Beyond Men Behaving Badly:  
A Meta-Ethnography of Men’s Perspectives on Psychological Distress and Help Seeking

Men’s hesitancy to seek help for psychological distress is demonstrated in the quantitative literature. Men’s perspectives and experiences need to be better understood to inform policy and practice. A meta-ethnography was conducted of 51 qualitative studies on men’s perspectives on psychological distress and help seeking. Findings indicate most participants’ conceptualizations of psychological distress are socially-based and many have difficulty with the term “depression.” Men’s accounts show notions of masculinity negatively impact mental health and acts as a barrier to help seeking. Challenging the common characterization of men, men reveal the impact of interpersonal factors on mental health. Gender is revealed as a determinant of health that interacts with economic security, ethnicity and sexuality. Implications for policy and practice are discussed.

Keywords: men’s mental health, qualitative meta-ethnography, masculinities, lay perspectives on mental health, determinants of mental health

A growing body of research has established men are far less likely to seek both informal and formal help for mental health problems (Addis & Mahalik, 2003; Galdas, Cheater, & Marshall, 2005). The unmet need for mental health care and support among men is a significant public health matter. One possible result of the gendered nature of help seeking is the startling statistics that in Western countries men die by suicide three to four times the rate of women. (World Health Organization, 2002). The literature exploring the nature of men’s mental health and help seeking behaviour is small, relatively recent (the majority of publications are from within the past decade) and growing. Much of the men’s mental health research to date has been larger scale quantitative studies focusing on the impact of masculinity on health. This paper centers the less well trodden path taken in the men’s mental

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health research literature: research that incorporates men’s views on mental health; more specifically men’s perspectives, experiences and responses to psychological distress.

This paper describes a systematic review of the qualitative research literature related to men’s perspectives on psychological distress and help seeking. The review takes the form of the most common method of systematic qualitative review: a meta-ethnography (Noblit & Hare, 1988). The study is a synthesis of the findings from 51 journal articles that analyze men’s perspectives on psychological distress and help seeking. This articles aims to increase awareness, and generate knowledge and new concepts related to men’s mental health that are relevant to mental health practice, policy and theory and elucidate gaps in the qualitative men’s mental health literature.

LITERATURE REVIEW

Help seeking is viewed as an important health behavior for men because it is one of the least contested sex differences found in the psychological literature and it is argued that avoiding help seeking has detrimental health effects for men (Addis & Mahalik, 2003). For example, Houle, Mishara, and Chagnon (2008) found evidence that reduced help seeking behaviour is an important factor associated with the gender difference in suicide completion. The search for explanations for men’s reduced help seeking behaviour has been the focus of much of the men’s health research over the past decade. Psychosocial explanations and the concept of hegemonic masculinity are most often cited in the literature.

Psychosocial Explanations of Men’s Help Seeking

The decision to seek therapy is strongly associated with the tendency to express emotions (Vogel, Wade & Hackler, 2008). Women are more likely to recognize and label feelings of distress as emotional problems (Addis & Mahalik, 2003; Möller-Leimkühler, 2002). Cramer’s (1999) model shows that levels of self concealment impacts help seeking. In addition, Ciarrochi and Deane (2001) found that those who reported feeling less skilled at managing emotions were less willing to seek help from family and friends for emotional problems and suicide ideation, and also less willing to seek help from professionals for suicide ideation. The concept of emotional competence is important for managing distress and seeking support from others. Even as children, boys are less likely to share their emotions. A recent study (Rose et al., 2012) found that male children and teens were hesitant to express their feelings because it would feel “weird” or be a waste of time. The hypothesis then follows that males are socialized, from a young age, to be less expressive with their emotions and thus are less likely to seek help.

Masculinity and Help Seeking

Mahalik (2003) argues that while many people experience stigma associated with mental health difficulties, men experience a gender-specific stigma against help seeking: society is less apt to accept lack of emotional control and perceived weakness from a man than from a woman. Courtenay (2000) argues that like crime, health beliefs and behaviour can be understood as “demonstrating gender” and that “doing health is a form of doing gender” (Saltonstall, 1993, p. 12). A number of studies have demonstrated that acceptance of tradi-
tional notions of masculinity impact men’s attitudes, intentions and behaviour towards help seeking (Mahalik, Burns, & Syzdek, 2007; Mahalik, Lagan, & Morrison, 2006; Smith, Tran, & Thompson 2008).

Most research in the area of men’s help seeking and mental health services has focused on showing the correlation between the acceptance of the masculine gender role and help seeking behaviour. Specifically, the focus of much of the literature on men’s health and help seeking is the impact of hegemonic masculinity. Hegemonic masculinity is described as the idealized pattern of masculinity in patriarchal societies (Connell, 1995). Within this paradigm, men are positioned as naturally strong, resistant to disease, unresponsive to pain and physical distress, and unconcerned with minor symptoms. Hegemonic masculinity acts as a cultural barrier to expressing emotions and revealing pain or weakness, thereby reducing the likelihood that men would reveal vulnerabilities and ask for help.

Missing Voices: Men’s Perspectives on Mental Health and Help seeking

Research on men’s mental health focuses on documenting the correlation between the acceptance of traditional masculinity norms and poor health outcomes and behaviours such as reduced help seeking. Most studies employ quantitative methods and have theoretical explanations and interpretations based on professional perspectives (Whorley & Addis, 2007). Absent from the dominant literature are the perspectives of men themselves (Oliffe, 2006; Rochlen & Hoyer, 2005). Rochlen and Hoyer (2005) argue that the issue of male help seeking could be approached using a social marketing perspective that includes an in-depth understanding of how men perceive the “product” of psychological help. This is most effectively done through talking to a diversity of men about their perspectives and experiences related to mental health and help seeking. The main rationale for undertaking this meta-ethnography is a pragmatic one: if mental health services are to adequately reach and effectively meet the needs of men it is essential that the male perspective on mental health and help seeking be better understood. This study seeks to reveal the current state of the qualitative evidence on men’s perspectives on psychological distress and help seeking using meta-ethnographical methods.

METHOD

The Interpretative Lens

The meta-ethnographic method is informed by both post-positivist and social constructivist research paradigms. The post-positivism is evidenced in the influence of Grounded Theory in the systematic method of coding qualitative data that is explained below. An example of the social constructivist influence is evidenced through the contention from Noblit and Hare (1988) that researchers undertaking meta-ethnographic interpretation should make their theoretical frameworks and biases explicit to situate themselves in relation to the research area. Within social constructivist research it is often held that bias in social science research cannot be eliminated, however an important aspect of high quality qualitative research is that the researcher be conscious of their biases, preoccupations, and worldviews and reveal these to the reader (Shek, Tang, & Han, 2005). Within this framework, it is relevant then, that the interpreter of the 51 papers in this review is influenced by a social con-
Social constructivist theories of gender define gender as a process that happens through relations with the outside world, rather than a trait (Kimmel, 2000). Gender is not a thing that one has (gender role), rather it is a set of activities one does. Gender is understood as actively constructed in systems, involving the negotiation of power relationships. Social location (race, class, age, sexuality, etc.) is understood to inform, shape and modify our conception of gender. This perspective on gender rejects simplifying notions of gender and masculinity and an overly simplistic focus on the dangers of hegemonic masculinity. Rather the emphasis is on the multiplicity and situational nature of masculinity and how gender interacts with other factors to influence behaviours related to mental health.

The term psychological distress is used in this study because it is a broad term that captures negative affective states including depression and anxiety and does not necessarily imply a disease state. A Determinants of Health Framework with emphasis on the Social Determinants of Health (SDOH) underlies the perspective on mental health and the interpretations in this article. The SDOH framework recognizes that the primary determinants of individual and population health are the living conditions to which people are exposed and to which often function to shape our individual health behaviours (Marmot & Wilkinson, 2006). Thus, the 51 studies within this study are viewed through a prism which sees masculinity as one of a complex web of determinants that impacts men’s health and health-related behaviours.

A Qualitative Method for Systematic Reviews: The Meta-Ethnography

A systematic review uses a protocol that is developed apriori to guide the process. The method attempts to use research methodology to reduce biases evident in typical narrative style reviews. The resulting product can be used as a tool for measuring the current state of the academic knowledge. A systematic review aims to help the reader to make sense of what may feel like a mountain of information in a given area. Methods for qualitative systematic reviews are less developed than those of quantitative reviews (i.e., meta-analysis). One of the most common forms of systematically synthesizing qualitative research is the meta-ethnography (Noblit & Hare, 1988). The meta-ethnographical method is used for synthesizing many forms of qualitative research—not just ethnographies. Noblit and Hare (1988) define the approach as one that “enables a rigorous procedure for deriving substantive interpretations about any set of ethnographic or interpretive studies” (p. 9). The goal of the approach is to represent in reduced form, the complexity revealed through the qualitative research and achieve a greater degree of conceptual development and insight. The process requires induction and interpretation so that new concepts or new understandings emerge.

Three Stages of the Study

The study borrows from the detailed meta-ethnographic methods described by Malpass et al. 2009 (who borrowed from Britten et al., 2002; Noblit & Hare, 1988) in so far as the process involved three stages: (1) a systematic search; (2) a critical appraisal; (3) synthesis using techniques of meta-ethnography.
Stage One: Systematic Search

Formulating the research question. The original research question that guided the search was: *what does the qualitative research literature reveal about men’s perspectives and experiences of distress, coping, mental health issues and help seeking?* This question guided the search process that involved looking for studies employing qualitative methods, with men as participants that answered all or part of this question. Through the searching process the question was refined to reflect the literature available and to exclude certain studies in order to keep the number of studies analyzed to a manageable number. The final guiding definition for the meta-ethnography is: *the review will synthesize published qualitative journal articles whose main focus is on men’s perspectives or experiences of psychological distress and help seeking.*

Search strategy and data sources. The first step involved a systematic search of electronic databases including: MEDLINE, Web of Science, CINHAL, Social Science Scholar’s Portal, and Google Scholar. The search terms in Table 1 were combined using the logic term “and”. Keyword search terms included combinations (see Table 1) of: “men,” “mental health,” “qualitative,” “interview,” “coping,” “depression,” “stress,” “psychological distress” “help seeking,” “anger,” “suicide,” “lay perspectives,” “anxiety” “bipolar,” “counseling.” and “Aboriginal.” The search occurred from June 2010 and was not limited to an earlier time period, although most studies found were from the 2000s and very few studies were found dating before 1995. The second step involved scanning reference sections of the papers that best met the search criteria.

Inclusion and exclusion criteria. The database search produced 2461 study abstracts. The 2461 studies were screened using inclusion and exclusion criteria that were refined so that there resulted in three levels of screening. The first screening process involved skimming abstracts using the following inclusion/exclusion criteria: men as participants, mental health or coping as a focus of the study, and a qualitative methodology. This screen reduced the number of studies from 2414 to 229. The 229 studies were downloaded into a file and read in more detail. The second screening process involved removing duplicates and

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Key Search Terms Used</th>
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<tbody>
<tr>
<td>Men + mental health + qualitative</td>
<td>Men + psychological distress + qualitative</td>
</tr>
<tr>
<td>Men + depression + qualitative</td>
<td>Men + counselling + qualitative</td>
</tr>
<tr>
<td>Men + coping + qualitative</td>
<td>Men + mental health + interview</td>
</tr>
<tr>
<td>Men + stress + qualitative</td>
<td>Men + depression + interview</td>
</tr>
<tr>
<td>Men + Help seeking + qualitative</td>
<td>Men + coping + interview</td>
</tr>
<tr>
<td>Men + anger + qualitative</td>
<td>Men + stress + interview</td>
</tr>
<tr>
<td>Men + suicide + qualitative</td>
<td>Men + Help seeking + interview</td>
</tr>
<tr>
<td>Lay perspectives + mental health + qualitative</td>
<td>Men + anger + interview</td>
</tr>
<tr>
<td>Aboriginal + men + mental health</td>
<td>Men + suicide + interview</td>
</tr>
<tr>
<td>Men + anxiety + qualitative</td>
<td>Lay perspectives + mental health + interview</td>
</tr>
<tr>
<td>Men + bipolar + qualitative</td>
<td></td>
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</tbody>
</table>

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used the following inclusion/exclusion criteria to guide the screening: the methods are qualitative, the study’s relevance to the research question (a focus is on men’s perspectives or experiences of psychological distress, depression and help seeking) the extent the study captures men’s perspectives on mental health (the study could include women but must include a separate analysis for men and women), the extent to which the study is relevant to the topic of mental health, the study reflects an issue for which people commonly seek support or counselling (i.e., depression, distress, abuse, mental illness, relationship problems). This screen reduced the number of studies from 229 to 91.

A final screening process involved excluding studies that addressed more serious mental health issues such as schizophrenia, studies with institutionalized populations, and a significant subset of studies that focused on men’s experiences of sexual abuse. The sexual abuse studies were excluded at this stage because they were deemed to focus on a specific issue that was not the focus of this review. This screen reduced the 91 studies to 46. An additional 5 studies were found using the reference sections of the 46 papers and two were received via the studies’ author, resulting in a final sample of 51.

Stage Two: Critical Appraisal

There is currently no accepted way to exclude qualitative studies based on quality, as there is in quantitative approaches. However, there are a number of checklists available to generally assess quality of qualitative research. Barbour (2001) criticizes the uncritical adoption of qualitative research checklists as technical fixes, but concludes that checklists may be useful to improve rigour. In their meta-ethnography, Britten et al (2002) did not exclude studies based on quality but did assess quality using a checklist. The present study used a quality assessment to inform the process, not as a method to exclude studies. The 12-item checklist assessment of qualitative research used in this study was developed by Shek et al. (2005) for reviewing the quality of qualitative social work publications. The tool has 16 criteria considered as indicators of quality qualitative studies. Each of the 16 indicators were put in an Excel spreadsheet and the study received a 1 if the criterion was present (see Shek et al., 2005 for more detailed descriptions of criteria). On average, the studies scored a 7.6 out 16 on Shek et al.’s criteria. In comparison to the studies reviewed by Shek et al., this sample was of higher quality. The 51 studies in this sample were much higher in the areas of: justifying the nature of the participants (93% vs. 50%), providing a detailed procedure (70% vs. 46%), researcher triangulation (78% vs. 21%), including a detailed audit trail (53% vs. 18%) and documenting limitations (58% vs. 29%).

The second stage in critical appraisal involved assessing whether each study was a “key paper” using the method used by Malpass et al. (2009). A paper was evaluated as a “key paper” if it was conceptually rich and was viewed as potentially making an important contribution to the synthesis. Twenty-eight of the 51 studies were identified as “key papers” (asterisked in Table 2).

Stage three: Synthesis. The objective of a meta-ethnography is that the findings of each study are translated into one another to develop new concepts or form new interpretations of the literature. The process treats each original study as data. The specific procedures involved in the data analysis and synthesis in this study are described below.
Table 2
**Key Characteristics of the Review Studies Included in the Meta-Ethnography**

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Country</th>
<th>Sample Size by Gender</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>*1. Alston &amp; Kent</td>
<td>2008</td>
<td>Australia</td>
<td>25 farm men; 62 family members</td>
<td>interviews</td>
</tr>
<tr>
<td>2. Alviderez Snowden, &amp; Kaiser</td>
<td>2008</td>
<td>U.S.</td>
<td>20 men; 14 women</td>
<td>semi-structured interviews</td>
</tr>
<tr>
<td>3. Bennett, Smith, &amp; Hughes</td>
<td>2005</td>
<td>U.K.</td>
<td>46 men; 46 women</td>
<td>semi-structured interviews and surveys</td>
</tr>
<tr>
<td>4. Bergmans et al.</td>
<td>2009</td>
<td>Canada</td>
<td>25 men; 27 ER staff</td>
<td>semi-structured interviews</td>
</tr>
<tr>
<td>5. Bhattacharya</td>
<td>2008</td>
<td>U.S.</td>
<td>6 men</td>
<td>focus groups</td>
</tr>
<tr>
<td>6. Black &amp; Rubenstein</td>
<td>2004</td>
<td>U.S.</td>
<td>17 men; 17 women</td>
<td>interviews</td>
</tr>
<tr>
<td>7. Black &amp; Rubenstein</td>
<td>2009</td>
<td>U.S.</td>
<td>4 men</td>
<td>focus groups</td>
</tr>
<tr>
<td>*8. Brownhill, Wilhelm, Barclay,</td>
<td>2002</td>
<td>Australia</td>
<td>75 men; 25 women</td>
<td>focus groups</td>
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<tr>
<td>&amp; Parker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Brownhill, Wilhelm, Barclay,</td>
<td>2005</td>
<td>Australia</td>
<td>75 men; 25 women</td>
<td>focus groups</td>
</tr>
<tr>
<td>&amp; Schmied</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*10. Cabassa</td>
<td>2007</td>
<td>U.S.</td>
<td>56 men</td>
<td>interviews and surveys</td>
</tr>
<tr>
<td>*11. Chuick, Greenfield, Greenberg,</td>
<td>2009</td>
<td>U.S.</td>
<td>15 men</td>
<td>interviews</td>
</tr>
<tr>
<td>Sheppard, Cochran, &amp; Haley</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*12. Clarke &amp; Ameron</td>
<td>2008</td>
<td>Web-based</td>
<td>45 men; 45 women</td>
<td>content analysis</td>
</tr>
<tr>
<td>13. Daggett</td>
<td>2002</td>
<td>U.S.</td>
<td>8 men</td>
<td>interviews</td>
</tr>
<tr>
<td>14. Danielsson, Bengs, Lehti,</td>
<td>2009</td>
<td>Sweden</td>
<td>10 men; 10 women</td>
<td>interviews</td>
</tr>
<tr>
<td>Hammarström &amp; Johansson</td>
<td></td>
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<tr>
<td>*15. Danielsson &amp; Johansson</td>
<td>2005</td>
<td>Sweden</td>
<td>10 men; 8 women</td>
<td>interviews</td>
</tr>
<tr>
<td>*18. Fu &amp; Parahoo</td>
<td>2008</td>
<td>Taiwan</td>
<td>19 men; 21 women</td>
<td>interviews</td>
</tr>
<tr>
<td>19. Gryzywacz, Quandt, Arcury, &amp;</td>
<td>2005</td>
<td>U.S.</td>
<td>11 men; 11 women</td>
<td>in-depth and structured interviews</td>
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<tr>
<td>Marin</td>
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<td></td>
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<tr>
<td>Hess, Owens, &amp; Aitken</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>*23. Johansson, Bengs, Danielsson,</td>
<td>2009</td>
<td>Sweden</td>
<td>10 men; 10 women</td>
<td>metasynthesis of 3 data sources:</td>
</tr>
<tr>
<td>Lehti, &amp; Hammarström</td>
<td></td>
<td></td>
<td></td>
<td>interviews; media, research</td>
</tr>
<tr>
<td>*24. Kendrick, Anderson, &amp; Moore</td>
<td>2007</td>
<td>U.S.</td>
<td>28 men</td>
<td>interviews; informal group discussions, and participant observation</td>
</tr>
<tr>
<td>*26. Lackey</td>
<td>2008</td>
<td>U.S.</td>
<td>38 men</td>
<td>interviews</td>
</tr>
<tr>
<td>27. Leavey, Rozmovits, Ryan, &amp; King</td>
<td>2007</td>
<td>U.K.</td>
<td>19 men; 21 women</td>
<td>interviews</td>
</tr>
</tbody>
</table>

*Table 2 is continued on page 209*
Determining how the studies are related. To begin, each study was read closely. An Excel spreadsheet was created to summarize the findings from each study. The spreadsheet included what Noblit and Hare (1988) refer to as “First and Second Order Constructs.” Participant quotes are considered “First order Constructs” because they reflect the interpretation of an experience by the participant. “Second Order Constructs” are the themes identified by the original authors; they are the authors’ interpretations of the participants’ interpretations. Each of the 51 studies had a row in the spreadsheet. The author pasted columns that included themes identified by the authors identified (second order constructs) and columns for the supportive participant quotes (first order constructs). Columns were also created for additional important findings noted by authors. This process was mostly cut and paste directly from the electronic journal articles as the intention was to keep the voices of both the authors and the participants and to strive to preserve the uniqueness of each study (Noblit & Hare, 1988). This process felt similar to the process of transcribing data.
Translating studies into one another and synthesizing translations. There was a final column in the spreadsheet for the researcher’s personal reflections or reactions to each study. This column served as a collection of memos that were used to begin the process of translating studies into one another. The memoing process allowed for the creation of a list of key metaphors, phrase ideas or concepts from each study and initial assumptions about relations between the studies began to form.

The next step is similar to thematic coding. From the reading, cutting and pasting and the memos, common themes emerged from the “data.” These common themes were put into a second Excel spreadsheet. The themes, which are my interpretations of the authors’ interpretations, are referred to as “Third Order Constructs.” Each of the 51 studies in the first Excel file were reviewed and summaries of the relevant author themes and participant quotes were cut and pasted into the new Excel file that was made up of columns reflecting the themes or third order constructs I identified. Through this process, if a new theme emerged, it was added to the new spreadsheet and the studies were re-read for relevant support of the new theme. Finally, each of the columns of themes were cut and pasted into a Word document and sub-themes were extracted through coding by hand. The resulting themes and sub-themes are discussed in the Results section in this review.

Noblit and Hare’s (1988) process of looking for translations that are reciprocal, refutational, and line of argument influenced this stage of analysis. This involved comparing the studies in terms of what they shared in common (reciprocal), where they departed from one another (refutational), and where the studies, when analyzed together build an argument about men’s mental health. In the results section below, concepts and themes that emerged from the 51 studies are described.

RESULTS

Description of the Synthesis Papers

Fifty-one papers met the inclusion/exclusion criteria and the screening process. Table 2 shows the key characteristics of each of the 51 papers including: the author, year published, country setting, sample size and makeup, and method of data collection. The studies were published in English refereed journals dating from 1993-2010. Only 5 of the 51 studies were published prior to 2000. From the 51 papers, the total sample of participants is 1,964. Of these, 1,477 are men and 487 are women. Of the 51 papers, 31 (60.7%) had “male only” samples and the rest included men and women. Only the men’s responses were coded and used in this analysis, although where relevant, author interpretations that involved gender comparisons were included.

Theme 1: Men’s General Understanding of the Concept of Psychological Distress

When the doctor wrote “depression” on the sick-list certificate, I did not approve. “Burn-out” had been better; at least it sounds as if you have been burning. (participant, Johansson et al., 2009, p. 640)

The most common theme emerging from the studies was that many men are uncomfortable with the term depression. Men often prefer terms such as “stress,” “distress,” “burnout,” or “sadness” (Alston & Kent, 2008; Cabassa, 2007; Danielsson et al., 2009; Emslie et al.,
2007; Johansson et al., 2009; Kendrick et al., 2007; Lackey, 2008; O’Brien et al., 2005; O’Brien et al., 2007; Oliffe et al., 2010a; Smits, de Vries, & Beekaman, 2005). Even some men that had been diagnosed as depressed noted they were reluctant to use the term depression. Some men did not label their experience as depression or as a mental health concern, despite having identifiable symptoms.

The trouble with the term depression was a common finding, yet few studies explored this finding very deeply. Some studies found that men perceived the experience of distress and depression as “facts of life” and as normal reactions to life’s stressors, thus it may be troubling for these men to label a mood or experience understood this way as an illness. Most studies used or implied a dichotomous definition of depression but this illness conception was not as evident in men’s perspectives. In addition, some men spoke of not knowing what “depression” was so they were not so much reluctant but unable to identify or label their experience as depression or a mental health problem. For example, one participant notes that before his diagnosis, “I didn’t have a name for depression, I didn’t know what it was” (p. 48, Emslie et al., 2007).

The most common author interpretation of the negative reaction to the term depression was the finding that many men aligned depression or problems with emotional health with feminine qualities or personal weakness (Alvidrez, Snowden, & Kaiser, 2008; Brownhill et al., 2002; Danielsson & Johansson, 2005; Lackey, 2008; O’Brien et al., 2005; O’Brien et al., 2007; Oliffe et al., 2010a; Smits et al., 2005). Many male participants described depression as a female affliction. For these men, the symptoms of depression such as the emotional responses of sadness and vulnerability challenge the rationality, control and leadership that are expected by popular notions of masculinity. Depression is then viewed as an “unmanly” diagnosis. For example, in a study of male Mexican immigrants, a derogatory term for depression was “menopausic” (menopausal) as a put down for depressed men (Lackey, 2008). Rochlen et al. (2010) found that for some men in their study, the conception of happiness was not a natural masculine trait. Similarly participants in Kendrick et al.’s (2007) study said they “chalk it up to just a part of life rather than depression” (p. 70).

A less common explanation for men’s discomfort with the term depression was the notion of generalized (as opposed to related to masculinity) perception of stigma (Alvidrez et al., 2008; Brownhill et al., 2002; Chuick et al., 2009; O’Brien et al., 2007; Soonthornchaiya & Dancy, 2006; Vicary & Bishop, 2005). Some men spoke of fear of the label “crazy,” embarrassment, and that depression and mental health are stigmatized among their families and communities. It is important to note that this finding does not hold true for all men. Some studies also identified men both with and without a diagnosis who readily accepted or used the term depression (Brownhill et al., 2002; Clarke & Ameron, 2008).

Few studies sought to understand how men define positive mental or emotional health. Two studies (Ritchie, 1999; Watkins & Neighbors, 2007) found that men described positive emotional health as having sanity, function, control and discipline over one’s life.

**Theme 2: Perspectives on Causes of Distress: The Social Explanation Reigns**

There’s two areas that cause depression: work and family. Nothing seems to depress us as much. (participant from Brownhill et al., 2002)

Of the 51 papers, 38 (75%) mentioned or focused on men’s perspectives on the etiology of depression and distress. Of the 38 studies that discussed causation, only 5 noted cases
where men endorsed biological explanations. The social causes men discussed fell into four main areas. The most common explanations men had for their distress were structural such as financial concerns or working conditions such as poverty, unemployment, financial insecurity and stressful working conditions (Alston & Kent, 2008; Bhattacharya, 2008; Black & Rubenstein, 2004; Black & Rubenstein, 2009; Brownhill et al., 2002; Chuick et al., 2009; Danielsson, et al., 2009; Fu & Parahoo, 2008; Gryzywacsz, Quandt, Arcury, & Marin, 2005; Johansson et al., 2009; Lackey, 2008; O’Brien et al., 2005; Pottie, Brown, & Dunn, 2005; Soonthornchaiya & Dancy, 2006; Vicary & Bishop, 2005). Other structural causes discussed by men include discrimination and social exclusion (Black & Rubenstein, 2009; Kendrick et al., 2007; Lackey, 2008; McAndrew & Warne, 2010; Menzies, 2007; Robertson, 1998; Ross, Dobinson, & Eady, 2010).

The second most common explanation for men’s distress are interpersonal issues (Alston & Kent, 2008; Bennett, Smith, & Hughes, 2005; Bhattacharya, 2008; Black & Rubenstein, 2009; Brownhill et al., 2002; Cabassa, 2007; Chuick et al., 2009; Dagget, 2002; Fu & Parahoo, 2008; Leavey et al., 2007; Menzies, 2007; Robertson, 1998; Soonthornchaiya & Dancy, 2006; Umberson & Williams, 1993). Men spoke of social isolation, and loneliness, divorce or relationship break-up or death of a partner, and conflict in personal relationships as stressful experiences that caused great distress and experiences of depression. Although this was a common finding across many studies, most authors did not focus on these issues with the exception of a study that focused on men and experiences with divorce (Umberson & Williams, 1993).

Third, a number of studies men explicitly spoke of the stress associated with being a provider or failing to provide for their families (Alston & Kent, 2008; Cabassa, 2007; Danielsson & Johansson, 2005; Oliffe et al., 2010b; Ritchie, 1999; Simon, 1995; Vicary & Bishop, 2005). Oliffe et al. (2010b) refer to the economic and interpersonal roles of men as “masculine signifiers.” For example, perhaps financial hardship causes stress for men because of their pressure to provide for their family which is a traditional masculine ideal. Or perhaps men experience relationship loss as a challenge to their masculinity and thus are distressed because they have lost their role as husband and father.

Last, the impact of early childhood and family of origin issues was notable for its near absence from men’s accounts. Danielsson et al. (2009) similarly notes that men in their study were generally vague about childhood and preferred to focus on the stressors they experience in the “here and now.”

Theme 3: Symptoms and Experiences of Psychological Distress

… it’s like a pressure on my body, a pressure on my head … kind of a pounding headache throughout your whole body. Being driven into bed and not able to get out of bed, not wanting to get out of bed, not wanting to eat, not wanting to function. It’s kind of something forcing you into a fetal position, crushing you in from the outside. It doesn’t go away. It just gets worse. (participant from Heifner, 1997, p. 14)

Of the 51 studies, 33 (65%) discussed the symptoms and experiences of distress from men’s perspectives. Many of the symptoms described by men were similar to the DSM-IV or other commonly recognized symptoms of depression and anxiety such as feelings of
worthlessness, hopelessness, fatigue and sleep disturbance, sadness, worry, and suicide ideation (Bhattacharya, 2008; Black & Rubenstein, 2004; Brownhill et al., 2002; Brownhill et al., 2005; Chuick et al., 2009; Emslie et al., 2006; Lackey, 2008).

The most common symptoms discussed among the 51 studies though are those that are less commonly discussed in the depression literature: feeling lonely and alienated (Clarke & van Ameron, 2008; Kim & Roberts, 2004; Leavey et al., 2007; McAndrew & Warne, 2010; Pottie et al., 2005; Robertson, 1998; Rochlen et al., 2006) somatic complaints (chest pains, stomach problems, sinus problems and breathing difficulty), and anger (Brownhill et al., 2002; Brownhill et al., 2005; Daggett, 2002; Danielsson et al., 2009; Danielsson & Johansson, 2005; Emslie et al., 2006; Heifner, 1997). A number of men also spoke of the feelings of loss of control (Heifner, 1997; Umberson et al., 2003).

The most common symptoms reported—loneliness and isolation was given the least attention by authors in the review studies. Most of the authors’ emphases were on men’s somatic complaints and anger/aggression. The preponderance for men to present with somatic complaints may be a reason their depression may be less likely to be recognized by health professionals. Furthermore, Heifner (1997) and others (Danielsson & Johansson, 2005) argue that measurement of depression is an issue because men appear to experience and exhibit different symptoms of depression (such as somatic complaints and anger). Similarly, Brownhill et al. (2005) theorize that gender differences in depression appear not in the experience of depression but in the expression of depression. They found that both men and women identified with the commonly accepted symptoms of depression. However, the men identified within themselves and observed in other men, and the women observed in men, an escalation of negative affect toward anger, or what Brownhill et al. (2005) refer to as a “big build” for which there is no concept in relation to the experience of depression. They argue that it is men’s need to maintain a sense of control that is associated with the escalation of negative affect; men hide their symptoms which leads to suppression of internal feelings that ‘build’ and explode. Men seek to exhibit a strong outer appearance but this belies the men’s inner suffering.

Theme 4: Coping

I was brought up not to show my emotions, and in a man’s life you always see on TV where the guys never show their emotions…. They’re bullet proof…. The big thing is we don’t show weakness. (participant from Chuick et al., 2009, p. 309.)

Anything to escape ... anything just to get rid of the hurt and pain and loneliness ... smoking pot, you just don’t care.... (participant from Brownhill et al., 2002)

I sort of blossomed in amongst new people, an interest and all the rest of it, and being one of a bunch. And that seemed to be important to me, to be one of the boys. (a participant from Emslie et al., 2006 describes the effective coping strategy of joining a bowling league, p. 2251)

Of the 51 studies reviewed 36 (71%) addressed how men cope with distress and depression. Of these studies, 32 (63%) revealed maladaptive coping responses and 23 (45%) revealed adaptive coping responses.
Maladaptive coping: Avoidance. The majority of the studies reviewed reveal that men made use of what Snyder and Pulvers (2001) describe as avoidant coping processes. With few exceptions—avoidance coping is not adaptive and makes matters worse. Most commonly, men shared that they used alcohol, drugs, risky sexual behavior, or work to distract or numb themselves from their feelings of distress and depression.

Men commonly discussed hiding or avoiding their feelings, and if they were to express or externalize their feelings it was often through, anger, aggression or hostility. Men described self-managing distress through suppression of emotions. Men in the studies and authors describe “internalizing,” “not thinking or talking about it,” “controlling feelings,” “putting up a front,” “self censorship,” and “the hidden self.” Rochlen et al. (2010) refers to “male concealments,” in that the male expression of emotion involves externalizing (through substance abuse or anger and aggression) but functions as their own “self-masks.”

Adaptive coping. Of the 51 studies 23 (45%) made at least mention of the adaptive ways in which men responded to distress and depression that are worth highlighting. Yet, with very few exceptions, the authors gave short shrift to men’s adaptive coping responses. Although not often elaborated by the authors, 20 of the 51 studies noted that at least some men spoke of the importance of social support to their mental health. It is much more common in the literature to focus on men’s lack of social support compared to women, yet a close reading of the studies in this review reveals that that many men benefit from the social support of family, friends, and community. For example, Emslie et al. (2006) found that men shared that “being one of the boys” was an important source of support for many men. A study examining football fans in the UK (Pringle, 2004) found that the sense of belonging and cathartic release of tension men experience as football fans was associated with greater mental health. As one participant explains: “it isn’t really socially acceptable for pharmacists to taunt people or verbally abuse them, but football allows you to get rid of pent-up aggression from work which is a very stressful environment” (p. 125, Pringle, 2004). In another study, suicidal men spoke of the important connection with intimate partners as the reason they did not act on their suicidal thoughts (Oliffe et al. 2010b).

A number of studies found that men described effective ways of problem solving, effectively utilizing inner resources, re-establishing control, and coming to terms or finding meaning in their personal experiences (Brownhill et al., 2005; Dagget, 2002; Skärsäter et al., 2003). Some men, especially immigrant men, described the importance of faith and spirituality in their coping (Black & Rubenstein, 2004; 2009; Oliffe et al., 2010b; Soonthornchaiya & Dancy, 2006). Getting active through sports and recreation was also noted as a coping mechanism for some men (Pringle, 2004; Pottie et al., 2005; Watkins & Neighbors, 2007).

Another active coping response that some men in these studies noted was seeking professional help (Dagget 2002; Skärsäter et al., 2003). A few men noted that medication helped them cope and also a few men noted reducing medication helped them cope more effectively (Chuick et al. 2009; Clarke & van Ameron, 2008).

A few studies in this review found evidence that traditional notions of masculinity can both harm and help. For example, Emslie et al. (2006) describe how their results suggest that it is important for men with depression to “reconstruct a valued sense of themselves and their own masculinity as part of their recovery.” For example, rather than seeing depression as making one powerless, some men described it as an heroic struggle from which they emerged a stronger person. Oliffe et al. (2010b) found that some masculine practices can ac-
tually mitigate suicide risk. The important masculine roles of father and husband acted as protection against suicide for some men in their study.

**Theme 5: Help seeking**

Men have a dominant position in our society and usually it’s better to be a tough person, a strong person, rather than to worry the whole family. They are usually labeled as the breadwinner, so I think this is one of the main reasons that keeps people away, especially men, from seeking help because when they are going for advice they may lose face, right?—so it is kind of a shame for them to get help. (participant from Oliffe et al., 2010, p. 11)

I say that the Americans have a lot of depression, too much depression. Unfortunately, they all want to solve it with pills. (participant from Lackey 2008, p. 234)

I went last year to the doctor actually. It got so bad I actually asked for help, for tablets. Had a long conversation ten, fifteen minutes talking it through and I found that very useful. I met with a counsellor weekly…I don’t think I would have got through it without it. So I am very proactive…. I think it’s important but other people are different. (participant from O’Brien et al 2005)

**Barriers to help seeking.** Of the 51 studies, 29 (57%) described men’s perspectives on barriers to help seeking. Barriers identified in the qualitative studies in this review fell into four sub-themes. The most common barrier expressed by men was social stigma—a concern over the perceived negative judgments of friends and family. Most surprising was the powerful impact of the gaze of other men. Men’s anxiety over the judgments of other men seemed to most dominate their concerns. Men spoke of fears of exposing their “vulnerable self,” being ostracized by other men or being made fun of for being perceived as weak, soft, feminine or homosexual. In a few cases men shared their disappointment in not having the connectedness with other men to share their problems (Heifner, 1997; Ritchie. 1999). Men spoke of the shame they experienced as a result of a diagnosis (Danielsson & Johansson, 2005; Johansson et al., 2009).

The second most common help seeking barrier was fear or apprehension related to health professionals. This barrier does not appear to be given much attention in the men’s help seeking literature but was almost as commonly reported as social stigma. The most common concern was that seeking professional help would result in being medicated. Some men spoke of seeking help and only being offered medication while they viewed their problems as more complex. Interestingly, this finding was mentioned by a number of authors, but tended to be overlooked in any deeper analysis.

A number of studies found that some men have challenges in communicating or sharing their mental health concerns. Men described their emotional problems as minor or insignificant compared to physical health problems. Men said that it was challenging to share underlying emotional problems, sometimes this was consciously avoided and other times men spoke of not being aware that their experiences were actually problems they should be sharing.

Some studies found that men avoid professional help because they prefer to manage or solve their problems themselves. Men spoke of the importance of maintaining control and
having strength in the face of personal adversity. Some of these men bluntly said that seeking help, rather than self help was a feminine action that shows weakness.

Facilitating factors to help seeking. Although much less common than the focus on barriers, there was mention of facilitating factors that triggered or encouraged men to seek help for their distress and depression in 14 of the 51 studies (27%). The most common facilitating factor is having a trusting relationship with someone who encouraged help seeking. In some cases the person of encouragement was a partner or spouse and in others it was a positive relationship with a professional such as a doctor. Smith et al. (2008) found that the severity of concerns and capacity to take on everyday activities was the most important influence on whether men seek help.

Two studies found that men’s personal attitude towards help seeking involved positioning help seeking as a “brave enterprise” (Oliffe et al., 2010b) and some men expressed pride in the strength it takes to ask for help (Alviderez et al., 2008). Some men identified mental health concerns as normal or as medical conditions which normalized help seeking (Alviderez et al.; Rochlen et al., 2010). Others said they sought help for what they saw as legitimate physical ailments (Bennett et al., 2005; O’Brien et al., 2005) that led them to get help for the underlying mental problems. Similarly, studies of men experiencing grief showed that men see loss of a spouse as a legitimate reason to seek help (Bergmans et al., 2009; Dagget, 2002). Other facilitating factors included the belief that treatment would be effective (Rochlen et al.) and having the community support to access traditional Aboriginal healing (Vicary & Bishop, 2005).

Theme 6: Perspectives of Men from Diverse Communities

Many people, especially Hispanic people suffer from depression here because sometimes they are discriminated against, because they don’t speak English, they go to certain places and people don’t understand them. (Lackey, 2008, p. 233)

… being well was like a large pizza with each slice representing an element of someone’s life. If a slice is removed the pizza is no longer whole. When elements of a person’s wellness are compromised they may be predisposed to physical or mental problems. (Aboriginal elder from Vicary & Bishop, 2005, p. 11)

Of the 51 studies in this review, 23 included data on specific populations of men. Most of the findings from these 23 studies are consistent with the rest of the sample and have been integrated into the findings described in the previous sections. However, there are some unique findings from studies of diverse populations of men associated with what Robertson (1998) refers to as “minority stress” that are worth examining separately. There is particular value in this data as these populations of men are largely ignored in the dominant quantitative studies of men’s mental health.

Immigrant men. The studies of immigrant men’s experiences of distress and depression included in this review reveal that the causes of distress and depression are seen as predominantly social in origin, and particularly related to arising out experiences of immigration and adaptation to a new culture. Men spoke of the significant financial pressures to provide for their families. Mexican labourers spoke of the pain and distress associated with
being separated from families. A number of men expressed that they felt stress as a result of different gender roles in Western cultures. Asian immigrant populations spoke of the pressure of filial piety. Filial piety is a set of values and beliefs that family members have about caring for dependent older family members. It is a guiding principle governing patterns of socialization, as well as providing specific rules of inter-generational conduct. Additionally, immigrant men spoke of the family-based shame associated with mental health issues that precludes them from seeking help.

In terms of protective factors, immigrant men spoke of the importance of family and peer support as they navigate a new culture. Faith was also an important part of healing for some men (Soonthornchaiya & Dancy, 2006). In addition, Oliffe et al. (2010a) found that some international students with depression found that Canadian culture was more open and encouraging in regards to discussing mental health issues.

**African-American men.** The studies in this review involving African American men found many common experiences and perspectives on mental health to white men. The notable differences included what Kendrick et al. (2007) describe as the “stress of being black in America.” Men spoke of the stress associated with racism, police surveillance, and “being different” than the majority white culture. Black men spoke of the family-based stigma that a mental problem is associated with. Faith was important to many black men. In their interviews with African American men, Alviderez et al. (2008) found that men spoke of the unique pressures of Black male stoicism. Black men spoke of the community pressure to be viewed as “super tough,” “hard,” and “holding it down” and the mental toughness that is required of black men (Watkins & Neighbors, 2007). Black men described pride and distrust of health professionals as reasons that prevented them from seeking help for mental health issues (Watkins & Neighbors, 2007). A participant in a study by Watkins and Neighbors (2007) reveals that seeking professional help for mental health problems is helpful to him, but not something he would admit to:

I’m not going to lie, my sophomore year I had a therapist. You tell people you have a therapist and you’re Black, that’s unheard of. But I’m still seeing a therapist today because [there is] a lot of stuff you can’t go see your boys about …. I guess what I’m looking for is an objective opinion; like that ambiguity of someone I don’t know. And that’s why a lot of people do choose a therapist. I think it’s starting to become more popular among Black people. But still, you don’t tell people you see a therapist. (p. 277)

**Gay and bisexual men.** The studies of gay and bisexual men in this sample focused on the distress and depression caused by the anxieties associated with sexuality and social exclusion. Many gay men spoke of the “loneliness and outsidership” of their experiences growing up gay in a homophobic society (McAndrew & Warne, 2010). The pressures to conceal one’s true identity often led to internalization of homophobia that is associated with self hatred that was particularly damaging for gay men, often leading to severe distress and suicide attempts, reflected by the much higher rates of suicide among gay men (King et al., 2008). Gay studies emphasize the impact of homophobic structures in society that impact the individual and critique the history of the medical and psychiatric profession as pathologizing homosexuality. In contrast to the other men in this review, the families and friends of gay men were not always sources of support but rather sources of rejection and pain.
McAndrew and Warner (2010) note that relationships with fathers were particularly troubling for many gay men. Gay men did find support within gay communities and improved mental well being is associated with self-acceptance of one’s sexuality.

**Indigenous men.** In the review of journal articles for this meta-ethnography, there were two that focused on the mental health of indigenous men. Vicary and Bishop (2005) found Aboriginal men do not tend to acknowledge or seek help in mainstream systems for their mental health problems. Men in this study said that the traditional male role had been weakened, resulting in identity crises that can lead to depression, violence and hopelessness. Women often assumed the roles of provider, thus creating a sense of isolation and resentment among men. In a study of the experiences of homeless Aboriginal men, Menzies (2007) emphasizes the impact of intergenerational trauma and the relevance of holistic frameworks for understanding Aboriginal mental health and treatment. The homelessness and mental health problems experienced by men in this study were associated with factors unique to the colonization of Aboriginal people. As Menzies (2007) notes, the complexities faced by this population of men requires interventions at many levels of society, policy and practice, and especially important to these men is opportunities for culturally relevant healing.

**Rural men.** Alston and Kent (2008) found that farmers continued to work hard and that many became increasingly socially isolated and prone to mental health problems as an Australian drought worsened. Men shared their feelings of stress, hopelessness and helplessness in response to the climate’s impact on their livelihood. The study revealed the identity crisis that resulted for these men as their identities as farmers as strong, stoic leaders in the community and at home were challenged. Alston and Kent (2008) note that in good times, the hegemonic masculinity inherent in the farming profession provides these men with power and influence in their communities and homes, but in bad times, these men suffer extreme stress and their masculine ideals prevent them from acknowledging problems or seeking help. The impact of class and how masculinity is tied to particular professions was mostly absent from studies. This study of farmers reveals how the power of hegemonic masculinity can be tied to particular profession or class and how masculinity can both benefit and potentially harm men’s mental health.

Common threads that appear across the studies of diverse men include stresses associated with social conditions: racism, social exclusion, cultural adaptation, and colonization. The changing nature of the roles of women and men in Western society was a concern for some men. Hegemonic masculinity and social exclusion worked together in many of these stories to prevent men from acknowledging or seeking help for their distress and depression.

**DISCUSSION**

**Beyond a Myopic Focus on Problematizing Masculinity**

The dominant masculinity and mental health literature has been criticized for its rather one-dimensional portrait of men (MacDonald, 2006; Riska, 2002). Robertson (2003) notes the dominant discourse among men’s health research boils down to: “men don’t take health seriously and continue to take more risks with their health than women” (p. 111). Common
is the characterization of “men behaving badly” for being unwilling or unable to seek help due to conceptions of masculinity (MacDonald, 2006). Men are understood to experience and express distress through anger and aggression and their symptoms are worsened because they suppress their emotions and avoid seeking help. The studies in this meta-ethnography both confirm this characterization and raise considerations for moving beyond the myopic focus on the negative impact of hegemonic masculinity on mental health. Men’s accounts reveal the impact of hegemonic masculinity is intertwined with other factors including the social causes of distress such as interpersonal and structural factors, symptoms that are associated with male distress, and both the maladaptive and adaptive coping strategies men engage in.

The damaging nature of idealized masculinity is demonstrated in most of the studies in this meta-ethnography. A particularly compelling finding in the qualitative research is confirmation of the notion that many men have a “hidden” or “concealed self” (Heifner, 1997). Many men spoke of how they are forced to hide their true feelings and vulnerabilities. This is a textbook definition of how hegemonic masculinity impacts men’s mental health. Further, many men in this review revealed using maladaptive coping techniques including alcohol, drugs and “bottling up” feelings until they erupted into more socially accepted masculine reactions such as anger and violence. Discussions related to anger and violence reveal that understanding and responding to men’s perspectives on mental health and help seeking has implications not only related to suicide prevention but is also relevant to preventing and responding to interpersonal violence.

Challenging the troubling nature of some forms of masculinity remains an important part of improving both men and women’s health, yet the focus on the negative aspects of masculinity needs to be broadened as masculinity and mental health studies expand in scope. In contrast to the dominate discourse related to men’s health, men spoke of the importance of relational factors to their mental health. Many men identified the causes of their distress as interpersonal and often described their symptoms as interpersonal. In addition, the most common adaptive form of coping for men was seeking social support from family and friends. Most of the authors in this review overlooked these findings and focused their analysis and discussion on the more troubling aspects of masculinity: independence and avoidance. The meta-ethnographic method of systematically reading and coding studies in detail challenges the typical picture of men as isolated brooders, revealing that the concept of masculinity is much more complex, situational and negotiated by each individual man.

Beyond gender, most studies in this review neglect to analyze the impact of other determinants of health (Marmot & Wilkinson, 2006). Gender is clearly a factor for men’s mental health but a masculinity-only focus distracts from the other powerful determinants of mental health. The studies of immigrant men in particular, reveal the problems with a biopsychosocial approach to mental health. Their experiences are shaped and experienced through complex interactions between masculinity and the external circumstances of acculturation, fleeing war and torture, and the struggle to provide and survive. Gay men are particularly not interested in being medicalized, as the damaging history between psychiatry and homosexuality has left lasting scars for many. Similarly, some African American men noted their distrust in mental health professionals (Watkins & Neighbors, 2007). Mostly absent still, in the review studies are any forms of class-based analysis. Class and social gradients are alluded to but often left unexplored. Many of the studies focused on middle class, educated men. Lee and Owens (2002) conclude that “research into men’s health ignores the
social context, or treats them as inevitable, is politically conservative, and seeks individual adaptation rather than social change” (p. 215). This review found few examples to refute their conclusions.

Lay Versus Professional Views of Mental Health

Robertson (2007) contends that lay knowledge and perspectives have the potential to “illuminate the complex relationships between identity, agency, and social structures” (p. 5). Men in the review studies clearly articulated a view of mental health that is inconsistent with the dominant approach in research and practice. Men spoke overwhelmingly about the causes of distress as being socially based; finances, work and relationships were key areas of concern. Most men had difficulty with the term depression itself, and when they did use the term, few found comfort in a disease-based definition. Most men externalized the experience of distress in terms of how they viewed their problems. There is clearly a schism between these external, socially based conceptions and the professional focus on psychological and biological understandings and treatment responses. This is particularly true for men from diverse ethno-cultural and sexual communities in this review, yet, the majority of authors paid little attention to these findings.

Another important theme expressed by men in the review studies was distrust in health professionals. More specifically, issues of fear of medication and being treated with lack of respect were addressed. The issue of distrust in health professionals was particularly salient for men from diverse backgrounds including Aboriginal men, African-American and Hispanic men, men who are homeless, and homosexual and bisexual men. These perspectives are particularly important for practitioners to become familiar with and add to the calls to increase professionals’ competence in understanding and helping people with diverse world views and life experiences. Although also left relatively unexplored by authors in this review, the impact of how services are conceptualized and delivered is an area worth pursuing in future studies of men’s mental health.

Implications for Mental Health Policy, Practice, and Research

Raising awareness of men’s mental health in general is an important implication for mental health policy, and practice. Many men in this review expressed the need for not only reducing the stigma men experience, but in raising awareness of mental health issues so that men can identify when they need help. In particular, a focus on educating other men may be an effective health promotion opportunity, since men described being significantly affected by the judgments of their peers. However, there is an important issue that needs to be addressed with any mental health promotion activities—the conceptualization of mental health for men in these studies was overwhelmingly socially-based. One wonders how successful a campaign to engage men in help seeking can be if it is based in the dominant paradigm of the disease-model. Increased education of health professionals on the questionable practice of over medication and evidence-based treatment beyond pharmacy is warranted. In particular, highlighting lay/patient perspectives on mental health for mental health professionals appears important.

This review suggests that suicide prevention and supports for men’s mental health may need go beyond the disease model of “depression” and look at broader community based initiatives that take social factors into account. In particular, reaching men where they are
and where they often struggle: in the workplace, may be effective. Many men spoke of the value of informal social supports, so the concept of “help” may need to be expanded to focus on effective coping rather than just attempting to engage men in traditional treatments such as medication and therapy.

There is also an important place for including men’s perspectives and experiences within the training and education of mental health professionals. There may be challenges for mental health practitioners in engaging with men, given that the profession is dominated by middle class women. As one seasoned female social worker I spoke with regarding men’s mental health shared: “I just don’t know what to do with men. Within the context of the mental health literature, “gender issues” most often refer to women’s mental health. There is a need to continue to shed light on men’s issues in mental health education, practice, and training and continuing to expand the research agenda related to men’s mental health.

Left mostly unexplored in the review studies, is the changing nature of masculinity and the impact of age on men’s perspectives. There is evidence for example, from the fathering literature (Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000) that notions of how masculinity impacts men’s fathering practice has changed dramatically. Men are more involved and engaged in fathering than in previous generations. A similar impact of changing masculinity on mental health practices has yet to be evidenced. Yet, evidence of the possibility of changing the nature of masculinity and challenging hegemonic masculinity underlines the importance of raising awareness of issues related to men’s mental health with young men and boys; particularly related to disputing the dominant discourse that emotional health is tied to the feminine.

The overall emphasis of the review studies was on maladaptive coping and barriers to help seeking. Yet a close reading of the studies reveals that many men found effective ways to cope and seek help for their problems. A few studies found evidence that masculine ideals are not always problematic, but rather various forms of masculinities may offer potential solutions as well as contribute to problems (Emslie et al., 2006; Oliffe et al., 2010b). There is merit in further exploring the strengths of men in relation to mental health. In addition, there is room to explore positive aspects of masculinity. Masculinity need not simply be understood as fear of the feminine and machismo. There is a form of masculinity that is still manly yet overlooked: the quiet strength, courage and a desire to protect and care for others including partners and children that is not captured in most of this literature.

Limitations and Strengths

There are a number of limitations and challenges to the meta-ethnographical method (for a more thorough discussion see: Atkins et al., 2008; and Doyle, 2003). A limitation inherent to this approach is that the method relies on the quotes and interpretations that are made available by the authors of the studies under review. In addition, this approach relies solely on the interpretation of the author. Another author may make somewhat different conclusions about the studies or draw different implications form the findings—such is both the contribution and the challenge of most interpretive research. Another limitation of this review is the inclusion of only peer-reviewed journal articles. No doubt there are missing perspectives from book chapters and the grey literature that could serve to inform the insights gained from this review.

While the interpretive nature of the method may be seen as a limitation to this approach, the meta-ethnographical method is an attempt to reduce bias in interpretation and increase
auditability through a planned and documented step by step approach to thoroughly reading and documenting the results of each study. This step by step approach was at times tedious, yet this approach allowed for some findings such as men’s conceptions of mental health, and the importance of interpersonal factors to emerge that may not have otherwise. Many of the themes emerged from the accounts of the men themselves and less so from the interpretations of the authors. Thus, this method allowed for capturing the perspectives of the study participants and did not just rely on the areas authors chose to focus on, which is often what traditional narrative reviews capture. The diversity of the men in the review studies is also a strength of this review. Clearly absent in the dominant quantitative literature are the perspectives of men from diverse ethno-cultural and sexual communities. There is a need for more studies that include the voices of diverse men, especially men from different classes and socio-economic levels, and ages.

Many of the studies in this review offer a more complex view of masculinity and mental health, going beyond the linear relationships described in the quantitative literature and fulfilling the promise of qualitative research in terms of providing more complex and nuanced understandings and models of men’s mental health. Inherent in this approach is that there is value in understanding “regular” people’s perspectives and experiences so that service responses can be relevant, useful, and humane.

**CONCLUSION**

This meta-ethnography captures the current perspectives and experiences of men related to distress and help seeking available in peer reviewed journal articles. The review reveals a more nuanced perspective on masculinities and mental health than is typically available in the quantitative literature. Men’s perspectives reveal a more complex notion of the relationship between masculinity and mental health than the dominant perspective in the literature.

Men’s mental health is a critical health issue that has been largely overlooked in much of the mental health literature and practice. The review reveals the challenges men face in terms of mental health and help seeking, as well as strengths that need to be better understood and harnessed. For mental health educators, this raises the importance of challenging the invisible nature of men’s issues. In an era of a focus on diversity, men need not be ignored because of the relative power they have within society. Men’s mental health is not a men’s issue, rather it is women’s issue, a children’s issue and an issue for society to contend with.

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