"Do They Chain Their Hands Up?": An Exploration of Young Men's Beliefs about Mental Health Services

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Young men tend to be less likely to seek help for mental distress due to barriers including beliefs about mental health services. However, little research examines beliefs of men who have not accessed services. In the present study, ten young men who had not utilised services participated in interviews regarding their beliefs about mental health treatment. Data were analysed with inductive thematic analysis within a social constructionist epistemology, resulting in five themes. Overall, participants expressed some trepidation about utilising services, and were aware that their knowledge was limited. Participants expressed a preference to fix problems independently, negative views about relying on prescription medication, and they likened talk-therapy to informal social support. Participants also acknowledged the limit of their beliefs, which were based on fictional depictions. It was concluded that better public education regarding treatment may reduce barriers to help-seeking.

Keywords: *Help-seeking, mental health services, young men, masculinity, New Zealand*

INTRODUCTION

Men typically demonstrate low rates of mental health service use (Pattyn et al., 2015; World Health Organization, 2002). This being the case despite higher rates of completed suicide for men compared to women indicating a significant need amongst men for such services (New Zealand Ministry of Health, 2016). Additionally, Clement et al. (2015) and Keown et al. (2016) found that young men in lower socio-economic groups experience high distress yet are among the least likely to seek help. Likewise, Lynch and colleagues (2018) noted that young men have particularly high suicide rates and low rates of help-seeking (relative to other groups) and found that young men experience many barriers to help-seeking.

Research has typically focussed on the notion of barriers as a key concept in understanding lower rates of health service utilisation amongst men. Barriers to help seeking may be classified as 'attitudinal,' referring to attitudes and beliefs, or 'structural,' relating to practical factors such as cost, distance, or time constraints (Andrade et al., 2014). Structural barriers have, unsurprisingly, been found to have a greater impact on rates of help-seeking among those unable to afford services, whereas attitudinal barriers affect men, irrespective of the degree to which they are impacted by structural barriers (Rice et al., 2018; Walker et al., 2015). The aim of the present study is on better understanding these attitudinal barriers.

Attitudes and beliefs are important concepts used by researchers in understanding mental health service utilisation amongst men (Yousaf et al., 2015). Understood in various ways, Fazio (1986) defines attitude as the "categorisation of an object along an evaluative dimension" (p. 214), with Petty (2018) further distinguishing attitudes, as comprising the emotional valence towards an object, from beliefs, as comprising statements – whether true or not – about the object. Attitudes and beliefs are seen to influence one another with substantial evidence linking attitudes to behaviours and vice versa – though this relationship is not perfectly predictive (Maio et al., 2018). Accordingly, men who hold negative attitudes towards mental health services, and who believe that services may be harmful or unhelpful, would be less likely to seek help.

Reviewing the literature, Yousaf et al. (2015) found that men's understanding of services, fear of diagnoses, and previous unhelpful experiences with service providers were barriers to help-seeking. Generally, research indicates that the public have a mixed understanding of talk therapy (Cramer, 1999), which would impact men's utilisation of services (McKelley & Rochlen, 2007; Rice et al., 2018). Specifically, Coles et al. (2010) found that some men expressed a general distrust of health services and were frustrated by the lack of appropriate services, whilst other studies indicate concerns about confidentiality (Gonzalez et al., 2005). Some men believed that pharmaceutical treatment was the only intervention available (House et al., 2018), with some believing that these drugs were dangerous and addictive (Lauber et al., 2005; Mirnezami et al., 2016).

Schultz (2005) argued that due to low rates of service use, public beliefs and attitudes towards specialist mental health services are often informed by popular media depictions, which tend to use extreme characterisations (Orchowski et al., 2006; Wedding 2017). Vogel, Gentile, and Kaplan (2008) found that people who reported watching more content relating to mental health services expressed greater fear and reduced confidence towards services. In contrast, men who *had* utilised services tended to endorse more positive views (Harris et al., 2016; Sierra et al., 2014). Considering New Zealand (NZ), men's mental health beliefs are also likely influenced by local

media with news reporting and campaigns impacting in ways not accounted for in overseas research. For example, Sir John Kirwan's campaign of normalising and educating men about depression has been influential (Wardell, 2013). NZ men's beliefs and attitudes would also be influenced by local cultural, family, and religious beliefs regarding mental health services (Lynch et al., 2018; Vogel et al., 2007).

Harding and Fox (2015) aimed to understand what men who had sought help believed were the key factors that enabled them to do so. Based on interviews with nine men, they found that prior to help-seeking, the men had been worried about services comprising "Freudian couches and personality changing drugs" (p. 457). Harding and Fox reported that all these men had previously had negative understandings of treatment and had felt relieved when actual treatment did not match their negative expectations.

Analysing interviews and focus groups of young men utilising a service in the North West of Ireland, Lynch et al. (2018) articulated several barriers to help seeking, including perceived and actual negative peer, community, and medical profession reactions, difficulty in articulating emotions and problems, a sense of compromised self-reliance and masculinity, the use of ineffective coping mechanisms (such as alcohol consumption), conservative religious norms, and an expectation of unsympathetic incomprehension from older generations.

Although the above studies provide useful insights, these participants' views were informed by the experience of service use. In contrast and focussing specifically on talk therapy and no other aspects of services, Midgley et al. (2016) interviewed young people about their beliefs of what this would entail and found that most participants did not know what might happen.

The above attitudes and beliefs can be usefully placed within a broader conceptual framework of gender and, more specifically, hegemonic masculinity. Separating the biological facticity of sex from the sociocultural embeddedness of gender, researchers have foregrounded the latter as a predominant factor in considering help seeking amongst, especially young, men (e.g., Cleary, 2012; Moller-Leimkuhler, 2002; Vogel et al., 2011). Research has indicated that men experience pressures to behave according to hegemonic masculine norms regardless of ethnic culture or other cultural categories (Ramaeker & Petrie, 2019; Tan et al., 2013).

Hegemonic masculinity refers to enduring gender-related power dynamics and behaviours typically privileging stereotypical masculine characteristics. These may include stoicism, an emphasis on self-control, and dominating those who exhibit stereotypical feminine traits such as openness and emotionality (Jewkes et al., 2015). Hegemonic masculinity; however, also needs to consider cultural variability. For example, Hamley and Le Grice (2021) claim that, prior to colonisation and allowing for cultural heterogeneity, Māori gender roles allowed for men in various roles to flexibly adopt both masculine and feminine behaviours. This contrasts with the rigidity associated with traditional western gender roles.

Hegemonic masculinity can thus be understood as preventing or delaying help-seeking, particularly for mental health concerns, as such behaviour is regarded as an incompatible feminine behaviour (Krumm et al., 2017). Seidler et al. (2016), for example, found that men who attempt to behave according to the dictates of hegemonic masculinity were less likely to seek help for depression. Although research has linked poorer mental health literacy and understanding of symptoms to delayed help-seeking irrespective of gender (Jorm, 2000, 2012), there is also evidence of a gender effect. Levant et al. (2009) found that alexithymia (i.e., an inability to articulate feelings) was associated with men who identified with hegemonic masculine values, suggesting that such men would have difficulty in articulating symptoms of mental distress. Accordingly, Swami (2012) found that men tend to have poorer understanding of common disorders such as depression. Interestingly, research indicates that men with poor mental health literacy also have a poor understanding of, and negative attitudes towards, associated services (Jorm, 2012), suggesting that even if symptoms are recognised, men may *choose* not to seek help. Thus, difficulty in recognising and articulating symptoms, and fear of stigma for experiencing mental distress or utilising services, are identified as barriers to help-seeking among men (Cleary, 2012; Clement et al., 2015).

The present study aims to address the question of what young men who have not accessed services believe such services entail and what factors act as barriers to such utilisation. Despite the relevance of attitudes and beliefs as a barrier to help-seeking being well established, further understanding is needed of what comprise men's attitudes and beliefs. Furthermore, since much of the extant literature have been quantitative studies (e.g., Coles et al., 2010; Furnham, 2009; Harris et al., 2016), further qualitative research is warranted in providing a more nuanced understanding of men's experiences and meaning making regarding services.

METHOD

Design

This study aimed to explore, using open-ended interview questions, men's beliefs and attitudes towards mental health services. An exploratory inductive, qualitative interview design was used.

The concepts formulated in this research were considered through a social constructionist epistemology. That is, data in this study were considered as products of time, place, and circumstance (Burr, 2015; Gergen, 1985). For example, the concept of 'attitudes' and 'beliefs' are viewed as being constructed in conversation and serving a social-contextual function. Furthermore, as Tuffin and Danks (1999) argue, the terms 'attitude' and belief' are used as pragmatic codes signalling the discussion of services and gender related issues, rather than as reified phenomena.

A 'reflexive' Thematic Analysis (TA) design based on Braun and colleagues' (2019) description was undertaken in this study as it theoretically aligns with the constructionist epistemology. Such a style acknowledges and embraces the author's own social context; at the time of collecting and analysing data, I was a 28-year-old urban based New Zealand European male, intern psychologist, and someone who had recovered from mental distress without accessing services. This reflexive design accepts

that inherent researcher subjectivity adds richness and context to the data (Braun et al., 2019).

Men's beliefs and attitudes regarding services were constructed in the context of semi-structured one-to-one interviews. Interviews were chosen to facilitate a flexible, iterative process of data generation.

Recruitment

This study was advertised via a custom-made Facebook page in January 2019. An advertisement was posted on a local public Facebook group with many members. The advertisement included the offering of a supermarket voucher thanks for the sharing of time and knowledge. Interested candidates contacted the researcher directly and were provided with the information sheet and consent forms.

Eligible participants included men between the ages of 18 and 30, who had not utilised mental health services and who were not working in or studying a mental health related field, as previous research has focussed on men who have accessed services (e.g. Harding & Fox, 2015). Whether participants had previously utilised services was based on their own definition of mental health services. It was recognised that young men may not have a clear definition of mental health services and therefore allowing participants to decide whether they had accessed services facilitated conversations regarding definitions of services and provided useful qualitative information. The age criteria were selected due to low rates of service use and growing suicide rates amongst young men (Keown et al., 2016; Lynch et al., 2018). Likewise, young men were selected, as previous research has indicated that young men are less likely to seek help than women, and more likely to minimise health issues than older men (Kessler et al., 1999; Moller-Leimkuhler 2002). There were no exclusion criteria relating to other demographic factors.

Table 1. Demographic descriptions of participants

Arjun was a 29-year-old straight Indian male, who was working as a head chef.
Timothy was a 21-year-old straight 'white' male, who was unemployed at the time of his interview.
Tane was a 20-year-old male of Maori, Indian, and European descent. Tane was planning to study to become a personal trainer at the time of interview.
Kris was a 19-year-old bi-sexual New Zealand European male, who was a student and a seasonal nature guide.
Simon was a 24-year-old gay New Zealand European male, who worked as a night auditor in a hotel.
Matt was a 28-year-old African male, who worked in hospitality.
Manish was a 28-year-old straight Indian male, who was a post-graduate university student, and previously worked in a bank.
Geoff was a 22-year-old straight European New Zealand male, who was a student and tutor at university.
Wiremu was a 26-year-old gay Maori European male, who worked as a regulation advisor.
Phil was a 26-year-old gay Samoan male, who worked as a policy analyst.
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Participants

Ten men who met inclusion criteria were interviewed. Although the focus was on gender, other aspects of participants' demographic details are recognised here. All participants identified as cisgender men and lived in the Wellington region of New Zealand Brief demographic descriptions of all participants, using their own words and pseudonym names, are provided in Table 1.

Data collection

Interviews followed a semi-structured schedule relating to understandings of mental health services; however, participants were encouraged to discuss topics of importance to them. Participants were asked what they believe mental health care in New Zealand involves, eliciting their understandings of types of services, and conversations around these services followed. Prompts included questions such as 'how effective is this form of treatment?' or 'how effective is this for men?' Participants were also asked whether anyone they know has ever experienced significant mental distress, and how they coped. If conversations arose about participants' own intentions or attitudes towards help-seeking and specific services, these topics were explored. Interviews ranged in duration between 26 and 53 minutes, with an average length of 39 minutes. Interviews were conducted in February 2019.

Interviews were conducted at a semi-private location of the interviewee's choice and agreed upon by the research team; nine interviews were conducted in private meeting rooms at university libraries, and one interview was conducted in a private meeting room in a government building. Interviews were digitally recorded and transcribed by the lead researcher/interviewer - a male, and trainee clinician at the time of data collection. Transcription followed an orthographic style, whereby the standard spelling of words was used. Data was not modified for grammatical sense or length to preserve the organic 'feel' of the discussion. This method of transcription was based on the recommendations of Braun and Clarke (2006; 2012), who noted that orthographic transcription that reflects the content of speech in a generally realistic and readable manner is adequate for TA.

Data Analysis

Reflexive Thematic Analysis (TA) was selected as the method for data analysis, due to its value in structured synthesis of data and generation of themes in relation to an open research question (Braun & Clarke, 2012). Data were analysed following Braun et al.'s (2019) six phases of thematic analysis: becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. This allowed for a clear, consistent, replicable methodological approach. In Reflexive TA, the primary researcher(s) inductively codes data. This method is unlike other forms of TA such as 'coding reliability,' in which inter-rater reliability is sought through enlisting

multiple coders. Braun argued that methods such as coding reliability seek to fit with quantitative methods and are less appropriate than reflexive TA in constructionist methodologies.

Familiarisation with the data commenced during interviews, as initial ideas were generated, and this step continued through into the next steps of data review and transcription, as possible relevant points were noted. The process of generating initial codes flowed through from familiarisation as shorthand codes were noted on transcripts. Initial codes labelled and begin to categorise data in an iterative process. Codes were also collated on a Microsoft Excel spreadsheet. Over all transcripts, 150 initial codes were generated during this process. The process of searching for, and reviewing themes, was also iterative. Initially codes were reviewed for similarities and grouped according to possible overarching themes. Data fitting within these initial themes was then collated and reviewed resulting in further refinement of thematic groupings until a coherent theme evidenced in the data was apparent to the researcher. During this process, several codes were elevated to tentative themes due to richness of data within some codes. Likewise, there were some interesting pieces of data that were not elevated to the level of theme or were omitted from the final report. Themes were then given tentative names, which were finalised during the report writing and as the theme was further defined. The most relevant and useful themes were identified and described in the report writing phase, and data were considered to represent dynamic and contextually bound constructions of meaning about services, rather than objective truths.

Ethical Considerations

This study was assessed through the Massey University research ethics process and deemed 'low-risk.' As a low-risk study, this research was subject to peer-review by a researcher not involved in this study prior to commencement.

Participants were provided with an information sheet and consent form explaining the purpose and scope of the research and freedom to withdraw at any time. Participants' mental health status was not discussed, as this study related to men who were not service users, and it was deemed outside of the scope of this study to assess mental health status. However, participants were also provided with a list of mental health services should they have concerns about their mental health. The interviewer was a trainee clinician under the supervision of a senior clinician, with whom all interviews were discussed. There was no expectation that participants would be at risk, as participants were from the general population, not a clinical population. Additionally, participants were informed that pseudonyms would be used to protect their privacy in the final report or publications and that all data would be securely stored.

To respect Treaty of Waitangi (Treaty) principles regarding engagement of Māori (New Zealand indigenous people) in research, Hudson and Russell's (2009) guidelines regarding Treaty principles were followed. Based on these guidelines, it was deemed essential that the study include participant(s) who identified as Māori. Additionally, this research was ethically assessed by a Māori researcher, allowing input into the research plan. Furthermore, Māori cultural values were included in the plan to engage with participants. Specifically, participants were offered an option to open and close the session in a way that would be most comfortable for them, and a karakia (blessing/transition) was offered. Additionally, shared kai (food) of biscuits was brought to each interview. Tangible benefits of this research to Māori may include better understanding of barriers to help-seeking in a New Zealand context, and possible improvements made based on the knowledge of these barriers.

ANALYSIS AND COMMENTARY

Analysis of the data resulted in identification of five themes: 1. *'This is all based off what I know from television.'* 2. '*So, it would be some form of social aspect to it.'*. 3. *'Maybe just deal with it yourself first.'* 4. '*You don't exactly know how to deal with coming off.'* 5. *'Cause they're the doctor, they know what's best for you.'*

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

Participants noted that their knowledge of mental health services was based on movies and television shows and they lacked alternative information sources. In the following extracts, participants discussed what they believe happens in inpatient mental health services:

> *(1) Phil: Um do they... uh... I'm just thinking (laughs) like scenes from movies like-*
>
> (2)
>
> *J: Yeah, no go ahead, like go ahead if that's what comes to mind -*
>
> *Phil: Do they lock them - you know like - chain their hands up or um do they put them in a room where there's like no knives or something like that - you know? (laughs)*
>
> (3)
>
> *(4) Arjun: (...) You know, um I don't - I - I don't think that screaming and shouting and being physical and aggressive and um you know - having some kind of traumatic experience is going to help a person in a situation like that. Um even though that person may be - you know - being wild and like - you have to understand they're not in the correct space uh mentally so... I - I don't think being very aggressive is - is and maybe that's just an assumption cause of movies but (hah) um I hope that's not the case in real life.*

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

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

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

Using what they had seen in film and television, participants described familiar scenes of a patient reclining in a therapist's office. Geoff framed his description of therapy as knowledge ('what I know') based on television (perhaps implicitly indicating limitations of the accuracy of this information). The impact of media on knowledge of services may be buffered by the recognition that media portrayals are often inaccurate. However, with a lack of alternative sources of information, it may be difficult to differentiate realistic portrayals from inaccurate ones.

'Maybe just deal with it yourself first'

Participants described their preference for assessing and 'dealing' with their own problems before, and in some cases instead of, seeking help. The following extract gets to the heart of the masculine need for control. Kris has been asked to clarify his view on seeking counselling:

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

Kris highlights what is perhaps a typical masculine ideal of being able to fix problems and 'move mountains,' evoking a powerful sense of autonomy. Interestingly, he also describes a level of pragmatism which aligns with hegemonic masculinity - doing what 'needs to be done' despite discomfort. That is, despite his preference to fix problems himself, Kris acknowledges that he would seek help if necessary, which softens the rigidity of his allegiance to independence yet maintains his adherence to masculine values. In the following extract, Tane explains how he believes someone with a mental health problem could get help:

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

For Tane, rather than accessing mental health services, the initial response to distress should be to attempt to assess what is causing the problem and then to fix the problem by changing habits and social groups. This response suggests controllability and agency in mental health. Redirecting his response to autonomous self-help, rather than explaining external help-seeking, may demonstrate the importance of independence. Notably, Tane stated that independent options should be attempted 'first' suggesting that external services may be acceptable if independent attempts fail.

When discussing talk-therapy, Manish explained his feelings on disclosing mental health problems:

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

Manish creates a hierarchy of steps which prioritises autonomously 'handling' the issue due to his discomfort in disclosing problems to others. Despite the context of discussing talk therapy, his next step would be to discuss the problems with his friends. Seeking professional services does not feature on his hierarchy and perhaps discussing the problem with friends deviates less from the imperative for autonomy than utilising professional services would.

'So, it would be some form of social aspect to it.'

When describing the process and benefits of talk-based therapy, participants tended to compare it to informal social support. Participants recognised the value of a confidential, safe space to talk; however, they also noted the limits of 'just talking:'

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

Timothy acknowledged the usefulness of talk-therapy among people who lack trustworthy confidants to whom they can talk. However, he also outlined the limitations of 'venting,' noting that some people need medication. This suggests a hierarchy of mental distress and appropriate treatment, in which medication may be necessary for more severe mental distress.

Matt also described a hierarchy of steps needed for mental health support, noting that talking to friends and family were the first steps. He went on to explain the triggers for seeking the next step – seeking talk therapy:

Matt: (…) If they (family) don't provide the environment for you to open up and get better then quickly seek the phone and then go from there. But if they provide an environment for you to open up and get help, then stay with them because you know they care and they - two ha- four hands is better than two hands. So, we have a support system and in mental health what you need most is a good support system to carry you through.

To Matt, the most important part in overcoming mental health problems was having a 'good support system,' which should be provided by family, but may

also be provided by professional services if family are not providing the right environment to open up. In a similar example, Tane explains what he imagines would happen in talk therapy:

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

Tane appears to position talking to family members about mental health problems as the preferred strategy and therapy as an alternate. Likewise, for him it seems talk therapy adds value through providing a safe space to expose vulnerability when talking to friends or family appears too difficult or might make things worse. The fear of talking to family suggests a sense of self and expected stigma in exposing problems to family and could also allude to instances when the causes of problems are connected to family.

Although he avoids the comparison to family, Simon also points to the interactive social benefits of talk therapy when attempting to describe what he believes it involves:

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

Simon stated that a therapist would be helpful through their availability as a dedicated social support person. This description suggests that having someone available to talk to about day-to-day problems is useful to reduce mental health problems. Simon's description focuses on the social support provided by a therapist; however, he also alludes to the more formal aspects of the therapeutic relationship through mentioning the need to book another session.

'You don't exactly know how to deal with coming off'

Participants demonstrated a common set of beliefs that medication can lead to reliance. In this extract, Wiremu explains why he believes it is problematic for people to be inappropriately prescribed psychotropic medication:

Wiremu: Probably prescription medication, I know you can become quite hooked on it, but also if you're on something for anti-depressants and you go on it for a really long time and then you have to come off for it, you don't exactly know how to deal with coming off of it.

Wiremu: (...) Like you go on it and then you're on it for - say - six months and then you're like 'okay no,' you're done and you decide to come off it, you're probably not gunna exactly know how to handle like your emotions or the moods that you'll suddenly be going through because you've just been so mellow and numb for like the past couple of months. Like I think it would be quite a bad shock for you. But then flowing on from that, like you may just turn to other ways of trying to cope with that because you haven't dealt with your emotions over the past, say six months, because they've always just been like mellowed out, so you may just turn to other forms to try to cope with something - like alcohol or like other drugs or something, so...

In describing the problems associated with weaning oneself off psychotropic medication, Wiremu created a scenario of potential problems for someone who has been on medication: reliance and withdrawal. The scenario suggests seeking emotional numbing, and possible substance abuse issues.

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

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

Arjun described the sequelae of addiction, which could spiral into further complicating factors. He suggested that medication creates more problems for someone already struggling, which goes beyond other participants' suggestions that medication may result in reliance. Arjun also went to some effort not to equate weak with vulnerable, perhaps mitigating a negative gendered view of mental 'weakness' through his stress on a less negative 'vulnerable.'

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

Despite describing discomfort with prescription medication and admitting the need for help, participants valued expert knowledge and advice of professional mental health care providers. Timothy would listen to his doctor if he were offered a prescription though he previously stated he felt uncomfortable using psychotropic medication:

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

Timothy: Yeah. I mean yeah - I would take it. Like my kind of view on any sort of medication is like 'I'm not a doctor,' like this person has gone through X amount of years of training to get to this point and like I'm not going to sit there and go like 'No! I'm not going to trust your judgement here because I read something on Facebook and they said medication's bad' so I'm guna - yeah I'm guna

trust the person who's got the personal experience talking to me and the - you know - the expertise of their degrees and qualifications and that kind of stuff. Yeah over just the random noise (laughs) of the world.

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

Prior to the following exchanges, Wiremu and Manish were discussing how they would respond to being offered a prescription medication. Fitting with the 'You don't exactly know how to deal with coming off'' theme, both reported hesitancy; however, they softened that view by noting their trust in health professionals:

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

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

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

These examples demonstrate a trust of the doctor for these participants; Manish and Wiremu indicated that the doctor's decision overrides their own attitudes and the doctor knows what is best for them, despite other hesitancies. Manish does indicate some critical consumption of medical advice; however, this is sacrificed if under time pressure, in which case he would trust that the doctor has given him what he needs.

DISCUSSION

We sought to improve understanding of young men's beliefs and attitudes towards mental health services, with consideration to how these beliefs may affect help-seeking. Five themes were formulated suggesting complex beliefs and attitudes towards services. This research contributed to the literature by exploring an area that has previously not been well-researched: the beliefs of men who have not accessed services. Addressing men's beliefs when they have no lived experience of services adds understanding to the important area of barriers to help-seeking and provides a stronger foundation to address such attitudinal barriers. By conducting an explorative, inductive study, themes relating to this area were able to be formulated, without a reliance on existing hypotheses or deductive reasoning. This method was useful as it resulted in the generation of complex and rich data, allowing for more nuanced implications about the influences of knowledge, masculinity, and media on beliefs about services and possible impacts on help-seeking.

Sources of knowledge

Participants reported that their knowledge about services was limited, mostly being sourced from television and movies. This finding aligns with the theses of Orchowski et al. (2006) and Wedding (2017) who both argued that film and television impact attitudes towards services. Likewise, McKelley and Rochlen (2007) suggested that men are unlikely to engage with talk-therapy due to a deficit of knowledge of talk-therapy, which is filled by negative portrayals in the media. Additionally, participants' description of images of 'comfy couches,' aligns with Harding and Fox's (2015) finding that men expected therapy to involve couches and suggests that both groups of men were influenced by similar fictional depictions of mental health services.

The finding that these men relied on media depictions for their descriptions of mental health services suggests a fundamental deficit in mental health literacy – an issue that previous research has suggested presents an important barrier to help seeking (Jorm 2012; Levant et al., 2009); however, the men in this research were somewhat more circumspect in their discussion of services. That is, despite describing ostensibly fearful beliefs of services as 'physical, aggressive… having some kind of traumatic experience,' (Arjun's words) and having cautious beliefs about seeking help 'I personally just try to handle it myself,' (Manish's words) participants also noted that they would seek help if they needed to. Indeed; while beliefs around harmful services, addictive medication, and masculine ideals about addressing problems without help may act as barriers, beliefs that services are socially supportive and that men should trust in experts are likely facilitators to help-seeking.

This study goes further than previous research regarding the impact of popular media on beliefs, as this research suggested awareness by participants that film and television portrayals may be inaccurate. Yet, despite awareness of the limitations of media portrayals, participants drew upon these representations in their descriptions of services. It appears that in the absence of alternative, more realistic depictions of services to draw upon, media depictions fill the void of understanding as McKelley and Rochlen (2007) suggested. However, it is also important to note that the extreme negative portrayals of services, which participants described, may reflect legitimate fears of services relating to higher rates of involuntary and harmful services experienced by Māori men (Drown, Harding, and Marshall, 2018) rather than resulting simply from popular media depictions.

Masculine Attitudes towards help-seeking

Participants expressed a belief that services should be a final resort, and that they preferred to fix problems themselves first. This finding fits with literature regarding the impact of hegemonic masculinities on

help-seeking. That is, independence, control, and repressed emotionality are barriers that are incompatible with help-seeking (Cleary, 2012; Krum et al., 2017).

As well as expressing discomfort with the idea of seeking-help, participants expressed stoic pragmatism in their recognition that they would do what they must to improve their mental health. That is, participants noted that they might seek help, despite discomfort. This pragmatism also appears to reflect hegemonic masculine values – of taking control and enduring discomfort, but in a way that supports help-seeking. This finding challenges claims that hegemonic masculinity is inherently incompatible with help-seeking and adds nuance to understandings of the impacts of masculinity on help-seeking behaviours. A similar finding was reported by Ridge, Emslie, and White, (2011) who found that firefighters framed help-seeking as a masculine act of exerting control over their health.

Beliefs and attitudes towards specific services

Without lived experience of talk-therapy, participants likened it to informal social supports such as talking with family and friends. Participants suggested that the primary benefit of talk-therapy was the provision of a safe and trustworthy space to discuss problems, particularly when informal supports were not providing this space. The finding that participants expressed that talk-therapy comprises supportive talking aligns with findings of Midgley et al. (2016), who found that young people expected therapy to be a chance to talk about problems. Based on Māori models of healthcare, where the importance of relationships is central (Hamley & Le Grice, 2021), this construction of talk-therapy may suggest positive beliefs towards talk-therapy from some participants.

It appeared that participants generally held positive beliefs regarding talk-therapy, consistent with literature indicating that men who *had* used services endorsed positive beliefs (Sierra et al., 2014). However, beliefs in the present study were mediated by participants' opinions as to how effective social support/talking was for coping with mental distress. That is, some participants described limitations of 'just talking,' fitting with other research indicating that men prefer medication to talk-therapy (Harris et al., 2016). Therefore, beliefs that talk-therapy comprises supportive talking may be a facilitator, or barrier to help-seeking, dependent on other factors such as the man's beliefs about the importance of talking and relationships.

Participants expressed concern about reliance on prescription medication. This contrasts with some literature suggesting men prefer medication (Harris et al., 2016). However, the results are equivocal as other studies have suggested that men prefer non-medical options (Sierra et al., 2014) and likewise, that the public in general perceives medication as addictive and unhelpful (Mirnezami et al., 2016). Participants' concern about medication broadly aligns with Harding and Fox's (2015) findings that men were concerned about medication before seeking treatment. However, the articulation of concerns differed as men in this study discussed concerns regarding reliance on medication, whereas participants in Harding and Fox's study expressed concerns regarding the impact of medication on their personality.

It appeared that participants' disfavour of medication was contingent on the belief that medication leads to reliance and prevents long-term autonomous coping skills. Perhaps participants' preference to manage problems independently – likely connected to hegemonic masculine values of control and autonomy – relates to their preference not to use medication.

Participants expressed the belief that mental health professionals know better than laypeople, and that their advice should be trusted. In some instances, participants even noted that they would accept their doctor's advice when it goes against other beliefs they hold. This apparent discrepancy may reflect that negative attitudes can be attenuated by the normativeness of a situation (that is, it is *normal* to listen to a doctor), and that more credible sources of information (such as doctors) can have stronger effects on beliefs than less credible sources (Fazio, 1986; Maio et al., 2018). This finding presents an interesting conflict between situationally normative behaviours and broader hegemonic masculine behaviours. Pattyn et al. (2015) articulated this conflict by highlighting the strains of maintaining the role of both a masculine man and a patient. This finding again highlights the complexity of attempting to understand the impact of masculine roles on help-seeking.

Research Applications

Based on the findings of this study, improving education regarding mental health services is warranted. Previous research has shown that education campaigns targeted to men reduce barriers to help-seeking through improving attitudes towards services and reducing fear of stigma (Hammer & Vogel, 2010). Additionally, men have expressed that education regarding mental health and services would be useful (e.g., Harding & Fox, 2015; McKelley & Rochlen, 2007). Substantial research has found that health literacy can be a barrier to help-seeking (Oliffe et al., 2020), and this study suggests deficits in mental health literacy among young men. In addition, growing research indicates that educational programmes designed for men, and which relate to key issues may be effective in improving literacy and help-seeking (Oliffe et al., 2020). Therefore, the development (and evaluation) of programmes designed for young men, which address beliefs highlighted in this study (such as the belief that services involve coercive and forceful treatment, and that medication is addictive) may be an effective application of the findings of this study. Likewise, providing choice in treatment options appears to be important in facilitating help-seeking, as the young men in this study expressed various preferences and opinions.

Education campaigns regarding the content of services may address several topics based on this research. It may be useful to have short 'profile' type videos, in which service providers describe who they are and their role. This would serve to offer more alternative sources of information to film and television. These videos may also focus on specific barriers highlighted in this study – for example, a talk-therapist explaining what talk therapy involves, and how it goes beyond 'just

talking.' Likewise, a medication prescribing clinician may openly discuss the possible risks and benefits of medication, with a specific focus on the fear that medication leads to reliance. Additionally, it appears that each of these videos should focus on framing services as supporting people to be independent and giving them tools to manage their distress (to align with the preference to fix problems independently). Such education campaigns may be disseminated on television and social media, which have been shown as effective platforms for public health campaigns in international and New Zealand indigenous Māori contexts (Austin et al., 2015; Wilson et al., 2005).

Limitations and future research

Despite the demographic diversity in this study, it is possible that through voluntary participation, this study included young men interested in mental health. It may also have been useful to ensure participation of men who identified as transgender, in addition to cisgender men, to further increase the diversity of the participants. Likewise, it is possible that the process of discussing and articulating mental health services in interviews may have facilitated the construction of more nuanced, explicit beliefs towards services (like Tomm's (1987) notion that questions are never neutral). That is, the construction of beliefs in such a study as this are likely different to the construction of beliefs in other situations that may be more relevant to 'real life' help-seeking.

This study is premised on the inferred link between opinions of young men and their behaviours in relation to help-seeking. Although research does support such a link between attitudes and behaviours (Petty, 2018), it is well established that there are limitations to this link. It is also worth noting that some preferences expressed in this study, such as the preference to fix problems independently may reflect common, non-gendered, responses to health problems such as normalising of problems (Biddle et al., 2007), and avoidance of the time and cost commitment of utilising services (Andrade et al., 2014). Nevertheless, these preferences were expressed by young men and tended to reflect hegemonic pressures for independence and control.

Future research may build upon these findings by interviewing more specific groups of men, such as men who identified as experiencing mental distress but have not sought help and groups of men with cultures that value different models of healthcare. Such studies would allow for a more deductive exploration of beliefs that contributed to perceived barriers to help-seeking. Likewise, men living in areas of high deprivation may be interviewed similarly to the method used in the present study. Higher rates of deprivation have been found to have a negative impact on help-seeking (Keown et al., 2016); however, deprivation was not an inclusion criterion in the present study. Future research may also use more deductive questioning methods to explore specific 'myths' about services, based on the foundation of this, and other studies.

Conclusions

This qualitative exploratory study explored the beliefs and attitudes of young men who had never accessed mental health services. The findings indicate that these young men lacked information to form confident opinions of services and relied on various indirect and possibly unreliable sources, including popular media, to inform their opinions. Although they preferred to maintain their autonomy and control over their health decisions, several were still willing to seek treatment despite expressing such values. Furthermore, various non-gendered belief systems such as adhering to the doctor's advice and valuing a support network were apparent.

These findings indicate that service providers and governmental agencies need to go further in addressing attitudinal barriers to help-seeking amongst young men, while researchers may further explore the form and impact of the beliefs identified in this study. Although hegemonic masculine values inform beliefs and attitudes towards help-seeking, this study suggests greater level of nuance and complexity at work in these young men's considerations around service utilisation and provides hope that young men are critical consumers of knowledge and may be open to information that softens attitudinal barriers to help-seeking.

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