	• Trust and progress • Participants felt the therapist being honest (25: +4) and the relationship being confidential (37: +4) to be very important. • They also placed importance on understanding the treatment process (40: +3) and making/recognising progress through working towards small goals (14: +4) the therapist linking back to earlier sessions (15: +2) • This group placed less value in items relating to the communication style of the therapist such as information conversation (44: -4), appropriate humour (42: -3) and positive and action focused language (39: -3) • This group thought it would be important for the therapist to challenge traditional male behaviours (27: -4) and consider the client's experience of being a man (6: +2)
Factor 5:	
• Comprised of 3 Q-sorts • Accounts for 10% of the variance • Average age 38.3 (range = 27-60) • 1 White British, 2 Black British • 2 Heterosexual, 1 Bisexual • All Employed	• Individual experiences and working hard • This group placed value in the therapist considering the individual's experience of being a man and thoughts around what it is like to be a man (8: +4) as well as the therapist being aware of their own views on men (10: +2) • Participants felt that factors relating to working hard (41: +3) and the importance of work life (4: +3) were important. • Participants placed less importance in factors relating to expectations of treatment (18: -2), the therapist describing the treatment process (40: -2) and expectations of roles (17: +4)
Factor 6:	
• Comprised of 3 Q-sorts • Accounts for 9% of the variance • Average age 43.3 (range = 26-70) • 2 White British, 1 Asian Indian • 3 Heterosexual • 2 Employed, 1 Retired	• Strengths and being a man • This group considered it important that the therapist understood the client's strengths and uses them in therapy (21: +4) • Participants in this factor felt it important to consider different experiences of masculinity (3: +3) , being a man and associated pressures (9: +3) and sexuality (2: +1) • Men in this group did not feel that it was as important for the therapist to be honest (25: -2) or accepting and supportive (23: -3) • They also placed less value in them being considered the expert on their lives (34: -3)
Factor 7:	

• Comprised of 2 Q-sorts • Accounts for 15% of the variance • Average age 56 (range = 51-61) • 2 White British • Both Heterosexual • Both Employed	• Equality in the relationship and a clear plan for treatment • Participants in this factor felt it important that the therapist consider their reason for therapy (19: +4) there is a clear route (16: +2) and plan for treatment (12: +4) and that expectations are clear for the therapist and client roles (17: +3) • This group also felt the relationship being equal, reciprocal (31: +2) and collaborative (33: +3) and being accepted and supported (23:to be important • This group placed less importance on the therapist using brief and specific communication (43: -3) and adapting language for men (38: -4) • They also felt the therapist considering the strengths of being a man (28: -4), sexuality (2: -3) and discomfort or shame (5: -3) as less important.

2.3.3 Second-order Analysis

2.3.3.1 Principal Component Analysis Results

A three-factor solution was revealed, explaining 77% of the total variance and representing six of seven Q-sorts, with one confounding sort removed (see Appendix K). The extracted factors met the Kaiser-Guttman rule but only had one or more significantly loading sorts (Watts & Stenner, 2005). If the original extraction criterion were used it would exclude valuable perspectives from men from different demographic groups. Results were derived from 27 of the 47 participants (Group One n= 11 and Group Two n= 16).

Consensus statements revealed shared viewpoints between the two groups and can be seen in Table 8. The groups both disagreed that the therapist should avoid challenging traditional male behaviours such as awkwardness or difficulty expressing emotions (27: -4), describing that an important aspect of therapy would be for this to be challenged, either subtly or overtly. However, in contrast, the groups believed it very important that the relationship with the therapist be confidential (37: +4). Both groups agreed with the placement of some items relating to communication style: the therapist using positive and action focused language (e.g. moving forward, picking up tools) (39: -1) and using gestures and body language (45: -2) in their communication were viewed as less important than other aspects of the therapeutic process. The groups shared views on the relationship with the therapist needing to be collaborative (33: 0) as important, though this was not considered as important as other aspects of the therapeutic relationship.

Table 8. Consensus statements from second-order analysis

	Statement	Agreed Position
27*	The therapist avoids challenging traditional male behaviours such as awkwardness or difficulty expressing emotions	-4
28	The therapist explores and considers the strengths of what it is like to be a man through treatment	-3
45	The therapist uses gestures and body language in their communication	-2
31*	The relationship between the client and therapist is equal and reciprocal (power, control and decisions are shared)	-1

39*	The therapist uses positive and action focused language (e.g. moving forward, picking up tools)	-1
6	Considers you as an individual and the client's experience	0
21	The therapist identifies the client's strengths and uses them in treatment	0
24	The therapist helps the client realise their experiences are understandable based on what they've been through	0
40	The therapist describes the treatment process using appropriate language that the client understands (e.g. does not use jargon)	+1
33*	The relationship with the therapist will be collaborative (the client and the therapist work in partnership and the therapist does not tell the client what to do)	+1
7*	The therapist considers emotions like rage, guilt, grief and fear	+1
16	The therapist ensures that the client is clear on the route of treatment, for example, the different parts of treatment and choices the client has	+2
22*	The therapist is encouraging	+2
30*	The therapist aims to understand the client's difficulties and accepts any doubts they have	+2
13	The therapist works with the client to agree a plan for treatment, skills practice, feedback and ways of checking progress	+3
19*	The therapist discusses the reasons for treatment and what happens in therapy	+3
37*	The therapist makes it clear the relationship will be confidential	+4

All statements are Non-significant at p <.01; *Non-significant at p < .05

2.3.4 Factor Interpretation

2.3.4.1 Factor A: Feeling safe and supported

The first factor accounted for 41% of the total variance and was the dominant factor in second-order analysis. Four factors from the first level of analysis loaded significantly onto this factor: Factor One: Feeling safe and in control, Factor Three: Honesty and expectations, Factor Four: Trust and progress and Factor Seven: Equality in the relationship and a clear plan for treatment.

In total, 21 participants (average age 40.81, range = 19-62) contributed to this perspective, 11 who had considered psychological therapy and ten who had not. The majority of the sample described themselves as White (90%: 15= White British, 1= White Anglo Saxon, 1= White Irish, 1=White Polish, 1= White Welsh), one participant described himself as Asian and another described himself as Mixed Race. Participants who described themselves as Heterosexual made up 76%, with two participants reporting themselves as Gay, two as Bisexual and one as Asexual. Participants who self-described as having no religious beliefs made up 71%; five participants reported Christian religious beliefs (1= Catholic Christian and 1= Methodist Christian) and one Buddhist. Most of the participants were employed or self-employed (86%: 3= self-employed), two retired and one student. A large proportion of the sample had accessed higher or further education after school (90%), with only two of the participants having left school after GCSE-level. Ten participants had completed a degree, with two having completed a Masters. Figure 7 provides an illustration of the factor array for Factor A. The Q-set containing the list of statements and their associated number can be seen in Appendix E.

Least Agree								Most Agree
-4	-3	-2	-1	0	1	2	3	4
44	2	8	3	6	18	35	25	23
41	26	5	31	21	15	17	19	37
27	43	11	9	24	29	16	13	14
	28	45	34	36	33	22	12	
	38	42	39	1	40	30	20	
			10	4	7			
				32				

Figure 5. Factor Array for Factor A: Feeling Safe and Supported

The viewpoint highlighted that participants placed importance in trust and safety within the therapeutic relationship. For example, by prioritising the therapist being honest (25*: +3) and value being placed on confidentiality within the relationship (37: +4):

'Absolutely essential that the client feels safe in exposing their innermost thoughts. This trust may take a long time to build in some cases, particularly when the client has been let down by their closest and dearest' – Andrew, 60 years old, White British, Heterosexual, retired, not considered therapy

Participants represented by this viewpoint identified that being treated like an individual (6: 0) and understanding the client's difficulties and accepting doubts were of importance (30: +2). Again, feeling safe and the therapist accepting and supporting the client (not judging the client) were identified as key and participants believed this would support men to overcome barriers to engaging in support (23: +4):

'A big barrier for seeing someone about mental health is being judged. I think a lot of the reason I've never seen someone is being judged by them /my friends /my family. If a therapist can be supportive and accepting from the start, and I know I'm not being judged, I'm more likely to accept help'- Gareth, 25 years old, White British, Heterosexual, employed, considered therapy

Participants prioritised items that described the therapist promoting agency for the client by helping the client feel stronger, more confident (35: +2), look after themselves and learn to manage their emotions (20: +3). This group also placed value in there being a clear understanding of treatment, including expectations of roles (17: +2), the client having a plan for treatment (13: +3), that is goal focused (12: +3) and the therapist helping the client to work towards small goals as stepping-stones towards long term progress was deemed particularly important (14: +4). This was described by a participant:

'It is important that the client be able to "see light at the end of the tunnel" and that they will be able to progress to it in small steps' – John, 60 years old, White British, Bisexual, employed, not considered therapy

Within this viewpoint, items relating to masculinity and gender role socialisation were considerations of how being a man may contribute to any discomfort or shame (5*: -2) and how different men might describe masculinity (3: -1), were rated as less important. The therapist challenging traditional male behaviours such as awkwardness or difficulty expressing emotions was deemed unimportant by all participants represented by this viewpoint (27: -4). Participants reasoning for the placement of this item varied as some participants described challenging traditional male behaviours such as awkwardness or

difficulty expressing emotions as an important thing to challenge throughout the process of therapy but that the importance of this would vary across individuals, as described below:

> *'I think this is generalisation that men are awkward or openly deal with emotions. I think before challenging some behaviours, assumptions should not be made on individuals and considerations should be made on a individual basis'* – Tom, 29 years old, White British, Heterosexual, employed, considered therapy

Participants represented within this factor placed less value in the communication style of the therapist, such as informal conversation (44: -4) and brief and specific language (43: -3). Participants appeared to feel that this would vary for different men in therapy and therefore this was deemed less important:

> *'It is important that the therapist uses language that the client understands and can relate to, but again this needs to be varied according to the client. overfamiliarity on the part of the therapist should be avoided'* – John, 60 years old, White British, Bisexual, employed, not considered therapy

This factor summarises the viewpoint that represents the largest proportion of participants within the study and illustrates the importance placed by men in feeling accepted, supported and safe within psychological therapy; through understanding the process (expectations and treatment goals) and through the relationship with the therapist. According to this perspective, men place less value in the communication style used in therapy and factors relating to masculinity.

2.3.4.2 Factor B: Gendered therapy and a relaxed approach

Factor B accounted for 19% of the total study variance. One factor from Group Two first level analysis loaded significantly onto this factor: Factor Six: Strengths and being a man (n= 3). In total, three participants (average age = 43.33, range = 26- 70) contributed to this perspective. It was decided to include this factor due to the novel perspective it brings from the representation of highly educated, employed and heterosexual men who had not considered therapy before. All three participants described themselves as Heterosexual, in full time employment and all had Masters degrees. One of the

participants described himself as Asian Indian and Hindu and the remaining two participants described themselves as White British: one reported having no religious beliefs and one described being Christian. Figure 8 provides an illustration of the factor array for Factor B.

Least Agree								Most Agree
-4	-3	-2	-1	0	1	2	3	4
41	8	24	28	33	20	44	3	1
36	17	14	39	25	11	9	37	29
45	15	4	40	26	22	5	21	42
	34	35	10	18	30	12	19	
	27	31	6	43	13	2	32	
			23	16	7			
				38				

Figure 6. Factor Array for Factor B: Gendered therapy and a relaxed approach

Participants within this group placed value in items acknowledging gender and the influence of masculinity within therapeutic discussions. The therapist considering the role of being a man and the pressure that may place on someone (9: +2), how different men might describe masculinity (3: +3) and the impact of the therapist gender on the relationship with the client were all deemed important (11*: +1). Furthermore, considering the strengths of what it is like to be a man through treatment (28: -1) and sexuality and related issues (e.g. performance, power, pornography) were also considered more important by men within this group than Factor A and C. Additionally, participants considered language and communication style being adapted for male clients (uses language that respects what it is like to be a man) as important (38: 0).

In contrast to Factor A, those represented in this group prioritised factors associated with communication style, such as the therapist using informal conversation (44*: +2), appropriate humour (42*: +4), brief and specific communication (43: 0). One participant shared his views on why this was important:

'Communication may be brief but may have greater depth and meaning' – Robin, 70 years old, White British, Heterosexual, Retired, not considered therapy

Participants placed more value in verbal communication, ranking the therapist using gestures and body language in their communication as least important (45: -4) as described by this participant:

'Body language is important but needs to be in support of simultaneous verbal communication' – Robin, 70 years old, White British, Heterosexual, Retired, not considered therapy

In this viewpoint, the therapist accepting the client where they are and not rushing them (29: +4) and identifying and using their strengths throughout treatment (21: +3) were considered important. However, the therapist being honest (15: 0), accepting and supportive (23*: -1) were considered less important than in other factors.

Items that were associated with client's gaining agency or autonomy were not considered as important by the participants represented by this viewpoint. This differed from the viewpoint represented by Factor A and C. For example, the client being encouraged to be the expert on their life and therefore being responsible for change (34: -2), the client feeling stronger, more confident and in control (35: -2) and the client being encouraged to value their own needs (36*: -4). One participant described his rationale for this decision:

'If I went to see a therapist, I would feel like that would be because I needed help with understanding what I needed, and I would want them to help me with figuring that out' – Bhavin, 34 years old, Asian Indian, employed, not considered therapy

There were some similarities identified in this group viewpoint with Factor A and C. Including an emphasis on hard work within therapy was not deemed important as participants in this group and Factor A did not believe it to be suitable to all and/or their treatment (41: -4). Participants described the importance of considering a man's childhood and upbringing and how they affect current difficulties and beliefs about being a man (1: +4) a viewpoint that was shared with participants in Factor C. One participant described why he felt this was important:

'This is important because it tells what extent traditional male stereotypes are playing a role in the clients' decision to choose therapy and how they feel about it' – Harry, 26 years old, White British, Heterosexual, employed, not considered therapy

This factor captures a different viewpoint to that represented within Factor A. This provides a unique perspective on factors associated with communication style of the therapist and discussions around gender and masculinity. This group felt that the important aspects of therapy are a strengths-focused approach that includes acceptance of the client and includes a relaxed communication style that supports the client's understanding.

2.3.4.3 Factor C: Personal autonomy and a flexible approach

This factor accounted for 17% of the total study variance. One factor from the first level of analysis loaded significantly onto this factor: Factor E (n= 3). In total, three participants (average age = 38.33, range = 27-60) contributed to this perspective. As with Factor B, despite this factor only having one significant loading it was decided to include it to ensure another unique perspective was not lost (Brown, 1980; Watts & Stenner, 2014). Only two Black British men were included in the analysis and both men were represented by this viewpoint. All three participants reported being in full-time employment and had accessed higher education (two had Undergraduate degrees and one had a Postgraduate degree). Two participants described being Black British and Heterosexual, one described being Christian and the other Muslim. The final participant described being White British, Bisexual and Christian. Figure 7 provides an illustration of the factor array for Factor C.

Least Agree								Most Agree
-4	-3	-2	-1	0	1	2	3	4
17	38	18	6	22	14	9	4	1
11	31	40	2	24	15	10	23	5
26	27	42	20	25	19	34	29	8
	28	43	12	30	21	36	32	
	44	45	39	7	35	37	41	
			16	33	3			
				13				

Figure 7. Factor Array for Factor C: Personal autonomy and a flexible approach

This viewpoint prioritised items relating to working hard within therapy (41*: +3) and importance of work life (4: +3). Items describing the client needing to be the expert on their life, taking responsibility for change (34*: +2) and agency in valuing their own needs (36: +2) were all viewed as important by participants represented by this viewpoint.

Participants placed value in consideration being made to how both the therapist (10: +2) and client viewed men and the experience of being a man (8*: +4). Additionally, in contrast to Factor A, this group believed the therapist considering how being a man may be contributing to any discomfort or shame (5: +4) was important. One participant described believing it was central to men's difficulties:

> *'I would go as far as saying that most problems that men have with themselves, especially inadequacy and failure stems from what is shown on media and what is expected of them as men by friends and family'* – Michael, 27 years old, Black British, Employed, not considered therapy

This group did not feel that the therapist telling the client a bit about themselves and their experience would be of importance (26: -4) and one participant described how they felt this may impact on their experience:

> *'Something the therapist believes are similar might be viewed as minor and not equivocal by the client, it could be invalidating'* – Michael, 27 years old, Black British, Employed, not considered therapy

Similarly, participants did not feel that acknowledgement of the therapist's gender and how this might impact the relationship was of importance when compared to other things (11: -4). One participant described their views on why they felt this:

> *'I don't think it's about the therapist at the end of the day and I trust them not to place the emphasis on them'* – Addae, 28 years old, Black British African, Heterosexual, Employed, not considered therapy

The therapist discusses expectations of roles (what the client can expect from the therapist, what the therapist can expect from the client and who is responsible for what) (17: -4):

> *'I feel this would feel quite forced and overly formal'* – Addae, 28 years old, Black British African, Heterosexual, Employed, not considered therapy

There were some similar views identified between this factor and Factors A and B. Most noticeable was the value placed on the therapist considering upbringing and how this shaped men's experiences and beliefs about being male (1: +4), which participants in this group and in Factor B believed to be very important. One participant described how the importance of his experiences in contributing to how he compared himself to others:

> *'Childhood shaped everything I did. from seeing people at school to seeing how my house compared to my friends, to not being let out at 'late' as others. This changed how I viewed myself'* – Addae, 28 years old, Black British African, Heterosexual, Employed, not considered therapy

In summary, this factor shows a distinct viewpoint that places value on the focus of the therapeutic relationship being on the client's individual experiences and views rather than what the treatment 'looks like'. The therapist's gender and discussions about expectations of roles were considered less important to participants represented by this viewpoint.

2.4 Discussion

The current study aimed to 1) assess viewpoints held by men on what factors would be important to them if they were considering engaging in therapy, 2) assess similarities and differences in viewpoints depending on demographic factors (e.g. age, ethnicity, sexuality, religion).

2.4.1 Summary of Findings

The study revealed three factors illustrating men's different viewpoints of which factors are important when considering engaging in psychological therapy. The small number of statistically significant factors suggests a diversity in viewpoints across men. The three factors illustrated distinct differences between viewpoints. However, there were some areas of consensus identified across these factors. The men represented by different factors were from a variety of demographic groups making it difficult to draw any clear conclusions relating to the influence of demographic factors on men's perspectives.

2.4.2 Consensus Statements

The consensus items (see Table 8) highlight areas of agreement across the sample. The literature in the Seidler et al. (2018) review suggested that the therapist should focus on a strengths-based approach to engagement rather than difficulties. However, men in the sample agreed that a vital part of therapy would be to challenge less positive traditional male behaviours in order to overcome barriers that may prevent progress. Previous research suggests that positive engagement and a strong therapeutic relationship is crucial in order to challenge behaviour within therapy, a finding that may explain why men in the study considered it important that the therapist supports the client emotionally (Skourteli & Lennie, 2011). There was a difference of opinion in items that strengthen the therapeutic relationship, a finding that contradicts previous literature suggesting that the therapeutic alliance is the most important factor within psychological therapy (Ardito & Rabellino, 2011).

Men agreed that gestures and body language were less important than other factors associated with communication style, supporting previous findings suggesting nonverbal communication is often a peripheral area of focus in the psychotherapeutic setting (Foley & Gentile, 2010). The recommendation for use of nonverbal communication derived from findings from two papers in Seidler et al. (2018) scoping review suggesting it was not of upmost importance. Men also agreed that considering the reasons for treatment and discussions around what will happen in therapy were important, consistent with previous research (Emslie et al., 2007).

Another finding supported by previous research is the importance of considering the impact of childhood and upbringing on views of being a man and current stress. Men who agreed that this was important had not considered accessing psychological therapy before (which may have influenced their viewpoint) but described believing that their childhood experiences shaped their individual views, and this therefore needed to be considered within therapy. Previous findings have suggested that gender roles are often reinforced within childhood and adolescence, this viewpoint supports the need for consideration of gender socialisation within psychological therapy (Fagot et al., 2000; Liddon et al., 2019).

2.4.3 Differing viewpoints

There were three distinct viewpoints identified by the analysis. Factor A represented the dominant viewpoint from men who have and have not considered therapy. Factor A captures a viewpoint that men place importance on feeling accepted, supported and safe within therapy and placed less value in the therapist's communication style and issues relating to masculinity. Factor B and C represented men from different demographic groups to Factor A, both provided different perspectives from men who had not considered therapy. Factor B illustrates a viewpoint describing men valuing a relaxed and informal therapist communication style and discussions around gender and masculinity. Finally, Factor C demonstrates that men value the consideration of individual experiences and views rather than the treatment structure and therapist style.

2.4.3.1 Trust in the Therapeutic Alliance

The dominant factor (Factor A) described men seeking feelings of safety, trust and unconditional positive regard from the therapist and therapeutic relationship. The therapist's ability to provide empathy and support has been found to be fundamental in building a therapeutic alliance where client's benefit more from therapy (Bachelor & Horvath, 2006).

Previous findings suggest that men are taught to suppress emotions and that their threshold for emotional sensitivity is heightened to emotions such as helplessness, sadness and weakness. Findings by Seidler et al. (2018) suggested that building a strong therapeutic alliance was vital to reduce feelings of stigmatisation and shame associated with seeking psychological help. Although some statements relating to therapeutic alliance were ranked lower in Factor B and C, statements relating to an accepting and supportive therapist were considered important, suggesting that this was deemed imperative to participants.

Findings consistently show that a good therapeutic alliance is the greatest predictor of positive clinical outcomes, regardless of the therapeutic approach (Ardito & Rabellino, 2011; Barber et al., 2000; Lambert & Barley, 2001). The current findings support recommendations by Rogers (1951) who considered these factors essential for client-centred therapy. Empathy and understanding also promote a positive attachment between therapist and client that endorses a strong therapeutic alliance (Bowlby, 2005; Skourteli & Lennie, 2011).

2.4.3.2 Agency and Expectations

The importance placed in the client understanding the process of therapy, what is expected of them and valuing their own needs within Factor A and C is suggestive of men seeking feelings of control within the therapeutic process. This finding differed within Factor B where men placed importance in the therapist taking a more active role in this. The finding from Factor B contradicts the idea of a collaborative therapeutic alliance and decision making which is central to various approaches in psychological therapy (Carr,

1998; Seidler et al., 2018). This viewpoint was representative of three men who had not considered therapy and it is possible this influenced their view.

Previous findings suggest that men consider seeking help as a loss of control which may explain the emphasis placed on empowering men to feel more autonomous within Factor A (Möller-Leimkühler, 2002). This supports models of male help-seeking that suggest interventions need to target this perceived loss of control to foster adaptive help-seeking (Addis & Mahalik, 2003). Collaborative approaches have been found to empower men to feel involved with the treatment process, building upon traditional masculine norms of independence, autonomy and strength (Brooks, 2010). In accordance with attachment theory, research has suggested the therapist acts as a secure base within a therapeutic relationship. A strong alliance allows the client to feel safe, enabling them to place trust in the therapeutic process, consequently, developing skills that support agency in emotional regulation (Bowlby, 2005; Farber et al., 1995).

The viewpoint in Factor B contradicted ideas of self-reliance that are prevalent in traditional masculinity and have been found to be a barrier to help-seeking (Heath et al., 2017; Labouliere et al., 2015). This suggests, men in Factor B may have different views of masculinity, a hypothesis supported by the value placed in the therapist considering how different men might describe masculinity. The men represented by this factor had not considered accessing therapy and were educated to postgraduate level. Men with higher levels of education have been previously identified as having more positive attitudes towards help-seeking and it is possible that education may have influenced their perspective on self-reliance (Sullivan et al., 2015).

2.4.3.3 Influence of Masculinity

There was a difference between the factors on the statements relating to masculinity. Men represented by Factor B and C, ranked discussions around masculinity and gender as an important aspect of psychological therapy. However, men represented by Factor A considered this less important. Those represented by Factors B and C had not considered therapy before which may have influenced their views. The consideration of how gender impacts men's experiences supports literature suggesting that a client's conceptualisation should be considered through a 'gendered lens' to make sense of their difficulties and

reduce shame associated with seeking psychological help (Good et al., 2005). Men in Factor B valued the therapist considering different views of masculinity suggesting that men felt the therapist should understand individual experiences and avoid gender biases (Owen et al., 2009).

Men represented by Factor A placed less value in these factors which could suggest that a strong therapeutic alliance is required in order to challenge traditional male behaviours or alternatively one participant suggested that these would be subtly challenged by men taking part in therapy.

2.4.3.4 Communication Style

Viewpoints differed in how much value was placed on therapist communication style. Men in Factor B valued more informal aspects of the therapeutic style such as humour, informal conversation and language adaptations. This supports previous findings that suggest tailoring communication style for men promotes engagement in psychological therapy (Syzdek et al., 2016). Additionally, men in Factor B valued the consideration of therapist gender, consistent with previous recommendations suggesting that therapists acknowledging gender within therapy improves outcomes (Felton, 1986). Men in Factor A and C placed less value on these items suggesting they valued the content of therapeutic discussions and relational style rather than communication style or gender of the therapist. This supports research suggesting that men have no preference of therapist gender (Pikus & Heavey, 2008). Communication has been found to be essential to the therapeutic relationship however, the features of communication considered key were relating to genuineness, validation, non-judgement and empathy rather than colloquial style or humour (Wachtel, 1993).

2.4.3.5 Treating Men as Individuals

Men represented by Factor C described believing it important for the therapist to considering men and their experiences individually and acknowledging their strengths. Men in Factor B ranked the client being the expert on their life higher than the men in Factor A and C. Furthermore, men in Factor B placed value in the items relating to working hard but acknowledged that this may not be appropriate for every man. Two of

the men represented by the Factor C viewpoint were Black British. Previous research suggest that racial identity and other demographic factors contribute to men's views of masculinity and attitudes towards psychological help (Mahalik et al., 2006; Rafal et al., 2018). The value placed on hard work is consistent with findings that have suggested that black men identify strongly with a good work ethic and the idea of being a 'good provider'. However, this also been shown to be important to white men (Bhagat, 1979).

Taken together, these findings support previous literature suggesting men's individual constructions of masculinity should be considered to avoid assumptions and biases (Mahalik, Locke, et al., 2003). These findings support the use of a systemic approach within psychological therapy enabling therapists to view the clients' problems in the context of the systems that affect them, as well as considering the impact of intersectionality (Burman, 2006).

2.4.4 Demographic Differences

The study aimed to examine whether viewpoints changed amongst different age cohorts, ethnicities, religious beliefs and sexualities. The large representation of men from dominant social groups within the sample is common within men's mental health research (Woodall et al., 2010). It is possible that generational differences and cohort effects across the sample may have influenced men's experiences of narratives around mental health and help-seeking and therefore their viewpoints. Previous research has shown that help-seeking intentions vary across men of different ages and it is possible that younger men may have a different understanding of psychological therapy or mental health to older men due to mental health campaigns and psychological therapy being more widely available since the introduction of IAPT in 2008 (Mackenzie et al., 2006). There were a variety of ages across the men represented by each factor however, the average age across the factors was similar making it difficult to draw any conclusions from this. The average age of men who had considered therapy was younger than those who had not considered therapy which may reflect a change in masculinity narratives across generations, though there is a lack of research to support this (Anderson, 2009). The diversity in age, sexuality, religion and education level represented by Factor A and B suggest these views may be representative of a wider group of men though these samples were predominantly represented by white men. It is possible that the

representation of the only Black British participants in the analysis within Factor C may support previous findings suggesting an influence of race on viewpoints, though due to such a small number we cannot draw any conclusions and further research is needed to examine this (Mahalik et al., 2006). The diversity across the different factors means it is difficult to draw any clear conclusions however, this supports the need for an individual approach, considering individual's experience depending on their age, race, culture, sexuality, employment status etc (Burman, 2003; Mahalik, Good, et al., 2003).

2.4.5 Clinical Implications

The findings from the current study have important implications for clinical practice. The dominant factor prioritised the importance of factors relating to the therapeutic relationship. Person centred approaches have previously been identified to support and empower clients which are in line with the viewpoints of men represented by Factors A and C. The emphasis placed on these factors suggest psychological therapists and services should prioritise strong therapeutic relationships with male clients. Furthermore, this information could be used to promote psychological services and increase awareness of key aspects of psychological therapy that may improve attitudes towards seeking psychological help. Men within the study suggested that there was not enough information on psychological therapy, different approaches and expectations. Given the findings suggesting some men view seeking psychological help as a loss of control, services should prioritise providing information to men that may manage their expectations and allow them to make informed choices, promoting feelings of agency.

The inconclusive findings relating to different demographic factors on viewpoints of men support the need for an individual approach. Idiosyncratic approaches and psychological formulation aim to understand individual experiences. Findings suggest some men would favour discussions around gender and the influence of masculinity promote the need for systemic psychological formulations that consider wider contextual factors such as family, community, culture, society. Understanding men within their context would support understanding of masculinity conceptualisation and allow for the implementation of systemic and culturally sensitive interventions (Shen-Miller et al., 2013).

Finally, the perspectives on communication style reiterate the importance of tailored and individualised approaches within psychological therapy. Therapists are often trained to adapt and deliver flexible and client-centred approaches that are responsive to the needs of individuals. Inviting clients to take an active role in identifying their needs and preferences of style within therapy would allow for more meaningful therapeutic experiences. Previous findings have suggested that approaches that value the client as the expert on their lives produce better outcomes in psychotherapy (Bohart & Wade, 2013). Promoting positive experiences of asking for help and improving men's understanding of what help is available is likely to encourage future help-seeking behaviour (Nahon & Lander, 2016).

2.4.6 Strengths and Limitations

A strength of the current research was that it used recommendations that were derived from previous research identified by Seidler et al. (2018). Q methodology allowed researchers to examine men's perspectives of these recommendations in a way that other methodologies would not have allowed. The recommendations were adapted to form the Q-set and it is possible that this process was influenced by researcher bias. In order to mitigate the risk of bias, two experienced clinicians were involved in this process aiming to define terms clearly and therefore avoid participant misinterpretation. The pilot study aimed to improve the accessibility of the Q-set however, it is possible that due to the online nature of the main study, participants were unable to clarify meaning if they did not understand a statement. Q-studies rely upon instructions and statements being clear and comprehensible to be successful (Watts & Stenner, 2014).

Only 27 of the possible 47 Q-sorts from participants were included within the analysis due to 20 being confounded. The Q methodology dictates that you exclude confounding sorts that significantly load onto one or more factor which means outlying views are excluded because they do not reach a consensus with other views included in the sample. This high proportion of confounded Q sorts suggests a lack of unanimity in the viewpoints of men included within the sample and implies factors that men view to be important in psychological therapy is idiosyncratic, a finding which supports previous research (Mahalik, Locke, et al., 2003). Due to the subjective nature of the process of factor interpretation within Q-methodology, there is a risk of interpretation bias

depending on the researcher's analytical skills. Follow up interviews with participants are sometimes used within Q-methodology studies which allow for validation of researcher's interpretation. Unfortunately, time constraints and the nature of anonymised participation within the current study did not allow for this and further replications of the study should incorporate this element to strengthen the findings (Stenner et al., 2000).

The FlashQ software enabled the researcher to access participants from across the UK and the physical 'drag and drop' method creates good ecological validity. However, difficulties were identified by participants and the researcher with the program. The study had a very high attrition rate between the demographic questionnaire and completion of the Q-sort and this may have been due to difficulties with the software. The Q-sort was only accessible using certain internet browsers and was not accessible via mobile device or Apple computer. Participants were unable to save their progress and data was only available to the researcher once participants had completed the full Q-sort. It was therefore difficult to ascertain attrition rates during the task and relied upon participants setting aside adequate time to complete the study. Some participants contacted the researcher to inform them that the software had crashed halfway through their Q-sort or after pressing 'submit' meaning data was lost.

There was a clear representation of dominant social groups of men within the sample (e.g. White British, heterosexual, highly educated and employed). There was a diversity in ages represented throughout the sample, but further diversity would be important for future research in order to compare viewpoints. Previous findings have suggested that men experiencing social disadvantage and inequalities are at high risk of suicide and therefore, inclusion of men from differing social groups in future studies would provide an essential insight into their perspectives (Samaritans, 2012). Despite efforts to ensure the current study was accessible to men without access to a computer or internet and with differing levels of literacy, future research would benefit from completing the Q-sorts in person and with fewer statements. Purposive sampling could have targeted men of specific demographic groups by recruiting from groups, charities, workplaces or via specially selected websites that attract or support men of a particular age, race, sexuality etc. An initial screening questionnaire could have been used to identify participants that could then be selected to take part in the sorting task. Furthermore, future research would benefit from understanding the impact of cohort

effects on men's viewpoints by selecting participants from particular demographic groups of men and comparing their viewpoints.

Due to the nature of the topic it is possible that participants who chose to take part were subject to selection bias and therefore held specific views about male mental health or psychological therapy. Only 51% of the sample disclosed having considered psychological therapy and it is possible that may have affected our results. Gaining the viewpoints of men who had not accessed psychological therapy was an important aspect of the study as it allowed for examination of viewpoints from men who had sought psychological therapy but not been able to access it. No information was collected regarding participant's experiences of mental health and it is possible that some participants had not experienced difficulties which may have influenced their viewpoints. Some participants volunteered this information within the post-sorting questionnaire, but further understanding of participant's current or previous difficulties with psychological well-being would have strengthened the analysis. This suggests a diversity of experiences within the participant group that may have implications for the results of the study. For example, men who have sought therapy but could not access it may have differing viewpoints to those who have never considered seeking help for their mental health. Further research could examine the differences between subgroups of men by gathering this information using a measure of mood or asking for men's experiences during the demographic pre-sorting questionnaire.

Unlike other surveys, Q methodology allows for holistic examination of feelings and opinions surrounding a topic and identifies common viewpoints which are represented by factors (Brouwer, 1999). Enabling communication of subjectivity operantly, means it can be systematically analysed (Stephenson, 1953). Attitudes have been found to influence behaviour and therefore results from the study provide important information that may have implications for service design (Abrams, 2016). Results from Q-studies aim to reveal specific viewpoints within the sample and are therefore, not able to be generalised to the wider population (Watts & Stenner, 2014). However, the identification of one dominant factor in the second-order analysis suggests that promoting feelings of safety in the relationship and managing expectations of treatment would be important factors for therapists to consider when conducting treatment with men. The study provides an essential insight into the viewpoints of men on factors of importance in

psychological therapy and helps to generate new hypotheses and ideas for future research.

2.4.7 Future Research

The current study has generated various findings which would benefit from further research. Having revealed that there were some common viewpoints within recommendations by Seidler et al. (2018) that would be important to them if they were to engage in therapy, examining these with a wider group of men would be beneficial. A longitudinal study could examine whether factors would differ for men following engagement in therapy. Additionally, it would be important to establish if findings from this study could be used to support men to understand what to expect from psychological therapy in order to promote positive attitudes towards, and consequently engagement in, psychological therapy (DeBate et al., 2018).

The post-sorting questionnaires allow for important information gathering of reasoning and rationale for sorting decisions which is crucial for factor interpretations. Unfortunately, some participants in the current study chose not to give reasons for their sorting decisions. Replication of the study face-to-face may allow for a richer understanding of viewpoints however, previous findings suggest that online Q-sorts produce similar results to those completed face-to-face (Reber et al., 2000). The Q-set aimed to be representative of the concourse and research has suggested that representative Q-sets containing different items will likely agree on similar viewpoints (Thomas & Baas, 1992). Participants were asked to identify further items they felt should have been included within the Q-set. Participants suggested that many of the issues with accessing psychological therapy were related to socioeconomic factors, knowledge and availability of therapy and others not understanding their difficulties. Participants described not being 'taken seriously' by friends, family and healthcare professionals. Two participants described having tried to access therapy but being prescribed medication instead. Others spoke about not knowing how to access help or what to expect from therapy, suggesting that more information (e.g. how to access therapy, what form it would take, examples etc.), increased awareness and prioritisation of mental health support would all be of benefit. It is crucial that further research aims to examine whether campaigns and interventions focusing on these factors will support men to

access help more easily. Given literature suggests men have difficulties understanding their emotional difficulties and asking for help it seems vital that support is more readily available, and that men, services and society have an improved understanding of men's mental health difficulties.

One participant suggested that the Q-set needed to include factors associated with initial access to psychological services and another commented on availability of therapy in the NHS being a factor preventing them from accessing support before. Whilst making use of the recommendations developed by Seidler et al. (2018) was a strength of the

study, they were intended to relate to factors that attract and retain men in psychological therapy. Three participants expressed frustrations at the lack of NHS resource and 'ridiculous' wait times to access psychological therapy that became a barrier for them. Further research understanding how men access and initially engage in psychological therapy would provide a useful addition to the current study. Helping to prevent ambivalence, drop out and disengagement would have important implications for services and the associated economic impact these have (Pederson & Vogel, 2007).

2.4.8 Conclusions

The current study aimed to understand what factors would be important to men if they were considering engaging in psychological therapy using Q methodology. The analysis identified three statistically significant factors, which illustrate viewpoints that men have regarding factors of perceived importance in psychological therapy. Whilst the findings are not able to be generalised to larger populations of men, they provide crucial insight into men's views on psychological therapy, consideration of which is essential for development of effective and meaningful services (Steen, Manschot & De Koning, 2011). The viewpoints can be understood within the context of previous findings and identify areas for further exploration. Examining whether viewpoints are similar across wider samples of men would be beneficial. In addition to this, examining viewpoints of clinicians working with men and men who have accessed psychological therapy before would provide a useful comparison. The findings could help inform promotion of mental health services by improving information and therefore, men's expectations of psychological therapy.

Appendix A Ethical Approval

ERGO II – Ethics and Research Governance Online https://www.ergo2.soton.ac.uk

Submission ID: 48207.A2
Submission Title: Engaging Men in Psychological Therapy (Amendment 2)
Submitter Name: Isabelle Cullis

Your submission has now been approved by the Faculty Ethics Committee. You can begin your research unless you are still awaiting any other reviews or conditions of your approval.

Comments:

-

Click here to view the submission

TId: 23011_Email_to_submitter___Approval_from_Faculty_Ethics_committee__cat_B___C_ Id: 198677

I.L.Cullis@soton.ac.uk coordinator

Appendix B Participant Information

Participant Information Sheet

Study Title: Engaging Men in Psychological Therapy
Researcher: Isabelle Cullis
ERGO number: 48207

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to tick a box at the end of this page to confirm you consent to participate.

What is the research about?

The researcher is a Trainee Clinical Psychologist and this research will be completed as part of Clinical Psychology Doctorate Training at the University of Southampton.
In 2017, there were 5821 suicides recorded in the UK and men made up 75% of these. UK male suicide rates are the lowest in 30 years however, men remain three times more likely than woman to take their own lives and suicide continues to be the leading cause of death in men under 45 (National Statistics, 2018). Despite these figures, previous research has shown that men are less likely than women to seek professional help for mental health problems. This study aims to understand what factors are important to men when considering psychological therapy. The results of the study could help to inform services in order to improve access for men and better meet their needs.

Why have I been asked to participate?

You have volunteered to participate in this research. We are aiming to seek the viewpoint of a diverse sample of men (or those who identify their sex as male) to take part in the research.

What will happen to me if I take part?

If you would like to take part in the research, please:

1. Read through the information available on this sheet
2. If you would like to take part please give your consent by ticking the box at the end of this form
3. Once you have consented to taking part you will be asked to complete an initial screening questionnaire which will ask for brief demographic information (age, ethnicity, sexuality, religious beliefs)
4. If you are eligible for the study you will then be directed to a link to the main research task. Please note this task may take you up to an hour to complete so it is important you set aside a sufficient amount of time.
5. The task requires you to read a series of statements and sort the value of each statement (in order of importance) based on your opinion and beliefs.
6. Once you have completed the task you will be asked to complete a brief post sorting questionnaire
7. Once you have completed the study you will be shown a debrief sheet which will include contact details for the researcher and you may request further information from them if you would like.
8. Upon completion you will be offered the chance to enter the prize draw.

Are there any benefits in my taking part?

By taking part you have the opportunity to enter into a prize draw for the chance to win a £200 amazon voucher.

This study aims to better understand the factors that are important to men when considering psychological therapy. The results will be utilised to contribute to our understanding in this area and may help to inform psychological services in order to better support men.

Are there any risks involved?

It is not anticipated that there will be any risks to you taking part in the study. Please only provide information that you are happy to provide. The research will ask you about the factors that would be important to you if you were considering accessing psychological support. If you are experiencing any difficulties that are having an impact on your mood and ability to function then it is important to visit your GP. Alternatively you can access support through the below organisations:

CALM, Campaign Against Living Miserably
Call: 0800 58 58 58
Find help online:
https://www.thecalmzone.net/

Mind, the mental health charity
Call: 0300 123 3393 or text: 86463
Find help online:
https://www.mind.org.uk/information-support/helplines/

Samaritans
Call: 116 123
Find help online:
https://www.samaritans.org/how-we-can-help/contact-samaritan/

Should you have any questions at any stages of the research please do not hesitate to contact the researchers.

What data will be collected?
If you consent to taking part in the study you will be asked to complete an initial online screening question which will ask for basic demographic information (age, ethnicity, sexuality) and whether or not you have accessed psychological treatment before.

If you are eligible for the research a link will appear to the FlashQ-sorting task. The task will ask you to sort a series of statements in order of importance based on your opinion and beliefs. This task will not ask you for any personal information. Electronic data will be stored on a password-protected university computer. Only the research team and regulatory authorities (for monitoring the quality of the research) will have access to the data. Once the study has ended, the documents will be archived for 10 years in a locked place which only people involved in the study can unlock, they will then be disposed of securely.

If you are not eligible for the research your data will not be kept and will be disposed of securely.

If you wish to take part in the prize draw we will require some personal contact details (e.g. email address). These details will **not** be linked to your task answers which will be non-identifiable. Once the research is complete these details will be destroyed.

Will my participation be confidential?
Your participation and the information we collect about you during the course of the research will be kept strictly confidential. As this is an online study your participation will be anonymous and we do not require your name or personally identifiable details.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Electronic data will be stored on a password-protected university computer. Only the research team and regulatory authorities (for monitoring the quality of the research) will have access to the data. Once the study has ended, the documents will be archived for 10 years in a locked place which only people involved in the study can unlock, they will then disposed of securely.

Do I have to take part?

No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to tick the consent box at the end of this page to show you have agreed to take part.

What happens if I change my mind?

You have the right to change your mind and withdraw at any time without giving a reason and without your participant rights being affected. However, as participation in this study is anonymous then data cannot be removed once you have submitted the questionnaire.

What will happen to the results of the research?

Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent.

Electronic data will be stored on a password-protected university computer. Only the research team and regulatory authorities (for monitoring the quality of the research) will have access to the data. Once the study has ended, the documents will be archived for 10 years in a locked place which only people involved in the study can unlock, they will then be disposed of securely.

Findings will be used to further understand the factors that help facilitate the engagement of men in psychological therapy. The results of the research will be written up into a research paper and it is the intention of the researcher for this to be published. The research may help to inform NHS and third sector services provide better support for men who need psychological help.

Should you like to have information about this research project when it has been completed then you may contact the researcher via email: i.l.cullis@soton.ac.uk
In the unlikely event that you have any concern or complaints with the participation, you can contact the University of Southampton's Research Governance Office at Rgoinfo@soton.ac.uk.

Where can I get more information?

If you have any questions or want to know more, you can contact:
Isabelle Cullis
Trainee Clinical Psychologist
Email: i.l.cullis@soton.ac.uk

What happens if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions.
If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the

public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.
Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at
http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

The study requires the use of an online survey through FlashQ. The data is submitted to the web server, which either creates an e-mail or writes the data directly to a database or text-file. This data will be anonymous as the survey will not ask you to include your name or any personally identifiable details.

Thank you for taking the time to read the information sheet and considering taking part in the research

☐ Please tick (check) this box to indicate that you consent to taking part in this survey.

Appendix C Participant Debrief Information

Understanding the Factors which Facilitate the Engagement of Men in Psychological Therapy
Written Debriefing Statement (001, 01/04/2019)
ERGO ID: 48207

The aim of this research aimed to understand what factors are important to men when considering engaging in psychological therapy.
Your data will help our understanding of what factors men would feel are important in order to inform services and enable better access for men who need support. Once again results of this study will not include your name or any other identifying characteristics. The research did not use deception. You may have a summary of the full research study at point of completion if you wish.
If you have any further questions please contact me:
Isabelle Cullis
Trainee Clinical Psychologist
Email: i.l.cullis@soton.ac.uk

Thank you for your participation in this research.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

If you are experiencing any difficulties that are having an impact on your mood and ability to function then it is important to visit your GP. Alternatively you can access support through the below organisations:

CALM, Campaign Against Living Miserably
Call: 0800 58 58 58
Find help online:
https://www.thecalmzone.net/

Mind, the mental health charity
Call: 0300 123 3393 or text: 86463
Find help online:
https://www.mind.org.uk/information-support/helplines/

Samaritans
Call: 116 123
Find help online:
https://www.samaritans.org/how-we-can-help/contact-samaritan/

Appendix D Pilot Study Advert

University of Southampton
School of Psychology

Are you interested in men's mental health?
Would you consider taking part in a study about engaging men in psychological therapy?

Participants must be:

- Male
- Over the age of 18
- Have **not** engaged in psychological therapy before

If you want to participate, you will be asked to complete a brief screening questionnaire. If you are eligible for the study you will be invited to meet the researcher and conduct a sorting task which is expected to take an hour.

You will receive a £10 amazon voucher to thank you for your participation in the study.

Please note participation in this study **could** take up to two hours and will require you to visit the University of Southampton.

Contact Information
To take part in the study or if want to know more, you can contact:
Isabelle Cullis
Trainee Clinical Psychologist
Email: i.l.cullis@soton.ac.uk

Appendix E Q-set

1	The therapist considers childhood & upbringing how these affect beliefs about being a man and any current stress
2	The therapist considers sexuality and any issues if relevant (e.g. performance, power, porn)
3	The therapist considers how different men might describe masculinity
4	The therapist considers importance of work life
5	The therapist considers how being a man may be contributing to any discomfort or shame around
6	The therapist considers you as an individual and the client's experience and expression of what it is like to be a man
7	The therapist considers emotions like rage, guilt, grief and fear
8	The therapist considers the client's thoughts around what it is like to be a man
9	The therapist considers the role of being a man and the pressure that may place on someone.
10	The therapist considers their own views on men and is aware of how that might affect their thoughts
11	The therapist recognises their own gender and how that might affect the relationship with the client
12	The therapist provides a clear plan for treatment that works towards the client's goals
13	The therapist works with the client to agree a plan for treatment, skills practice, feedback and ways of checking progress
14	The therapist helps the client work towards small goals as stepping-stones towards long term progress
15	The therapist links back to earlier sessions to help you see your progress
16	The therapist ensures that the client is clear on the route of treatment, for example, the different parts of treatment and choices the client has
17	The therapist discusses expectations of roles (what the client can expect from the therapist, what the therapist can expect from the client and who is responsible for what)
18	The therapist discusses the expectations of treatment (expected progress, any rules/boundaries)
19	The therapist discusses the reasons for treatment and what happens in therapy
20	The therapist explores expectations for the treatment to promote the client looking after themselves and learning to manage their emotions
21	The therapist identifies the client's strengths and uses them in treatment
22	The therapist is encouraging
23	The therapist will be accepting and supportive of the client as they are (does not judge the client)
24	The therapist helps the client realise their experiences are understandable based on what they've been through
25	The therapist is honest
26	The therapist tells the client a little about themselves and their experiences where appropriate
27	The therapist avoids challenging traditional male behaviours such as awkwardness or difficulty expressing emotions

28	The therapist explores and considers the strengths of what it is like to be a man through treatment
29	The therapist accepts the client as he is and does not rush them
30	The therapist aims to understand the client's difficulties and accepts any doubts they have
31	The relationship between the client and therapist is equal and reciprocal (power, control and decisions are shared)
32	The therapist will support the client emotionally
33	The relationship with the therapist will be collaborative (the client and the therapist work in partnership and the therapist does not tell the client what to do)
34	The therapist makes it clear they believe the client is the expert on their life and are responsible for change
35	The therapist aims to help the client feel stronger, more confident and in control
36	The therapist stresses that the client should value their own needs
37	The therapist makes it clear the relationship will be confidential
38	The therapist adapts language and communication style for male clients (uses language that respects what it is like to be a man)
39	The therapist uses positive and action focused language (e.g. moving forward, picking up tools)
40	The therapist describes the treatment process using appropriate language that the client understands (e.g. does not use jargon)
41	The therapist puts an emphasis on hard work and moving forward in life
42	The therapist uses appropriate humour e.g. jokes
43	The therapist uses brief and specific communication
44	The therapist engages in informal conversation and uses informal language when appropriate (e.g. swearing)
45	The therapist uses gestures and body language in their communication

Appendix F Study Advert

University of Southampton
School of Psychology

Are you interested in men's mental health?
Would you consider taking part in a study about engaging men in psychological therapy?

Participants must be:

- Male
- Over the age of 18
- Have **not** engaged in psychological therapy before

If you want to participate, you will be asked to complete a brief screening questionnaire. If you are eligible for the study you will then be asked to complete an online sorting task questionnaire which is expected to take an hour.

By taking part you have the opportunity to enter into a prize draw for the chance to win a £200 amazon voucher.

Contact Information

To take part in the study or if want to know more, you can contact:
Isabelle Cullis
Trainee Clinical Psychologist
Email: i.l.cullis@soton.ac.uk

Appendix G Study Poster

UNIVERSITY OF Southampton

Are you male, above the age of 18 and interested in men's psychological well-being?

Would you consider taking part in a study about improving access to psychological therapy for men?

If you want to participate, you will be asked to complete a brief screening questionnaire. You will then be asked to complete an online sorting task questionnaire which is expected to take up to an hour.

Responses will be anonymous

By taking part you have the opportunity to enter into a prize draw for the chance to win a £200 amazon voucher

https://www.isurvey.soton.ac.uk/33658

Please be aware that unfortunately the sorting task programme is only compatible with web browsers that allow Adobe Flash Player and will not work on a phone

If you do not have access to the internet and would like to take part in the study please telephone the research team on:

07xxxxxxxxx

Please be aware you will need to be able to travel to the University of Southampton campus.

Participants must be:

- Male
- Over the age of 18
- Have not accessed psychological therapy before

Contact Information:

If you have any questions, please contact:

Isabelle Cullis

Trainee Clinical Psychologist

Email: i.l.cullis@soton.ac.uk

Ethics number: 48207

Version 001

Appendix H Pre-Sorting Questionnaire: Demographic Information

What is your age?
What is your ethnicity?
How would you define your sexuality?
Do you hold religious beliefs? (If yes, please state what religion)
What is your highest level of education?
What is your current employment status?

Appendix I Post Sorting Questionnaire

Please explain why you agree most or disagree most with the following statements you have placed below	
"+4"	
"+4"	
"+4"	
"-4"	
"-4"	
"-4"	
Are there any additional items that you think should have been included in the Q sort? e.g.other statements relating to improving access to psychological therapy for men)	
Do you have any comments on supporting men to access psychological therapy or this study in particular?	
Is there anything else that you think would be useful to share?	

Appendix J First Order Analysis

Table 9 Group One Correlational Matrix

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
2	100	15	16	22	26	32	-14	21	-5	16	8	16	27	15	1	-9	7	-1	16	-3	33	28	11	15
5	15	100	37	39	31	13	45	17	18	34	35	34	9	47	24	13	36	26	8	20	46	31	-13	37
8	16	37	100	44	42	37	39	55	14	35	36	45	16	69	49	14	43	28	-19	30	53	38	8	43
10	22	39	44	100	41	33	21	32	8	34	19	25	21	35	8	-12	21	11	-8	-6	38	26	8	22
17	26	31	42	41	100	14	42	17	-8	18	13	40	23	61	39	19	38	3	-29	9	32	36	7	36
18	32	13	37	33	14	100	1	38	8	2	36	36	3	32	19	10	26	16	-18	8	33	11	-2	28
19	-14	45	39	21	42	1	100	5	20	8	16	25	3	53	26	6	49	32	-11	26	43	8	-5	30
21	21	17	55	32	17	38	5	100	-22	23	32	31	43	45	8	0	25	17	-24	9	38	18	18	22
22	-5	18	14	8	-8	8	20	-22	100	19	3	-16	-12	12	4	9	22	21	-11	10	7	-8	-6	-16
23	16	34	35	34	18	2	8	23	19	100	16	13	16	20	11	-3	13	35	-8	16	18	2	24	18
24	8	35	36	19	13	36	16	32	3	16	100	34	7	37	25	1	17	27	-20	12	45	18	-13	36

26	16	34	45	25	40	36	25	31	-16	13	34	100	32	58	19	21	33	45	6	35	51	37	8	96
27	27	9	16	21	23	3	3	43	-12	16	7	32	100	26	11	-15	6	22	5	-11	28	28	25	27
28	15	47	69	35	61	32	53	45	12	20	37	58	26	100	32	14	59	34	-37	30	53	32	-4	56
31	1	24	49	8	39	19	26	8	4	11	25	19	11	32	100	21	47	5	2	8	22	35	8	15
35	-9	13	14	-12	19	10	6	0	9	-3	1	21	-15	14	21	100	19	16	3	5	18	18	6	14
37	7	36	43	21	38	26	49	25	22	13	17	33	6	59	47	19	100	30	-12	18	39	29	5	33
38	-1	26	28	11	3	16	32	17	21	35	27	45	22	34	5	16	30	100	-7	66	41	22	3	51
39	16	8	-19	-8	-29	-18	-11	-24	-11	-8	-20	6	5	-37	2	3	-12	-7	100	-3	22	37	29	9
40	-3	20	30	-6	0	-10	14	-10	10	15	7	-8	4	23	-6	4	29	3	-3	100	27	20	-2	40
42	33	46	53	38	32	33	43	38	7	18	45	51	28	53	22	18	39	41	22	27	100	67	14	53
43	28	31	38	26	36	11	8	18	-8	2	18	37	28	32	35	18	29	22	37	20	67	100	5	34
46	11	-13	8	8	7	-2	-5	18	-6	24	-13	8	25	-4	8	6	5	3	29	-2	14	5	100	11
47	15	37	43	22	36	28	30	22	-16	18	36	96	27	56	15	14	33	51	9	40	53	34	11	100

Table 10 Group One Unrotated Factor Matrix

Sorts	Factors							
	1	2	3	4	5	6	7	8
2	0.2851	0.5272	-0.1862	0.0434	0.1335	0.3118	-0.0244	0.3324
5	0.6028	-0.1552	0.0590	0.1585	0.2546	0.2293	-0.3339	0.0170
8	0.7771	-0.0847	-0.2184	0.0436	0.0450	-0.0190	0.2081	-0.1434
10	0.5064	0.1606	-0.4030	0.0450	0.3191	0.1185	-0.2243	0.1878
17	0.5965	-0.0225	-0.2665	0.3552	-0.1590	-0.3153	-0.2089	0.3142
18	0.4489	0.0729	-0.3028	-0.1883	-0.2190	0.4563	0.3534	0.2090
19	0.5268	-0.4661	0.0800	0.2030	0.0976	-0.2056	-0.3244	-0.1044
21	0.5182	0.2877	-0.4180	-0.3107	-0.0672	-0.1067	0.2322	-0.2911
22	0.0829	-0.5061	-0.0053	0.0934	0.5391	0.2661	0.1989	0.1220
23	0.3630	0.0022	-0.1205	-0.1987	0.6515	-0.1609	0.1191	0.1265
24	0.5049	-0.0814	-0.1338	-0.2466	-0.1540	0.3965	0.0069	-0.3272
26	0.7443	0.1764	0.2776	-0.2156	-0.3233	-0.1002	-0.0751	0.2304

27	0.3534	0.5262	-0.1280	-0.1136	0.1124	-0.3439	-0.1209	-0.2159
28	0.8304	-0.2183	-0.1930	-0.0041	-0.1401	-0.1483	-0.1006	0.0325
31	0.4462	-0.1214	-0.0550	0.5316	-0.1209	-0.0688	0.2924	-0.2990
35	0.2065	-0.1770	0.2751	0.3065	-0.2529	-0.0064	0.4885	0.3239
37	0.6169	-0.2966	-0.0311	0.3018	-0.0038	-0.0905	0.1390	-0.0531
38	0.5385	-0.2119	0.4427	-0.4595	0.2144	-0.0538	0.1101	-0.0353
39	-0.0977	0.5213	0.6162	0.3334	0.2168	0.1998	-0.0378	-0.0778
40	0.4040	-0.2895	0.4934	-0.3717	0.0547	-0.0489	0.0694	-0.0350
42	0.7731	0.2085	0.1972	0.0910	0.0825	0.2591	-0.0400	-0.1381
43	0.5492	0.3632	0.2841	0.3709	-0.0374	0.2066	-0.0471	-0.1874
46	0.0998	0.4428	0.0991	0.0893	0.3249	-0.4534	0.4354	0.0517
47	0.7309	0.1396	0.3589	-0.2523	-0.2480	-0.1128	-0.1357	0.2084
Eigenvalues	**6.6989**	**2.1847**	**1.9122**	**1.6442**	1.4992	1.3159	1.1913	0.9492

Table 11 Rotated Factor Matrix

	Factor Loadings		
	1	2	3
2	0.3217	**0.5275X**	-0.1106
5	**0.4337**	-0.0203	**0.4499X**
8	**0.7419X**	0.0288	0.3279
10	**0.6417X**	0.1767	-0.0404
17	**0.6308X**	0.0441	0.1660
18	**0.5366X**	0.1001	0.0238
19	**0.3714**	-0.3303	**0.5041X**
21	**0.6564X**	0.2983	-0.0789
22	0.0835	**-0.4717X**	0.1832
23	**0.3570X**	0.0500	0.1280
24	**0.4778X**	-0.0051	0.2262
26	**0.3942**	0.3680	**0.6094X**

27	0.3377	**0.5508X**	-0.0255
28	**0.7713X**	-0.0846	**0.4153**
31	**0.3838X**	-0.0401	0.2608
35	-0.0089	-0.0775	**0.3789X**
37	**0.5061X**	**0.1707**	**0.4292**
38	0.1427	-0.0142	**0.7143X**
39	**-0.4822**	**0.5998X**	0.2620
40	0.0092	-0.1055	**0.6923X**
42	**0.4664**	**0.3892**	**0.5577**
43	-0.2333	**0.5109X**	**0.4459**
46	0.0004	**0.4644X**	0.0144
47	0.3335	0.3454	**0.6722X**
% Explained Variance	20	10	15

NB. X indicates a defining sort. Bold type shows significant factor loadings > 0.38

Table 12 Group Two Correlation Matrix Between Sorts

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1	100	-13	37	37	13	65	32	50	39	32	33	51	49	12	40	45	51	29	36	-13	39	24	0
3	-13	100	8	5	-43	-16	-13	-38	1	5	-5	2	0	17	-6	6	-5	15	7	5	13	2	0
4	37	8	100	31	-8	33	26	22	26	45	45	37	40	23	8	35	52	35	34	13	46	23	7
6	37	5	31	100	14	20	16	21	31	7	29	28	31	45	5	26	41	16	27	-6	18	18	-26
7	13	-43	-8	14	100	8	20	45	7	1	-5	-9	17	5	2	-10	10	18	4	0	-8	5	6
9	65	-16	33	20	8	100	39	45	40	35	43	65	44	17	52	55	29	21	36	-10	60	26	-1
11	32	-13	26	16	20	39	100	26	24	37	16	42	21	2	24	33	28	18	23	14	29	16	16
12	50	-38	22	21	45	45	26	100	29	18	21	27	22	8	11	19	30	13	0	-10	19	19	3
13	39	1	26	31	7	40	24	29	100	36	39	60	32	36	17	39	54	48	20	10	42	21	15
14	32	5	45	7	1	35	37	18	36	100	23	51	35	6	24	27	35	50	45	15	37	9	8
15	33	-5	45	29	-5	43	16	21	39	23	100	35	23	45	43	36	43	13	25	7	59	34	21
16	51	2	37	28	-9	65	42	27	60	51	35	100	37	13	54	57	47	33	33	-8	45	15	4
20	49	0	40	31	17	44	21	22	32	35	23	37	100	20	28	29	50	32	39	4	46	5	-3

25	12	17	23	45	5	17	2	8	36	6	45	13	20	100	-8	35	53	16	13	23	9	23	23
29	40	-6	8	5	2	52	24	11	17	24	43	54	28	-8	100	22	16	15	35	-6	51	20	-1
30	45	6	35	26	-10	55	33	19	39	27	36	57	29	35	22	100	45	29	22	4	33	6	10
32	51	-5	52	41	10	29	28	30	54	35	43	47	50	53	16	45	100	51	22	29	32	24	32
33	29	15	35	16	18	21	18	13	48	50	13	33	32	16	15	29	51	100	41	3	21	6	29
34	36	7	34	27	4	36	23	0	20	45	25	33	39	13	35	22	22	41	100	-3	30	3	-14
36	-13	5	13	-6	0	-10	14	-10	10	15	7	-8	4	23	-6	4	29	3	-3	100	2	12	13
41	39	13	46	18	-8	60	29	19	42	37	59	45	46	9	51	33	32	21	40	2	100	47	12
44	24	2	23	18	5	26	16	19	21	9	34	15	5	23	20	6	24	6	3	12	47	100	26
45	0	0	7	-26	6	-1	16	3	15	8	21	4	-3	23	-1	10	32	29	-14	13	12	26	100

Table 13 Group Two Unrotated Factor Matrix

Sorts	Factors							
	1	2	3	4	5	6	7	8
1	0.7259	-0.3151	0.0312	-0.0573	-0.1481	-0.0737	-0.0683	-0.1273
3	-0.0261	0.6008	-0.4763	-0.1019	-0.0790	-0.0301	-0.1683	-0.1581

4	0.6252	0.2344	-0.0424	-0.0981	-0.0061	0.2445	0.1453	-0.4642
6	0.4570	0.0778	0.1579	-0.2814	-0.6465	0.1173	0.0150	-0.0316
7	0.1127	-0.4383	0.6360	-0.1863	0.1044	0.2777	-0.1537	0.2146
9	0.7500	-0.3605	-0.1530	0.1847	-0.0674	-0.1473	0.0686	0.0238
11	0.4945	-0.1974	0.0905	0.0060	0.3282	-0.0334	0.4261	-0.0829
12	0.4414	-0.4882	0.4810	0.0433	-0.0609	-0.0593	-0.0220	-0.2893
13	0.6671	0.1535	0.1405	-0.0614	0.0244	-0.2733	-0.1379	0.0922
14	0.5919	0.0441	-0.1890	-0.2663	0.4500	0.1181	0.1003	-0.1364
15	0.6281	0.1796	0.0021	0.4379	-0.2104	0.1111	-0.0324	0.1585
16	0.7575	-0.1247	-0.2481	-0.0098	0.0637	-0.3716	0.0753	0.0339
20	0.6182	-0.0686	-0.0364	-0.2863	-0.0704	0.2389	-0.0256	0.0843
25	0.3972	0.5496	0.3664	0.0152	-0.3922	-0.0652	-0.0108	0.2488
29	0.5042	-0.3225	-0.3921	0.3208	0.0875	0.0795	-0.0708	0.4349
30	0.6312	0.1009	-0.0702	-0.0313	-0.1060	-0.5003	0.2096	0.0253
32	0.7246	0.3222	0.3587	-0.1268	0.0090	-0.0543	0.0192	0.0416

33	0.5322	0.2117	0.0647	-0.4211	0.3999	-0.0190	-0.4224	0.0163
34	0.5213	-0.0387	-0.3645	-0.3443	0.0250	0.3804	-0.0881	0.2187
36	0.0775	0.4552	0.2532	0.0544	0.2662	0.2561	0.6012	0.2318
41	0.6967	0.0089	-0.3086	0.3766	0.0203	0.2730	-0.0784	-0.0766
44	0.3676	0.1267	0.1657	0.5914	-0.0562	0.3178	-0.1431	-0.2502
45	0.1641	0.3484	0.3597	0.3701	0.5166	-0.1800	-0.3094	0.0117
Eigenvalues	**6.8313**	**2.1097**	**6.8313**	**1.5693**	1.5042	1.1619	1.0205	0.8792

NB. Bold type shows factors that were extracted with Eigenvalues >1.00 and met Humphrey's Rule

Table 14Group Two Rotated Factor Matrix

	Factor Loadings			
	1	2	3	4
1	**0.5225**	-0.0442	0.3640	**0.4722**
3	0.1661	0.0876	**-0.7485X**	-0.0586
4	**0.5673X**	0.2444	-0.0730	0.2653

6	**0.5272X**	0.1382	0.1480	0.0107
7	0.1047	0.0172	**0.7746X**	-0.1811
9	**0.3839**	-0.0760	0.2627	**0.7264X**
11	0.3264	0.0391	0.2861	0.3191
12	0.1979	0.0670	**0.7524X**	0.2380
13	**0.5531X**	0.3186	0.1204	0.2648
14	**0.6274X**	-0.0433	-0.0564	0.2455
15	0.2103	**0.4500**	-0.0098	**0.6097X**
16	**0.5586**	-0.0476	0.0403	**0.5788X**
20	**0.6347X**	-0.0345	0.1341	0.2196
25	0.3578	**0.6808X**	-0.0296	-0.0431
29	0.1302	-0.1903	0.0185	**0.7492X**
30	**0.5078X**	0.1669	-0.0038	0.3588
32	**0.6561X**	**0.5440**	0.1769	0.1266
33	**0.6997X**	0.1372	0.0064	-0.0341

34	**0.6200X**	-0.2475	-0.1401	0.2436
36	0.0851	**0.4919X**	-0.1067	-0.1402
41	0.2870	0.1497	-0.1077	**0.7785X**
44	-0.0984	**0.5068**	0.0952	**0.5028**
45	-0.0780	**0.6287X**	0.0536	0. 1026
% Explained Variance	19	10	9	15

NB. X indicates a defining sort. Bold type shows significant factor loadings > 0.38

Appendix K Second Order Analysis

Table 15 Correlation Matrix Between Sorts

Sorts	1	2	3	4	5	6	7
1 Grp1 Ft1	100	12	54	76	34	21	71
2 Grp1 Ft2	12	100	15	9	25	35	0
3 Grp1 Ft3	54	15	100	63	8	19	48
4 Grp2 Ft4	76	9	63	100	27	11	57
5 Grp2 Ft5	34	25	8	27	100	1	13
6 Grp2 Ft6	21	35	19	11	1	100	17
7 Grp2 Ft7	71	0	48	57	13	17	100

Table 16 Unrotated Factor Matrix

Sorts	Factors						
	1	2	3	4	5	6	7
1 Grp1 Ft1	0.9013	-0.1105	0.0804	-0.1589	0.0959	-0.1810	0.3189
2 Grp1 Ft2	0.2499	0.8334	0.0631	0.3445	0.3436	-0.0478	-0.0102
3 Grp1 Ft3	0.7524	-0.0868	-0.2433	0.4548	-0.2651	0.2933	0.0640
4 Grp2 Ft4	0.8639	-0.1857	0.0723	0.1420	-0.1322	-0.3521	-0.2288
5 Grp2 Ft5	0.3733	0.2990	0.8148	-0.1848	-0.2040	0.1744	-0.0347
6 Grp2 Ft6	0.3185	0.6368	-0.5174	-0.3959	-0.2598	-0.0133	-0.0302
7 Grp2 Ft7	0.7821	-0.2523	-0.1368	-0.2718	0.3839	0.2528	-0.1442
Eigenvalues	**3.0397**	**1.3073**	**1.0252**	0.6356	0.4715	0.3395	0.1811

NB. Bold type shows factors that were extracted if they had Eigenvalues >1.00

Table 17 The Rotated Factor Matrix

	Factor Loadings		
Q Sorts	1	2	3
1 Grp1Ft1	**0.8727X**	0.0807	0.2510
2 Grp1Ft2	-0.0260	**0.7796X**	**0.3904**
3 Grp1Ft3	**0.7689X**	- 0.1907	0.0725
4 Grp2Ft1	**0.8613X**	0.0077	0.2100
5 Grp2Ft2	0.1507	0.0436	**0.9317X**
6 Grp2Ft3	0.1772	**0.8413X**	-0.1886
7 Grp2Ft4	**0.8327X**	0.0089	-0.0224
% Explained Variance	41	19	17

NB. X indicates a defining sort. Bold type shows significant factor loadings > 0.38

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