

**MASCULINITY AND DEPRESSION:
MEN'S SUBJECTIVE EXPERIENCE OF DEPRESSION, COPING AND
PREFERENCES FOR THERAPY AND GENDER ROLE CONFLICT**

Zakaria Batty

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ABSTRACT

In response to calls for much needed research on the relation between gender role conflict and therapy or counselling (Cournoyer & Mahalik, 1995), this study examined the relation between gender role conflict and the types of therapy that men prefer for the treatment of depression, comparing men scoring high and low on the gender role conflict scale. The study also examined whether exposure of men reporting high or low gender role conflict to either emotion-focused or thought-focused therapy through the use of a counselling video influences subsequent preference for type of therapy, and the role of coping as a mediator in the relationship between gender role conflict and therapy preference. Furthermore, the study examined traditional men's perspectives on therapy focussing in particular on issues inherent in living with the experience of depression: coping with depression, seeking help for depression, and the barriers to seeking help. The central aim of the thesis was to examine how to make psychological services more appealing to men who have experienced depression.

The results of stage one suggested that the participants who are high on gender role conflict prefer biomedical therapies/medical services (e.g., medication) more than men who score low on the gender role conflict scale. The results also revealed that both high and low gender role conflicted men ranked modality of therapy first in importance, accessibility second and length of therapy third, and focused on the therapist's professional characteristics, such as the experience level, more than on the demographic traits of the therapists (e.g. age, race, ethnicity).

The results of stage two suggested that exposure of gender role conflicted men to emotion or thought focused therapy affected the participants' subsequent preferences for therapies.

Coping was found to mediate the relations between gender role conflict and therapy preferences, with task coping was significantly related to the three favoured therapies, biomedical, behavioural and psychoanalytical.

The results of the last stage of the research revealed several issues associated with depression in men high on gender role conflict. The men reported that the psychosocial stressors associated with their depression are unemployment, financial hardship, failure, social loss and lack of family support. Results also showed that men have difficulties in initiating the help-seeking process, and they prefer to cope with depression on their own, through avoidance or problem solving coping, but not emotional coping. Men's socialization to fear emotionality, to conceal vulnerability and to be independent was identified as the greatest barrier to seeking help. Establishing rapport and trust was reported to be a central matter in seeking help. The men reported that in order to gain trust and maintain it, the help provider should show them kindness, respect for their independence, security, empathy, have unconditional positive regard and genuineness in talking and listening.

Overall the current research revealed insights into men's experience of depression, their therapy preferences, their coping strategies, the physical and psychosocial barriers that deter them from seeking help, and many practical suggestions for possible interventions to help men cross the barriers and open up. It is concluded that understanding the traditional men, their socialisation and its impact on depression, on the man's help-seeking behaviour and attitudes, is certainly needed to assist in meeting the needs of men and to influence the transformation of traditional men.

DECLARATION

I certify that this dissertation does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person where due reference is not made in the text.

Signed:-----Date:-----

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INTRODUCTION

The death of a loved one, loss of a job, or the ending of a relationship are arduous experiences for any person to bear. It is normal for feelings of sadness or grief to develop in response to such stressful situations. Those encountering such experiences often might describe themselves as being “depressed.” However, sadness and depression are not the same. While feeling sad will lessen with time, the disorder of depression can continue for months, even years. A depressive illness involves feeling sad more intensely and for longer. Such feelings are severe enough to interfere with people’s daily lives, and persist for weeks or months rather than days. Depression causes a huge amount of suffering. It is a major reason for people taking time off work, causes great problems in peoples' home lives too, and can lead to death from suicide or from self-neglect (American Psychiatric Association, 1998).

Some people may unfortunately view depression as weakness or laziness. For mental health professionals this is not the case; they regard depression as a real and common illness, like heart disease, diabetes, or arthritis (Stoppard, 2000). To them, like any disease or illness, it has symptoms, types and causes. The most common symptoms of depression consist of a persistent sad mood; loss of interest or pleasure in activities that were once enjoyed; significant change in appetite or body weight; difficulty sleeping or oversleeping; physical slowing or agitation; loss of energy; feelings of worthlessness or inappropriate guilt; difficulty thinking or concentrating; and recurrent thoughts of death or suicide (American Psychiatric Association, 2000; Davis & Moss, 1983; Fadem & Simring, 1997). For diagnosis, in addition to these inclusion criteria, there are also exclusion criteria; for example, schizophrenia or other neurological diseases need to be

excluded. Moreover, there should be no evidence of recent death in the family, since some of the symptoms of depression are also normal expressions of personal loss and mourning (American Psychiatric Association, 1998; Davis & Moss, 1983). Depression is not a homogeneous illness and depressed patients do not form a homogeneous group. Depression can follow a spectrum, from mild depression, in which there is some impairment of daily life, to severe major or unipolar depressive disorder, in which activities of daily life are virtually impossible. Unipolar major depression typically presents in discrete episodes that recur during a person's lifetime (American Psychiatric Association, 1998; Fadem & Simring, 1997); Dysthymic Disorder or Dysthymia is a less severe yet typically more chronic form of depression. Dysthymia is diagnosed when depressed mood persists for at least two years in adults (one year in children or adolescents), and is accompanied by at least two other depressive symptoms. Many people with dysthymic disorder also experience major depressive episodes (American Psychiatric Association, 2000; Ciechanowski et al., 2004; Fadem & Simring, 1997; Lizardi et al., 2004). While unipolar major depression and dysthymia are the primary forms of depression, a variety of other subtypes exists. These subtypes are categorised by presence or absence of physical symptoms, by presence or absence of psychotic symptoms, or by presence or absence of a precipitating social stress (Blatt, 2004; Davis & Moss, 1983; Feinberg, 1992).

The etiology of depression is far from completely understood. Many cases of depression are triggered by stressful life events, yet not everyone becomes depressed under such circumstances. Some people may find that major life events such as past parental neglect, physical and sexual abuse, or early disruption of attachment bonds, do not lead to depression, while other people may find that less important events such as moving house,

losing a job, or having a baby, do lead to a period of depression (see Blatt, 1974, 1990, 1998; Blatt & Blass, 1992; Bowlby, 1940, 1958, 1960, 1973, 1980; Fonagy, 2001; Freud, 1953, 1961 & 1964; Holmes, 1995; Kessler, 1997; Klein, 1935 & 1946; Royal College of Psychiatrists, 1998). The intensity and duration of these events, as well as each individual's coping skills and reactions (Boyd-Wilson et al., 2000; Chino & Funabiki 1984; Compas et al., 1993; Funabiki et al., 1980; Kleinke, Staneski & Mason 1982; Nolen-Hoeksema, 1987, 1990 & 1991; Pearlin & Schooler, 1978), quality of social support network (Cohen & McKay, 1984; Cohen & Wills, 1985; Thoits, 1986), and certain personality traits (e.g. neuroticism, dependence and self-criticism, perfectionism, interpersonal dependency, impulsivity) underlie or explain certain people's increased susceptibility to depression (see Abramson, Metalsky, & Alloy, 1989; American Psychiatric Association, 2000; Beck, 1983; Blatt & Zuroff, 1992; Brown et al., 1994; Clark et al., 1994; Corruble et al., 1996; Costa & McCrae, 1995; Eysenck, 1952 & 1956; Eysenck & Eysenck, 1976, 1985; Flett & Hewitt, 2002; Frost et al., 1990; Garyfallos et al., 1999; Hirschfeld et al., 1977; Hirschfeld & Holzer, 1994; Hirschfeld & Shea, 1992; Huprich, 1998 & 2001; Institute of Medicine, 1994; Ingram et al., 1998; Jang et al., 1998; Klein, 1990; Klein & Miller, 1993; Klein & Shih, 1998; McDermut et al., 2003; Nolen-Hoeksema, 1990; Pfohl et al., 1991; Phillips, Gunderson, Hirschfeld, & Smith, 1990; Shea & Hirschfeld, 1996; Phillips et al., 1998). In some people, having a close relative who has depression could reflect a genetic predisposition to depression (American Psychiatric Association, 2000; Carey & DiLalla, 1994; Craddock et al., 2001; Duffy et al., 2000; Fadem & Simring, 1997; Kendler & Prescott, 1999; Kendler et al., 2001; Rutter, 2003; Mendlewicz & Rainer 1977; Sullivan et al., 2000; Tsuang & Faraone, 1990; Wender et al., 1986). In other people, drinking alcohol or using street drugs such as cannabis, ecstasy or cocaine can trigger depression, as can certain physical illnesses or

medicines prescribed by doctors (Mitchell, 1998; Steffens & Krishnan, 1998). However, in other people, it is difficult to find a cause, and depression appears to strike “out of the blue.” Though theoretical approaches tend to emphasise one set of presumed causal influences over others, explanations based on a single factor (whether social, psychological or biological) have now generally been discarded in favour of more complex multifactorial approaches (Mc Grath et al., 1990). That is why depression and many other mental health problems are broadly described as the product of a complex interaction between biological and psychosocial factors (see Anderson, 1998; Engel, 1977; Kaplan, 1990; Matarazzo, 1980; Thase & Howland, 1995; Schwartz, 1982; Stoppard, 2000).

Depression is a serious illness that negatively affects how people feel, think, and act. Depression is very common. At any one time, about 15-30% of people have some kind of depression (American Psychiatric Association, 1998 and National Health Services-UK, 2000). Over a lifetime, there is a 60-70% chance that a person will suffer from some kind of depression or worry bad enough to affect his or her daily living (American Psychiatric Association, 2000; Culbertson, 1997; Nolen-Hoeksema, 1990 & 1995; Regier et al., 1993; World Health Organization, 2005; Weissman, Blond, Canino et al., 1996).

Currently, depression is the fourth most common cause of disability worldwide. As medical advances and improvements in living standards start to reduce the impact of physical illnesses such as pneumonia, the relative impact of depression is rising. It is estimated that by the year 2020, depression will be the second most common cause of disability in the developed world, and the number one cause in the developing world (World Health Organization, 1994, 1995 & 2005).

Fortunately, depression is very treatable. The majority (80%-90%) of people who receive treatment and counselling experience significant improvement, and almost all individuals derive some benefit from seeking professional help (see American Psychiatric Association, 2000). Depression can almost always be treated successfully. There are three avenues: medication, such as antidepressants (American Psychiatric Association, 2000; Davies, 1999; Fadem & Simring, 1997; Reimherr, Wood, Byerley et al., 1984; Thase, Carpenter, Kupfer et al., 1991); psychological therapies that either target the depressive symptoms (the cognitive or behavioural therapies) or specific interpersonal or current psychosocial problems related to the depression (e.g. brief dynamic, interpersonal therapy, supportive therapy, group therapy) (see Abramson, Metalsky & Alloy, 1989; Beck, 1996; Beck, Hollon, Young et al., 1985; Beck, Rush, Shaw et al., 1979; Briston & Bright, 1995; Corney, 1987; Elkins, Shea, Watkins, et al., 1989; Fadem & Simring, 1997; Francis-Cheung & Grey, 2002; Gallagher-Thompson, Hanley Peterson, & Thompson, 1990; Klerman et al., 1984; O'Leary & Beach, 1990; Peterson & Halstead, 1998; Shea, Elkins, Imber et al., 1992; Sher, Baucom, & Larus, 1990); or social treatments, such as increased activities and befriending (see Elkins, Shea, Watkins, et al., 1989; National Institute of Mental Health-NIMH, 2004). Whilst focusing on one aspect of treatment may provide a cure, it has also been reported that focusing on two or three aspects of treatment (drugs, therapy and social treatments) may provide quicker and more long-lasting benefit (Eells, 1999; Hollon et al., 1992; Keller et al., 2000; Klerman, Weissman, & Markowitz, 1994; Manning, Markowitz, & Frances, 1992; McCullough, 2000; Reynolds et al, 1999; Weissman, Prusoff, DiMascio et al., 1979). Not all patients respond to the same therapy, but a patient who fails to respond to the first treatment attempted is highly likely to respond positively to a different treatment (American Psychiatric Association, 1998; Fadem & Simring, 1997).

Unfortunately, people may not recognise their symptoms as signs of depressive illness, or they may fear the reactions of co-workers, friends, and family to their diagnosis, due to social stigma about mental illness. Consequently, millions of people with depression do not seek help or support, and unnecessarily experience problems at their jobs or in their relationships (Cochran & Rabinowitz, 2000; Good & Wood, 1995; Real, 1997). It has been claimed that entire countries are facing a loss in productivity because of depression (Francis-Cheung & Grey, 2002). All of this suggests that there is a mental health crisis. At the heart of this crisis is people's unfamiliarity with or ignorance about depression, its causes and symptoms, and the available therapies or help. The ignorance is at its peak when depression strikes men.

Historically, clinicians as well as scientists have believed that men, in contrast to women, are protected from depression (Baxter et al., 1987; Brown et al., 1994; Weiss et al., 1999) and the rates of mental disorders from hospital and outpatient census figures (American Psychiatric Association, 2000; Nolen-Hoeksema, 1995; Robins & Reiger, 1991; Stoppard, 2000) have tended to support this viewpoint. However, there is growing evidence to suggest that men may not be adequately counted in studies examining rates of depression, that men are equally vulnerable to depression for the same reasons that make women depressed, but they remain unidentified, undiagnosed, and untreated (e. g. Cochran, 2001; Cochran & Rabinowitz, 2000; Lynch & Kilmartin, 1999; Pollack, 1998; Real, 1997). Men are thought to hide or “mask” their feelings of depression (Cochran & Rabinowitz, 2000; Real, 1997) and not to seek professional help (e. g. Cochran, 2001; Cochran & Rabinowitz, 2000; Lynch & Kilmartin, 1999; Pollack, 1998; Real, 1997). Over the last three decades, many studies have examined differences in the frequency with which men and women seek help for medical, mental health, and substance abuse

problems. The findings have consistently shown that, as a group, men are on average, less willing than women to seek professional help for psychological problems (Cochran, 2001; Cochran & Rabinowitz, 2000; Gove, 1984; Gove & Tudor, 1973; Pollack, 1998; Vessey & Howard, 1993), and they are more reluctant to seek help in the case of depression, (Blazer et al., 1994; Kessler et al., 1994; McKay et al., 1996, Thom, 1986; Robbins, 1989; Robins & Reiger, 1991) even casually from friends. Furthermore, large numbers of men, more than women, suffer from problems closely related to depression, such as alcohol and drug abuse (Blazer et al., 1994; Kessler et al., 1994; Real, 1997; Robins & Reiger, 1991; Schutte, Brennan, & Moos, 1998), and the suicide rates in men continue to be alarmingly high (Anderson, Kochanek & Murphy, 1997; Cochran & Rabinowitz, 2000; Heifner, 1997; Moscicki, 1997; Whitaker, 1987; World Health Organization, 1993, 1994 & 1995).

Silverman (1994) called attention to the importance of gender-related knowledge, acknowledging its impact upon "the cause and treatment of psychological disorders" (p. 228). However, Silverman recommended that instead of just providing facts how frequently men and women demonstrate a set of behaviours it is better to provide an explanation for the differences between men and women in help-seeking patterns, and why men as a group should be less likely to seek help and to cope with their depression on their own. Heppner (1995) proposed that for some individuals, in particular males in therapy, their troubles or issues seem to be very intertwined with gender-role issues. Moreover, Heppner recommended that from a clinical perspective, it is imperative to focus on the impact of masculine gender role socialisation and to better define how some men are particularly affected by culturally prescribed gender-role concerns. Scholars (Leafgren, 1990; O'Neil, 1982, 1990; Pleck, 1981 & 1995) have discussed the restrictive

nature of gender role socialisation across the life span and its consequent impact on the health, well-being of individuals and seeking help, and they have hypothesised that internalizing the ideological position that men should be tough, competitive, and restricted emotionality can have detrimental effects on a man's physical and mental health (Courtenay, 2000; O'Neil, 1982). O'Neil et al. (1986) have defined this strain as gender-role conflict. O'Neil et al. (1986) noted that the fear of the feminine is a guiding force for adult men concerning what is appropriate gender-role behaviour, and it is also a harsh part of the perpetually restrictive gender-role socialisation process for boys and young men. To research the effect of gender role and gender role conflict on mental health, O'Neil and colleagues developed the gender role conflict scale (GRCS) and proposed that four factors underlie gender role conflicts: (1) success, power, and competition; (2) restrictive emotionality; (3) restricted affection between men; and (4) conflict between work and family (Good et al., 1995; O'Neil et al., 1986). Studies have found that gender role conflict in men is negatively related to mental health (e. g., Cournoyer & Mahalik, 1995; Good et al., 1995; O'Neil et al., 1986). Men high on gender role conflict were found to be less likely to seek psychological help (Good, Dell, & Mintz, 1989). Such men also reported higher anxiety and decreased social intimacy (Sharpe & Heppner, 1991). Good and Wood (1995) found that all four subscales (1-success, power, and competition; 2-restrictive emotionality; 3- restricted affection between men; and 4- conflict between work and family) of the Gender Role Conflict Scale (O'Neil, Helms, Gable, David, & Wrightsman, 1986) were related to the level of depression in college men. The highest correlations with level of depression were reported for conflict between work and family and restrictive emotionality. In addition, Shepard (2002) found that three of four gender role conflict subscales (1-success, power, and competition; 2- restrictive emotionality; and 3- restricted affection between men) were associated with depressive symptom

patterns, with restrictive emotionality being associated with all three symptom patterns. Both of these investigations confirm a relationship between conflict related to masculine gender role and depression in men.

As Addis and Mahalik (2003) noticed “there is little doubt that traditional helping services are underutilized by many men experiencing a wide range of problems in living. It is also likely that a variety of masculinity ideologies, norms, and gender roles play a part in discouraging men’s help seeking for depression....Men’s difficulty with accessing health services is may be attributed to a mismatch between available services and traditional masculine gender-roles emphasising self-reliance, emotional restrictiveness, and power” (Addis & Mahalik, 2003). Silverman (1994) called attention to the importance of providing an explanation for the differences between men and women in help-seeking patterns, and why men as a group should be less likely to seek help and to cope with their depression on their own. Brooks and Good (2001) emphasised the necessity to treat men as a unique culture to be understood in relation to depression and seeking help. Heppner (1995) recommended that from a clinical perspective, it is imperative to focus on the impact of masculine gender role socialisation and to better define how some men are particularly affected by culturally prescribed gender-role concerns. Cournoyer and Mahalik (1995) called for more research about gender and therapy or counselling, particularly in the case of depression in high gender role conflict men. This is because few studies have focused on depression in men, and fewer still have looked at the barriers that stand between men and therapy, what types of therapy men prefer, and what would make psychological services more appealing to men. The need to address this issue has become imperative.

The present study designed to respond and contribute to the call for research on depression in men. More specifically, it was designed to examine (1) the relation between gender role conflict and therapy preferences for depression; (2) to identify whether exposure of men reporting high or low gender role conflict to either emotion-focused or thought-focused therapy through the use of a counselling video influences subsequent preference for type of therapy, (3) to analyse the role of coping as a mediator of the relationship between gender role conflict and preferences for therapies, and (4) to provide an in-depth examination of man high on gender role conflict perspectives on therapy and living with the experience of depression: seeking help for depression, the barriers to seeking help, and their views on how to make psychological services more appealing.

The thesis is designed in the following way.

The first chapter starts with a brief review of research on depression and gender with a focus on the factors that account for the emergence of gender differences in depression, and emphasis on the idea that rigid adherence to the male gender role is “dysfunction-producing” (Pleck, 1981; O’Neil et. al, 1986; Eisler & Skidmore, 1987). It concludes with defining the problems that the present study covers and an overview of how these are addressed by means of three related studies.

The second chapter covers the methodology, results, and discussion of the first study, which examines the relation between gender role conflict and therapy preferences for depression so as to determine whether GRCS can predict the therapy that men (scoring high and low on GRCS) choose.

The third chapter addresses the methodology, results, and discussion of the second study, which examines two issues, firstly how a specific variation of counselling technique (i.e.

emotion- focused versus thought-focused) may affect preferences for therapies of men reporting high and low gender role conflict. Secondly it analyses the role of coping as a mediator of the relationship between gender role conflict and preferences for therapies.

The fourth chapter outlines the methodology and discussion of the third study, which consists of an in-depth analysis, based on semi-structured interviews, of men high on gender role conflict perspectives on therapy, in particular issues inherent in living with the experience of depression: its causes, coping, seeking help for depression, the barriers to seeking help, and men's views on how to make psychological services more appealing.

The fifth chapter is the concluding chapter that summarises the results of the three studies, and discusses the implication of the findings, and suggestions for future studies.

CHAPTER 1

LITERATURE REVIEW

DEPRESSION, GENDER AND GENDER ROLE CONFLICT

The present chapter reviews the current research findings on depression and gender, with a focus on the factors that account for gender differences in rates of depression among women and men, and emphasis on the idea that rigid adherence to the male gender role is “dysfunction-producing” (Pleck, 1981; O’Neil et al., 1986; Eisler & Skidmore, 1987). It concludes with an outline of the problems that the present study covers, and an overview of how these are addressed by means of three related studies.

I. Depression and Gender

A. Depression is a Women’s Illness

Depression is often traditionally thought of as a woman’s illness (Francis-Cheung & Grey, 2002). Results of epidemiological studies are relatively consistent, pointing to depression as a problem that particularly afflicts women more than men (Stoppard, 2000; Nolen-Hoeksema, 1987; Miles, 1988; Weissman, Blond, Canino et al., 1996). For example in a comprehensive review of all the general population studies conducted in a range of countries, including the United States of America, Puerto Rico, Canada, France, Germany, Hong Kong, Iceland, Korea and Taiwan, adult women predominated over men in lifetime prevalence rates of major depression (Piccinelli & Homen, 1997). Adult women in the United States, Sweden, Denmark, and Australia are estimated to be twice as likely as adult men to experience unipolar depression at some point in their lives (American Psychiatric Association, 2000; Culbertson, 1997; Nolen-Hoeksema, 1990 & 1995; Regier et al., 1993; World Health Organization, 2005; Weissman, Blond, Canino et

al., 1996). For major depression, which is a more disabling illness than a number of other medical conditions, researchers have quoted a female-male ratio of 4:1, although rates vary with ethnicity and culture (Sileo, 1990). Research and clinical work has associated women's greater susceptibility to depression with various explicit psychosocial and biological factors, which are outlined below.

1. Psychosocial Factors in Women's Depression

Psychosocial factors have been found to contribute significantly to both depression and anxiety; the risk of psychosocial factors contribution to depression is estimated to be around 60% to 65% (Brown, Andrews & Harris, 1986; Finlay-Jones, 1989). Research conducted in working-class neighbourhoods suggests that a combination of life stress and inadequate social support contributes to women's greater susceptibility to depressive symptoms (Brown et al., 1994; Kessler et al., 1994; Turner & Marino, 1994). According to various studies, being poor is stressful for both men and women, but women (white, black or Hispanic) who are poor appear to be at the greatest risk for depression compared with all other population groups (Miranda & Green, 1999). Women constitute more than 70% of the world's poor (United Nations Development Report, 1995). Furthermore the numbers becoming poor are increasing (United Nations Development Report, 1998) and women with children are the largest group of people living in poverty, even in developed countries such as Australia (Shaver, 1998). Poor women have disproportionately higher rates of past exposure to trauma, including rape, sexual abuse, crime victimisation, and physical abuse; poorer support systems; and greater barriers to treatment, including financial hardship and lack of insurance (Miranda & Green, 1999). Many of the same risk factors apply to single mothers, whose risk of depression is double that of married mothers (Brown & Moran, 1997). Another stressful issue that is related to poverty and

which seems to contribute to depression in women is gender inequality. Recent research suggests that gender inequality in many countries is widening rather than narrowing because of the structural adjustment programs (United Nations Development Program, 1998), especially in the poor nations. The structural adjustment programs, which involve economic and social changes in developing countries, seem to be leading, in certain developing countries, to sudden, disruptive and severe decreases in public sector employment, social welfare spending, health care spending, and education; changes of income; and rapid increase of basic goods prices (Astbury & Cabral, 2000; World Health Organisation, 2005). This is affecting the poor, and significantly increasing gender inequality because of the separate roles men and women play and the different constraints they face in responding to policy changes and shifts in relative prices (Bandarage, 1997; Kirmani and Munyakho, 1996). The significant increase in gender inequality has been linked to an increase in the rate of common mental disorders (Kawachi et al, 1999; Patel et al, 1999; World Health Organisation, 2005).

Other life stressful events that have been investigated in relation to the aetiology of depression extensively included such experiences as the death of a child of any age, death of a husband or partner, two or more abortions, sexual abuse, and physical violence in the marriage or relationship (Brown, Bifulco & Andrews, 1990; Bifulco, Brown & Adler, 1991; WHO, 2005). Research has found that women are more likely than men to have experienced past sexual abuse (i. e., rape, incest, and other unwanted and inappropriate physical or sexual interactions between a child, adolescent, or adult and another person) (Russell, 1984; Finkelhor et al., 1990). Physical and sexual abuse is strongly associated with the subsequent development of major depressive disorder (Weiss et al., 1999), both shortly after the abuse and long after (Burgess & Holmstrom, 1974; Carmen, Rieker, &

Mills, 1984; Cutler & Nolen-Hoeksema, 1991; Kilpatrick et al., 1979; Wirtz & Harrell, 1987). One study found that more than half of a group of adult women seeking therapy for depression had a history of sexual abuse as children (Carmen et al., 1984).

Other research has found almost three quarters of the severe events occurring in the six months prior to the onset of depression involved entrapment or humiliation (Brown, Harris & Hepworth, 1995). This finding accords with various theories of self psychology, which posit women are at risk of depression because they are more likely than men to base their self-esteem on their relationships with others (Brown, Harris & Hepworth, 1995; Chevron, Quinlan, & Blatt, 1978; Jordan, Kaylan & Surrey, 1991; Kaplan, 1986). Both psychoanalysis and cognitive-behavioural theories of depression hold that relying on the acceptance and approval of others for one's self-evaluations and self-esteem puts one at risk of depression (Bibring, 1953; Calvete & Ardenoso 2005; Chodoff, 1972; Rehm, 1977; Rudolph et al., 2005), because the approval of others is not always reliable. Behavioural and cognitive theories of depression also hold that people who tend to become unassertive and helpless in the face of frustration, who have low expectations about their ability to control important events, who have pessimistic views of the future and the world, and who blame themselves for the negative events in their lives are at increased risk of depression (Abramson et al., 1989; Abramson, Seligman & Teasdale, 1978; Beck, Rush, Shaw & Emery, 1979; Lewinsohn, 1974). Social rank theory investigated the role of various key variables in the development of depression and found that all the above variables have a high risk of occurring in women (Allan & Gilbert, 1997; Broadhead & Abas, 1998; Craig, 1996; Gilbert, 1992; Gilbert & Allan, 1998). Social rank theory found women to be more likely than men to perceive themselves as inferior or in an unwanted subordinate position, to have low self

confidence and to behave in submissive or non assertive ways, having a sense of defeat in relation to important battles, and at the same time, wanting to escape but being trapped (Astbury, 1999; Radloff, 1975). Moreover, research has found that women have multiple roles in the home and at work (National Institute of Mental Health, 2004) and they generally occupy lower status jobs with little decision making discretion, factors that have also been found to be highly predictive of depression (Stansfield, Head & Marmot, 1998)

Other lines of research have found that because women tend to use more emotion-focused ways or ruminative ways of coping (e.g. thinking and talking about a problem) rather than seeking out a distracting activity (Boyd-Wilson et al., 2000; Chino & Funabiki, 1984; Funabiki et al., 1980; Kleinke, Staneski & Mason, 1982; Nolen-Hoeksema, 1987 & 1990; Pearlin & Schooler, 1978), and, on average, have less economic power, they may be more likely to perceive their problems as less solvable, thus remaining preoccupied with negative thoughts and consequently reducing their sense of control over their environment (Compas et al., 1993; Nolen-Hoeksema, 1991). For both genders, individual environmental experiences play a large role in depression (Bierut et al., 1999).

2. Biomedical Factors in Women's Depression

It has been suggested that women's greater vulnerability to depression may be amplified by endocrine and reproductive related events such as menstruation, pregnancy, miscarriage, childbirth, premature delivery, infertility, abortion and menopause, as well as by a greater susceptibility to hypothyroidism (Thase & Howland, 1995).

The most popular biological theory of females' greater vulnerability to depression is that deregulation of the ovarian hormones (estrogens and progesterone) causes depression in females (see Nolen-Hoeksema, 1990). This idea originally emerged from observations that at least some women tend to become depressed during periods of rapid shifts in

levels of ovarian hormones, such as the premenstrual period and the postpartum (Cutrona, 1982; Moos et al., 1969; The Royal Women's Hospital, 2000). However, the evidence for this hypothesis is still mixed (Janowsky & Rausch, 1985; Nolen-Hoeksema, 1990; Rubinow & Roy-Byrne, 1984). Although some studies have found a link between hormones and depressed mood in women (Buchanan et al., 1992), many of these studies are considered to have serious methodological flaws, and an equal number have found no relationship between women's hormones and moods (Nolen-Hoeksema, 1990). For example, for years it has been known that some mothers feel severely depressed after having a child and the cause of depression was explained on bases of hormonal changes, but it is only recently that researchers have realised that more than 1 in 10 fathers also suffer psychological problems during this time (Areias et al., 1996; Ballard et al., 1994; Barnett & Morgan, 1996; Leathers, Kelley & Richman, 1997; Post and Antenatal Depression Association - PANDA, 2005; Soliday, McCluskey, Fawcett & O'Brien, 1999) and research found that it is mostly related to psychosocial factors such as the men becoming more affective and parental (Francis-Cheung & Grey, 2002), conflict with the partner (Small et al., 1994; Stice et al., 2004), or conflict between work and family (Good & Wood, 1995; O'Neil et al., 1986; Shepard, 2002) rather than biological factors. Similarly, menopause has been found to have little bearing on gender differences in depression. For example, Pearlstein et al. (1997) researched menopause and concluded that it does not appear to be associated with increased rates of depression in women. Untreated mental health problems are likely to worsen at menopause, but menopause by itself does not trigger depression (Thacker, 1997).

The interaction between stressful life events, individual experiences, and genetic factors also plays a role in the etiology of depression in women. Some research suggests that sex-related differences in hemispheric processing of emotional material might further

predispose women to experience emotional stressors more intensely (Baxter et al., 1987). Other research suggests that genetic factors may alter women's sensitivity to the depression-inducing effect of stressful life events (Kendler et al., 1995).

In summary, research suggests that it is the psychosocial context which contributes to higher rates of depression in women (Helgeson & Fritz, 1998; Kaplan, 1986), whereas the evidence supporting a biological cause for increased depression in women is still inconclusive (Nolen-Hoeksema, 1995).

II. Explanation of the Differences in Rates of Depression between Women and Men

While depression is historically thought of as an illness that mainly affects women, and the rates of mental disorders from hospital and outpatient census figures (American Psychiatric Association, 2000; Nolen-Hoeksema, 1995; Robins & Reiger, 1991; Stoppard, 2000) have tended to support this viewpoint, and the belief that men, in contrast to women, are protected from depression (Baxter et al., 1987; Brown et al., 1994; Weiss et al., 1999), there is growing evidence to suggest that men may not be adequately counted in studies examining rates of depression, that men are equally vulnerable to depression for the same reasons that make women depressed, and that depression in men is a serious and, if untreated, potentially fatal condition (e. g. Cochran, 2001; Cochran & Rabinowitz, 2000; Lynch & Kilmartin, 1999; Pollack, 1998; Real, 1997). The growing evidence that men may not be adequately counted in studies examining rates of depression is better supported by several explanations, namely, the gender bias explanation, and the gender role socialisation explanation.

A. The Gender Bias Explanation for the Difference in Rates of Depression between Women and Men

According to the World Health Organization (2005) and various researchers (e.g. Parker & Hadzi-Pavlovic, 2004; Real, 1997; Stoppard, 2000) gender bias occurs in the treatment of psychological disorders.

1. The Difference in Referral between Men and Women

Women are more likely to be diagnosed with depression because they are more likely than depressed men to be referred and admitted to hospital. According to many researchers (e.g. Astbury, 1996; Gitlin & Pasnau, 1989; Showalter, 1987; Stoppard, 2000; Ussher, 1991 & 1997) women being referred more than men could be related to the cultural construction of woman as having greater biological vulnerability to psychological disorders (i.e. hysteria). In addition according to Terrence Real (1997) women are more likely to be diagnosed with depression than men because many medical doctors and mental health professionals, as well as family members and friends, may find it easier to diagnose women with depression more than men because of the fear of the stigma and shame surrounding depression for men, a disorder which is regarded as an emotional and not a manly illness.

2. The Difference in Seeking Help Attitudes between Men and Women

Another gender bias appears when enquiries are made about symptoms of depression or other mental disorders; women are more likely than men to admit to having mental health problems and thus they are more likely to seek professional help (Stoppard, 2000). There is a large and consistent body of experimental research which supports the common belief that men of different ages (Husaini et al., 1994), ethnicities, and social backgrounds (D'Arcy & Schmitz, 1979; Neighbors & Howard, 1987) are on average, less willing than

women to seek professional help for depression, or for other problems either closely related to depression, such as substance abuse and stress (Blazer et al., 1994; Kessler et al., 1994; McKay et al., 1996, Thom, 1986; Robbins, 1989; Robins & Reiger, 1991), or not related to depression, like physical disabilities (Husaini, Moore, & Cain, 1994; McKay et al., 1996; Thom, 1986; Weissman & Klerman, 1977). Other studies have found that men, in comparison to women, rarely use mental health services (Cochran, 2001; Cochran & Rabinowitz, 2000; Gove, 1984; Gove & Tudor, 1973; Pollack, 1998; Vessey & Howard, 1993). As well, studies have consistently found that women seek psychiatric help at a higher rate than men with similar emotional problems (Kessler et al., 1981). Also, research has documented that in general, women are more likely than men to recognise and label non-specific feelings of distress as emotional problems (Carpenter & Addis, 2000; Dickstein et al., 1990; Leong & Zachar, 1999; O'Neil et al., 1985). Research has found that men are more reluctant to seek help in the case of depression, even casually from friends, and tend to report that they would never seek psychotherapy for depression (Padesky & Hammen, 1981; Weissman & Klerman, 1977). Thus, assessing gender differences in depression by looking at those who receive treatment is not an appropriate way for determining whether there is a true gender difference (Parker & Hadzi-Pavlovic, 2004).

3. The Difference in Manifestation of Depression between Men and Women

A further gender bias explanation is that many of the depression symptom measures include items that reflect depression responses that are more likely to be experienced by women, such as crying, change of appetite or weight, than by men (Boyd-Wilson et al., 2000; Chino & Funabiki, 1984; Funabiki et al., 1980; Kleinke, Staneski & Mason, 1982; Nolen-Hoeksema, 1987 & 1990; Pearlin & Schooler, 1978). Men tend to manifest

depression differently from women via problems such as suicide (Anderson, Kochanek & Murphy, 1997; Cochran & Rabinowitz, 2000; Heifner, 1997; Whitaker, 1987) alcohol and drug abuse (Blazer et al., 1994; Hanna & Grant, 1997; Kessler et al., 1994; Real, 1997; Robins & Reiger, 1991) and others, outlined below.

a. Suicide

Suicide is a significant mortality risk factor for men of all ages and races. According to the report of the World Health Organization (1993, 1994 & 1995) men are around 3 to 4 times more likely to kill themselves than women in all age categories. However, the report noticed that in some countries the ratios of committing suicide could be even higher than 3 to 4 times, for example in Finland the ratio of male-female death by suicide is 10:1, while in Ireland the ratio is 11:1 (World Health Organization, 1993, 1994 & 1995). Reports from the United States and United Kingdom show that suicide rates for men vary in range from 20 to 25 per 100,000 for males between 18 and 35, to as high as 30 to 70 per 100,000 for men over age 65 (Anderson, Kochanek, & Murphy, 1997; World Health Organization, 1994 & 1995). In Australia, until 1997 the statistics of death by suicide were similar to those of U.S. and U.K, but since 1998 there has been an overall increase in rates among persons aged 25-44 and decrease in rates among the young and elderly (Hoogland & Pieterse, 2000; Australian Bureau of Statistics, 1999). Men aged 25 - 44 make up about 40% of total suicides, while elderly men suicide accounts for nearly 20% of total suicides in Australia. Suicide in Australia is more common amongst men in rural and remote areas than in capital cities and other urban locations (Hoogland & Pieterse, 2000; Australian Bureau of Statistics; 1999). Suicide in Australia and worldwide is commonest amongst men who are separated, widowed or divorced (Cochran & Rabinowitz, 2000; Cochran & Rabinowitz, 2003; Hoogland & Pieterse, 2000), but men

who are separated are at higher risk of suicide than widowed or divorced males (Cantor & Slater, 1995). Furthermore, suicide in men is more likely if the man is a heavy drinker (Commonwealth Department of Health and Aged Care, 2000), drug abuser (National Health and Medical Research Council, 1996), and has a coexisting antisocial personality disorder and/or a co-occurring psychiatric disorder (schizophrenia, panic disorder, or major depression). Moreover, a family history of conduct disorder, sexual abuse, violence, or suicide further increases suicide risk. Finally, in older men, physical illness is a significant risk factor for suicide. Researchers and clinicians advise that any male who is depressed or who is being treated for depression and who fits into any of these categories should be considered at increased risk for suicide (Cochran & Rabinowitz, 2003).

Research shows that 2 out of 3 people who kill themselves have seen their GP in the previous 4 weeks and nearly 1 in every 2 would have done so in the week before they kill themselves. Moreover, about 2 out of 3 people who kill themselves would have talked about it to friends or family (Royal College of Psychiatrists, 1998).

For a man who feels suicidal, there is nothing more demoralising than to feel that others do not take him seriously. He would often have taken some time to pluck up the courage to tell anybody about it (Morgan et al., 1998). Suicide, for men, symbolises an effort to "take control" of a life that is perceived to be swerving out of control (Heifner, 1997), but in a drastic and dramatic coping strategy. A recent Australian study found that on average, for every completed male suicide there are five attempts, while for every completed female suicide there are 35 attempts (Hoogland & Pieterse, 2000).

b. Different Addictive Behaviours

Apart from the above lethal way of coping with depression, depressed men may try to make themselves feel better by relying on one or a combination of the three major coping strategies; instrumental or problem-focused coping (i.e. active coping, planning, suppression of competing activities, restraint coping, seeking of instrumental social support), emotion-focused coping (i.e. seeking emotional social support, positive reinterpretation, acceptance, denial, turning to religion); and avoidance coping (Billings and Moos, 1981 & 1984; Carver et al., 1989; Folkman & Lazarus, 1988; Lazarus and Folkman, 1984). But in general, men, far more than women, may try to make themselves feel better by relying on avoidance as a coping strategy, which may include distraction, denial, social diversion, behavioural disengagement, alcohol or drug use (Amirkhan, 1990; Billings and Moos, 1981; Bonin, McCreary & Sadava, 2000; Lazarus & Folkman, 1984; Nolen-Hoeksema, 1987, 1995 & 1999; Pearlin & Schooler, 1978; Ugal, 2003), as well as a selection of compulsive actions, such as gambling, spending, sex or even excessive exercising (Real, 1997).

The problem does not rest in the coping strategies themselves; the problem lies with how a depressed person uses them. Any person can turn to mood-altering behaviours such as drinking, gambling, watching television, drugs or other activities, but while non-depressed people usually use alcohol, drugs, television for fun, relaxation and to enhance an already adequate sense of self esteem, depressed men rely on such stimulants to gain relief from distress, achieve self soothing and to rectify and desperately boost an inadequate self esteem (Real, 1997). And once the man uses those coping strategies or defences to alleviate his mood and boost his self esteem when he is depressed, he may keep using them, and thus can become addicted (Khantzian, 1987; Real, 1997). A depressed man may feel happy about himself when his object of defence or addiction is

available, but his sense of self-worth can drop and his depression re-surfaces when his connection with his object of addiction is disrupted. This is dangerous and will usually make things worse in the long run (Nolen-Hoeksema, 1990; Real, 1997; Royal College of Psychiatrists, 1998). According to addiction experts (Khantzian, 1985 & 1987; Khantzian et al., 1990) any form of defence used in depression, whether addiction to substances (alcohol and drugs), persons (known as erotomania) or activities (gambling, violence, stalking, workaholism) will temporarily alleviate depression, but at the same time can exacerbate it (Khantzian, 1985 & 1987; Khantzian et al., 1990) and simultaneously each form of addiction will bring with it more problems.

Substance addiction is considered to be one of the major forms of problems closely related to depression, and it affects far more men than women. Alcoholism runs at 8.2 percent in women and 20.1 percent in men (Blazer et al., 1994; Kessler et al., 1994; Real, 1997; Robins & Reiger, 1991; Schutte, Brennan, & Moos, 1998), and drugs dependency is 5.9 percent in women while in men it is 9.2 percent (Kessler et al., 1994; Robins & Reiger, 1991). Alcohol and drugs affect the person's brain chemistry and with it mood, as well as being addictive (Marlat, 1987). The physical, social, and psychological consequences of addiction can make a person feel hopeless, weak and sad (Francis-Cheung & Grey, 2002; Blume, Schmaling & Marlat, 2001), and with time, people can develop tolerance toward the substances they are using and thus more quantities and money will be needed to lift their mood (Khantzian et al., 1990; Marlat, 1987). This often leads to irresponsible, unpleasant or dangerous behaviour. For example, research shows that approximately 15% of alcoholics and a high rate of heroin addicts die by suicide (Commonwealth Department of Health and Aged Care, 2000; National Health and Medical Research Council, 1996).

While addiction to substances is known to be related to depression, researchers have just started to investigate the relation between depression and the other forms of addiction, such as erotomania, violence, workaholism (Khantzian et al., 1990). According to clinical observations and theory, most mental health professionals would not detect those addictive behaviours or the underlying depression that nourishes them, and people are usually categorised as having “personality disorders” (Real, 1997).

In erotomania, or love addiction, the depressed man gains his self esteem from the person he is in love with or from sex, but when relation or affair ends, his sense of self worth plunges and he starts having withdrawal symptoms. The withdrawal can drive him back to the next sexual conquest (Real, 1997). In severe cases the withdrawal can have a negative impact and symptoms develop similar to those of substance detoxification, such as panic attacks, obsession, psychotic breakdown, an increase in the level of depression, stalking, homicide and suicide (Mellody, 1992). The problem could be worse when the man is having an affaire or affaires and he has a partner or a family (wife and kids), which leads to tension with the wife or partner, arguments, divorce, collapse of the family and other problems (Amirkhan, 1990; Billings & Moos, 1981; Bonin, McCreary & Sadava, 2000; Lazarus & Folkman, 1984; Nolen-Hoeksema, 1987, 1995 & 1999; Pearlin & Schooler, 1978; Khantzian et al., 1990; Real, 1997; Royal College of Psychiatrists, 1998; Ugal, 2003). Of all men, those who are divorced are most likely to kill themselves, probably because depression is more common and more severe in this group (Nolen-Hoeksema & Larson, 1999). This may be because following divorce, as well as losing their main relationship, men often lose contact with their children, may have to move to live in a different place, and can find themselves financially impoverished. These are stressful events in themselves, quite apart from the stress of the break-up, and are risk

factors for depression. This is especially true when the loss is not acknowledged and not addressed in supportive psychotherapy (Stroebe, 1998).

In matters of violence, men are known to be more violent than women. Men make up close to 93 percent of the total of the jail population (Kimbrell, 1995). Some studies have shown that men who commit violent crimes are more likely to get depressed than men who don't. However, it is not known if the depression makes their violence more likely, or if it is just the way they lead their lives (Royal College of Psychiatrists, 1998). Based on whom the depressed person is abusing, there are two forms of violence: external and internal. In external violence the depressed man is considered to be releasing his hurt by inflicting it upon others, in the form of verbal outburst of anger or irritability, physical violence (Francis-Cheung & Grey, 2002), bullying or stalking (Real, 1997). Violence makes him feel better because it helps him release his pain and boost his self esteem. In the case of internal violence, the man turns the violence inwards, against himself. He may engage in self injury or mutilation, such as cutting his arms with a knife or razor, although this is more common in women, or hitting himself or even suicide (Francis-Cheung & Grey, 2002; Real, 1997). Terrence Real (1997), in his book "I do not want to talk about it", considered addiction to violence to be a form of what he calls "elevation", in which the "man's sense of power becomes inflated, so that he feels supremely gifted, even godlike" (p. 64-65). For Real (1997), the addiction to violence is the most plain and direct form of elevating intoxication, because the man acts as a superior by torturing and domineering others.

In contrast to violence or stalking which is easy to spot as a problem, workaholism for men is less obvious because it is culturally approved and rewarded. A job provides a person with a lot of resources. Such resources include time, money, a social network of

friends as well as more individualised and psychological resources (Cohen & McKay, 1984; Cohen & Wills, 1985; Francis-Cheung & Grey, 2002; Lincoln et al., 2005; Thoits, 1986). Research has shown that 14.28% of men who become unemployed for any reason, such as retiring from paid employment or leaving work, will develop a depressive illness in the next 6 months (Kinsella & Gist, 1995), and if a man gets depressed, he may well find it harder to get another job, which may make his depression worse (Caplan, 1989). Hobfoll (1989) found that people who lose their jobs and are without financial resources, without a support network, and with little time to find another job, were less able or less likely to exert proactive efforts in looking for work than their more resource-wealthy counterparts. Although work is important still workaholism can bring with it problems. Depressed workaholic men tend to give their work a higher priority than their personal and home life, which produces conflicts with their wives or partners (Royal College of Psychiatrists, 1998). Furthermore, workaholism promotes fewer healthy behaviours and that can have tragic impact on ones' health, particularly for men, as overall men are known to have less healthy habits and lifestyles than women (Davies et al., 2000; Kandrack et al., 1991; Walker et al., 1988) such as, sun exposure, driving risks, physically dangerous activities, and sexually transmitted infections (Mermalstein et al., 1992; Weissfeld et al., 1990; Zuckerman, 1994) together with men's failure to adopt positive health behaviours, for example conducting regular check-ups (Katz et al., 1995). The statistics show that men's life expectancy is 7 years less than women's (US Dept of Health and Human Services; 1995) and that they have higher rates of the 15 leading causes of death (Courtenay, 2000).

In conclusion, as was outlined studies have consistently found that men of different ages, ethnicities, and social backgrounds are, on average, less willing than women to seek

professional help for physical and mental health problems, particularly depression, and thus many men who are depressed remain unidentified, undiagnosed, and untreated. As suicide rates in men continue to rise (Australian Bureau of Statistics, 1999; Hoogland & Pieterse, 2000; World Health Organization, 1993, 1994, 1995 & 2005) and large numbers of men suffer from problems closely related to depression, such as alcohol and drug use (Blazer et al., 1994; Kessler et al., 1994; Real, 1997; Robins & Reiger, 1991; Schutte, Brennan, & Moos, 1998), it is clear that depression is a matter of serious concern for men

B. Gender Role Socialisation and the Difference in Rates of Depression between Women and Men

The fact that men and women differ in how frequently they demonstrate a set of behaviours, such as depression, reveals little about the biological, psychological, or cultural processes responsible for the observed differences (Mechanic, 1978). The sex-differences or gender bias explanation outlined above is limited in that it fails to provide an explanation for differences between men and women in help-seeking patterns, and leaves it unclear why men as a group should be less likely to seek help and to cope with their depression on their own.

Instead of sex differences, Silverman (1994) called attention to the importance of gender-related knowledge, acknowledging its impact upon “the cause and treatment of psychological disorders” (p. 228). Heppner (1995) proposed that for some individuals, in particular males in therapy, their troubles or issues seem to be very intertwined with gender-role issues. Moreover, Heppner recommended that from a clinical perspective, it is imperative to understand how some men are particularly affected by culturally prescribed gender-role concerns.

1. Masculine Gender Role Socialization

Gender role socialisation paradigms begin with the assumption that men and women learn stereotyped gender attitudes and behaviours from cultural values, norms, and ideologies about what it means to be men and women (Pleck, Sonenstein, & Ku, 1993; Thompson & Pleck, 1986). For example, traditional gender role stereotypes portray men as strong, self-reliant, stoic, aggressive, physically tough, and having control of their emotions (Brannon & David, 1976; Good, Dell, & Mintz, 1989; Levant & Pollack, 1995; Pleck, 1981; Pollack, 1998; Real, 1997). Furthermore compared with women, men tend to be far more concerned with being competitive, powerful and successful (Davies et al., 2000). Research shows that traditional gender roles for men have both positive and negative effects on their psychological well being (Cournoyer et al., 1995; Good et al., 1994). Stereotypically masculine qualities that are usually considered advantageous or positive include self-esteem, assertiveness, and independence (Antill & Cunningham, 1979; Bem, 1974, 1977; Whitley, 1983, 1985). However, research suggests that there are also burdens associated with the traditional male gender role. These include increased risk-taking and self-destructive behaviours (Meth, 1990), increased stress (Eisler & Skidmore, 1987), increased levels of anxiety and anger (Eisler, Skidmore, & Ward, 1988); lack of concern for health (Nathanson, 1977), poor health-related behaviours (Eisler et al., 1988; Kandrack et al., 1991; Walker et al., 1988), increased perception of being invulnerable to a variety of health concerns (Savage, 1993; Weissfield et al., 1990), increased psychosocial and physiological risk factors for developing cardiovascular disease (Watkins, Eisler, Carpenter, Schechtman, & Fisher, 1991), emotional inexpressiveness (Fleck, 1981), and the drive to accumulate money, power, and sex partners (Kimmel & Levine, 1989).

2. Gender Role Conflict and Related Concepts

Recent theory and research on gender role socialisation has focused upon the conflict that men experience when striving to attain traditional masculine goals such as success, power, and restricted emotionality (O'Neil, 1982). Many scholars (Leafgren, 1990; Pleck, 1981 & 1995) have hypothesised that men may experience a loss of psychological well-being trying to achieve these masculine goals. The empirical research supporting this view indicates that the maladaptive psychological effects may be due in part to the restrictive nature of the traditional gender roles to which men attempt to adhere, as well as the psychological strain felt when there is a failure to achieve these masculine role ideals (Blazina & Watkins, 1996; Good & Mintz, 1990; Good et al., 1995; Sharpe & Heppner, 1991).

O'Neil et al. (1986) have defined this strain as gender-role conflict. According to O'Neil gender role conflict is a psychological state where “rigid, sexist, or restrictive gender roles” learned during socialisation have negative consequences or impact which include “personal restriction, devaluation, or violation of others or self” (O'Neil, 1990; p. 25). Thus, gender role conflict is a combination of cognitive, emotional, unconscious, or behavioural problems caused by the socialised gender roles learned in sexist and patriarchal societies.

Gender role conflict, as described by O'Neil and his associates, is a multidimensional, complex concept, and quite individualised in the way it is learned, internalised and experienced (O'Neil, 1981a & b; O'Neil et al., 1985; O'Neil et al., 1986; O'Neil et al., 1995). There are also generational, racial, sexual orientation, class, age, and ethnic differences in the experience of gender role conflict.

Despite all these differences, O'Neil and associates were able to develop a scale that measures gender role conflict level. The scale consists of four factors:

Success, power, and competition (SPS); this is a measure of the emphasis that a man places on achievement, authority and control over others, and the struggle against others for personal gain.

Restrictive emotionality (RE); this refers to a man's difficulty with his own emotional self-disclosure, as well as discomfort with the emotional expressiveness of others.

Restrictive affectionate behaviour among men (RABBM); this is an index of discomfort with expressions of caring between men.

Finally Conflict between work and family relations (CBWFR) which refers to the level of distress experienced by men due to the impinging of work or school on personal and family life (O'Neil, 1981b; O'Neil et al., 1986).

Following O'Neil, it can be argued that the psychological underpinning of gender role conflict or strain includes the fear and rejection of those qualities deemed feminine (O'Neil, 1982; O'Neil et al., 1986). According to O'Neil and his associates (1986), the fear of the feminine helps define what is optimally masculine, guiding the development of "appropriate" masculine gender roles through assessing and then rejecting those gender-specific behaviours considered traditionally as feminine. This includes, but is not limited to, emotional intimacy, vulnerability, and emotional dependency. O'Neil et al. (1986) noted that the fear of the feminine is not only a guiding force for adult men concerning what is appropriate gender-role behaviour, but also it is a heavy-handed part of the socialisation process for boys and young men, perpetuating the restrictive gender-role patterns of prior generations. Gender role conflict and its relation with fear of the feminine has been observed by other theorists and researchers. Maguire (1995) explained

that the early severing of emotional attachment with the mother causes men to deny their "psychic femininity," helplessness, vulnerability, and the wish to return to a symbiotic relationship with the primary love object. Blazina and Watkins (1996) suggested that, as a way of protecting themselves from gender-role conflict, males project these intrinsic needs onto women, attempting to distance themselves from their shame of not matching the traditional gender ideal. Levinson and colleagues (1978) proposed that men perceive feminine parts of themselves as dangerous and try to neglect or repress them. Karen Horney (1932) suggested that men fear women and attempt to distance themselves from the feminine. She also noticed that men's sense of masculine identity is unsteady, never quite being on solid ground. Men are left with two options: distance themselves from the feminine or engage in hyper-masculine behaviour as a way of compensating for fears of a failing sense of masculinity. Horney suggested that this dread of the feminine drives many of the stereotypical masculine behaviours.

3. Gender Role Conflict and Empirical Investigations

a. Gender Role Conflict and Psychological Well-being

Over 130 studies have used the gender role conflict scale in correlation with a wide variety of demographic and health variables (O'Neil & Good, 1997).

Those studies examining the relationship between gender role conflict and psychological well being have shown that adherence to the traditional male role has been linked to poorer psychological health (Cournoyer & Mahalik, 1995; Davis, 1988; Good & Mintz, 1990; Tokar et al., 2000; Sharpe & Heppner, 1991). For example, assessing a variety of psychological health dimensions, Sharpe et al. (1991) reported that two gender role conflict factors were positively correlated with depression, and three out of the four factors were correlated with anxiety, low self-esteem, and low capacity for intimacy.

Cournoyer and Mahalik (1995) examined the relation between gender role conflict factors and psychological well being for both college-aged and middle-aged men. Their results indicated that three of the four gender role conflict factors were related to psychological well being and particularly related to higher levels of depression and anxiety. Good and Mintz' (1990) study of gender role conflict and depression in college men similarly found that all four gender role conflict factors were associated with higher scores on a measure of depression.

Good and Wood (1995) identified a pattern of relationships between gender-role conflict and help seeking that the authors labelled double jeopardy. Different components of gender-role conflict were associated with an increased likelihood of depressive symptoms.

Studies indicate that of the four factors of gender role conflict, restrictive emotionality (RE) is most closely linked to psychological well being. For example, Blazina and Watkins' (1996) study of the masculine gender role conflict effects on college men's psychological well-being, chemical substance usage, and attitudes toward help-seeking, found that those indicating greater RE had decreased psychological well being including more anxiety, more anger, and greater similarity to personality styles of chemical abusers.

b. Gender Role Conflict and Willingness to Seek Help for Psychological Problems

Good, Dell, and Mintz (1989) found that gender role conflicted men who had restrictive emotionality (RE) and restrictive affectionate behaviour among men (RABBM) “were more reluctant to seek help for psychological problems.” Furthermore, Blazina and Watkins (1996), Blazina and Marks (2001), and Robertson and Fitzgerald (1992), found that gender role conflicted men regarding the factors of success, power, and competition

and restrictive emotionality had negative attitudes towards seeking professional psychological help.”

4. Criticisms of Empirical Research: Gender Role Conflict and the Need for more Research

Given the results from the studies noted above, there seems substantial evidence to suggest that gender role conflict relates to psychological health (e.g. Blazina & Watkins, 1996; Good & Wood, 1995; O’Neil, 1997; Tokar et al., 2000), and attitudes towards help seeking (e.g. Good, Dell & Mintz, 1989; Blazina & Marks, 2001; Blazina & Watkins, 1996; Robertson & Fitzgerald, 1992; Tokar et al., 2000). Men who experience gender role conflict seem to be reporting greater psychological distress than other men, while being more reluctant to seek assistance; they find it difficult to ask for help when they are depressed - it can feel unmanly and weak, thus they often hide or mask their feelings of depression (Cochran & Rabinowitz, 2000; Real, 1997). Investigations are clearly needed to understand how to facilitate men to seek psychological assistance when they are depressed, and how to meet the requirements and therapy preferences of men. There is specifically a need for research in the following areas- areas in which existing studies have not addressed the part of gender role conflict or in which various results are conflicting or inadequate, as it is outlined below.

a. Gender Role Conflict and Men’s Preferences for Therapy

Researchers have argued that there is an urgent need to examine gender role conflict in relation to therapy or counselling, as such research might provide practitioners with more specific clues (Cournoyer et al., 1995). Taking into account a wide range of client variables is important to therapeutic outcome. Clients have preferences, beliefs and

expectations about therapy as well as about the professionals they consult. This has important practical implications. As Furnham and Wardley (1990) commented: "...if a person goes to a therapist for therapy that he or she does not understand, believe in, or has unrealistic expectations of, it may well be that he or she will fail to take part in the therapy or will render it ineffective." This is supported by Vera et al.'s (1999) study of perceptions and evaluations of similarities and differences from their counsellors, as a variable affecting therapeutic outcome. Vera et al. asked 47 community mental health clients (males and females) in an open-ended format to describe the ways in which they were similar and different from their counsellors (age, gender, ethnicity, etc.). They also asked them to rate how significantly these similarities and differences affected counselling. Results revealed that similarities, which clients preferred, had a stronger impact on the counselling relationship. The importance of clients' therapy preferences in relation to therapeutic outcomes has been explicitly addressed in two recent published studies. In the first study, by Navjot Bedi and colleagues (2000), patients with major depression were treated for 8 weeks either using non-specific counselling or antidepressants. Patients were generally satisfied with both treatments, although some measures indicated slightly more dissatisfaction among patients treated with antidepressants. In the other study, by Elaine Ward and colleagues (2000) non-directive counselling and cognitive-behavioural therapy, as well as "usual general practitioner care" were used in reducing depression. Satisfaction ratings were higher for the psychological treatments than for usual care. Both research studies concluded that general practitioners should refer depressed patients to counsellors if patients prefer this. Patients expressing a strong preference for counselling will probably do just as well with their choice as with antidepressants (Lam, 2001). The importance of clients' therapy preferences in relation to therapeutic outcomes is also indicated in Furnham and

Wardley's (1991) examination of the extent to which a sample of British respondents differentiates between various "psychological therapies." Their research has noted that the respondents differentiated between cognitive therapy, behavioural, psycho-dynamic therapy, regression therapy (e.g., hypnosis), biomedical/medical therapies (e.g., chemotherapy, psychosurgery), and feedback therapy. Not only were some of these therapies viewed as more efficacious, but "expected efficacy was also found to be inversely related to client experience" (Furnham & Wardley, 1991). Studies indicate that a client's previous experience affects their expectations and evaluations of therapies. Furnham and Wardley (1988) reported that "patients who were visiting a homoeopath had quite negative opinions about the effectiveness of traditional doctors." This was because the patients were not satisfied "with the quality of traditional medical care and with medical services in general." It is clear that these variables significantly affect outcomes.

While client preference for specific types of therapy is critical, existing studies relating to patients' preferences for therapies for depression are conflicting and/or non-conclusive. Research that has looked into patients' preferences for therapies for depression in general has shown that most patients prefer non-medication treatments, such as counselling, for treatment of depression (Priest, Vize, Roberts, Roberts & Tylee, 1996). However new evidence suggests that though this could be true in the case of the overtly depressed (patients whose symptoms are clear to everybody); it is not necessarily true in the case of the covertly depressed (people whose depression is hidden from those around them and from their own conscious awareness). This is especially so in the case of men who rarely seek help (Real, 1997). Investigations (Good, Dell, & Mintz, 1989; Good et al., 1995; Wills & DePaulo, 1989) indicate that a number of men are in need of psychological

assistance but their response to problem labelling and help seeking may be different to women's.

The differing conclusions of the foregoing studies indicate that the issue of therapy preference in the case of depressed men is still a debatable and inconclusive issue (Good, Dell, & Mintz, 1989; Good et al., 1995; Wills & DePaulo, 1989; Real, 1997; Marlat, 1987; Styron W, 1994). Moreover, most researchers recognise (Glass et al., 2001; Grencavage & Norcross, 1990; Stiles et al., 1986) that there is a sparsity in research, not only about clients preferences for therapy's types, but also about clients' attitudes and behaviours in relation to therapeutic conditions, such as accessibility, length of therapy, modality of therapy and therapist's characteristics, which affect both the utilisation and success of mental health services. Furthermore, with the notable exception of Terrence Real (1997), the issue of therapy preference in men has been mostly ignored or has not been addressed or studied qualitatively.

b. Relationship between Men's Coping and Therapy Preferences

Researchers have argued that the validation of the gender role conflict model relies on reducing dependence on simple correlational designs and on exploring more complex relationships, including the role of mediating variables, especially the impact of coping as a mediator on gender role conflict related issues such as therapy (Heppner, 1995; Llewellyn-Smith, 1999). Mediator model place stress on describing how relationships between variables (i.e. gender role conflict) and criterion (i.e. therapy preferences) (Baron & Kenny, 1986; Kenny, 2005) occur, rather than identifying when they occur (Quittner, Gleckouf & Jackson, 1990). To do that, mediator models usually look to the intervening variables or the indirect pathways that could be affecting the relationships between variables.

Studies that have used the mediator model have repeatedly shown the importance and fertility of mediator hypotheses as a method of inquiry (Quittner, Gleckouf & Jackson, 1990). A significant and well studied example of mediator variables, which has been examined between different sort of stressors and their outcomes, is coping.

Coping, which is defined as the sum of behavioural and cognitive efforts that a person uses to adjust to a stressful event or condition (Lazarus & Faulkman, 1984), consistently and through different research studies, has been found to mediate people's adjustment in stressful situations (Lazarus & Faulkman, 1984).

Research dealing with people's coping strategies in response to distressing situations has consistently shown that different people employ different strategies, and that strategies vary in efficacy. Emotion-focused coping, which targets regulating the emotional distress caused by stress, seems to be highly related to negative results, such as depression and self blame (Endler & Parker, 1990). Task oriented coping, which aims at changing or regulating the source of stress seems to be related to positive results, for example, lower rates of depression (Endler & Parker, 1990). The consequences of avoidance strategies, which try to avoid the stressor through using drugs, alcohol, or any distracting means, are not clear yet. They have both positive (Kliwer, 1991) and negative outcomes (Real, 1997).

To date, the possible relationships between coping as a mediator and traditional gender role have only been briefly addressed, by Bergen (1996) and Peter Llewellyn-Smith (1999). This is surprising given the abundance of research that has consistently linked coping strategies to mental illness, including depression (Carver et al., 1989; Chino and Funabiki, 1984; Endler & Macrodimitris, 2001; Endler & Parker, 1990 & 1994; Felsten, 1998; Funabiki et al., 1980; Kleinke, Staneski & Mason, 1982; Morrow & Nolen-

Hoeksema, 1989; Nolen-Hoeksema, Morrow & Fredrickson, 1989) and the edifice of research that has examined the relationship between psychological well being and mental illness and gender role conflict (Cournoyer et al, 1995; Eisler & Skidmore, 1987; Eisler, Skidmore, & Ward, 1988; Good, et al, 1994; Meth, 1990; Stewart & Lykes, 1985). Both Bergen (1996) and Peter Llewellyn-Smith (1999), relying on the hypothesis that that rigid adherence to the male gender role is “dysfunction-producing” (Blazina & Watkins, 1996; Good & Wood, 1995; Pleck, 1981; O’Neil et. al, 1986; Eisler & Skidmore, 1987), and that particular coping styles are “tentatively” linked to certain gender roles (Eisler, 1995), hypothesised that the gender role conflict affects the choice of coping repertoire, which in turn affects adjustments. Bergen (1996) examined the coping strategies that college aged men typically employ in relation to seeking help. His technique was to employ vignettes designed to induce high or low gender role conflict. The results of the study led Bergen to conclude that the coping strategies of college aged men do not mediate the relationship between gender role conflict and well being.

In 1999, Peter Llewellyn-Smith both criticised and extended Bergen’s research methodologically and conceptually. Llewellyn-Smith (1999) criticised Bergen’s research for using a middle-class college sample and excluding any analysis of critical antecedent variables, such as age. Furthermore, he criticised Bergen’s design for resting upon two false assumptions: 1) assuming that high scores on gender role conflict are definitely related to pathology and 2) the use of vignettes to induce high or low gender role conflict, assuming that gender role conflict is a situational stressor, while O’Neil et al.’s (1981a, 1981 b, 1986 & 1995) construct is designed to measure men’s gender role conflict levels (high and low) and attitudes beyond situations and contexts. In his exploratory research Llewellyn focused on the role of coping style as a mediator of the relationship between traditional male gender roles and psychological pathology. The results of the research led

Llewellyn (1999) to conclude “individuals coping repertoire mediates the relationship between gender role stress and wellbeing.”

c. Gender Role Conflict across Demographic Groups

There is a need for further information about the extent of gender role conflict across diverse samples of men from various racial, ethnic and socio-economic groups, as well as across different age groups. Lack of existing information about the extent of gender role conflict across these demographic variables is in part due to sampling and response biases in collecting data, but specifically there is a scarcity of data relating to non-college aged men. For example, Wisch et al. (1995) examined the impact of gender role conflict and emotion vs. thought based counselling, through the use of a counselling videotape, on psychological help seeking in men. Results indicated that men scoring high on gender role conflict who viewed a counselling session that focused on feelings are least likely to indicate a willingness to seek psychological help compared to other men. However some limitations of this study must be mentioned. First, the sample primarily consisted of white undergraduate males. Caution must thus be employed in generalising these results to older men, less educated men of the same age, and men from other cultures and ethnic backgrounds.

There is evidence to suggest that GRC is experienced differently by different age groups. For example, Cournoyer and Mahalik (1995) examined the relation between gender role conflict factors and psychological well being for both college-aged and middle-aged men. Their results indicated that college-aged men scored significantly higher on “Success Power and Competition” than middle-aged men; and that middle-aged men scored significantly higher than college aged men on “Conflict between Work and Family Relations”. No age group differences were found for “Restrictive Emotionality” or

“Restrictive Affectionate Behaviour between Men”. Theodore and Lloyd (2000) replicated the Cournoyer and Mahalik study in a sample of educated middle-class Australian males across three age groups (18-24, 36-45, and 60-plus years). The study replicated the results of Cournoyer and Mahalik (1995) in respect to the analyses of age-group differences. They concluded that, in general terms there must be many parallels for men in both cultures of the United States and Australia.

However, with regards to age-group differences in the studies of Gender Role Conflict and its relation to psychological well-being, the research as a whole is limited and more research is needed.

d. Qualitative and Combined Methodologies

Gender role conflict empirical studies have been critiqued due to the fact that most of the research has relied on simple correlational designs. Heppner (1995) proposed that one way of diminishing the reliance on simple designs is to use qualitative research, which could be useful for discovering additional dimensions or new perspectives on gender role conflict or in relation to gender role conflict. On the other hand, Davidson-Katz (1991) proposed the use of a “complex of methodologies” (quantitative/qualitative), instead of one method, which could prove fruitful in studying the issue of depression and therapy preferences in depth, especially from the point of view of men. Another alternative is to explore more complex relationships, including the moderating and mediating variables that are required to give greater specificity to the GRC model (Heppner, 1995), especially examining the impact of coping as a mediator on gender role conflict related issues such as therapy.

In general, coping seems to clearly mediate stress-outcome relationships. However the role of coping as a mediator in relation to gender role conflict is not clear due to scarcity

of the existing research (two studies only) and the conflicting or contradictory results of the two studies (Bergen, 1996 and Llewellyn-smith, 1999) due to differences in methodologies and concepts. Clearly as Llewellyn-smith (1999) suggested further research is needed to extend Bergen's research beyond his limited framework, in the same time, as Heppner (1995) suggested, further research is needed about the role coping as a mediator of gender role conflict relationships with various variables, among which men's preferences for therapy, a central issue in the current research.

III. The Present Study

Given the results from the studies above it seems that the issue of gender role conflict, depression and therapy preferences has not yet been addressed in sufficient depth and specificity. There is a need for more research in the areas of gender role conflict and men's therapy preferences, and in men's coping and therapy preferences, as well as a need for qualitative and complex methodologies studies. The current study has four central aims, distributed on three stages:

Stage One Aims

The first stage aims to examine the relation between gender role conflict and therapy preferences for depression so as to determine whether GRCS can predict the therapy that men (scoring high and low on GRCS) choose.

Stage Two Aims

The second stage aims (1) to examine whether exposure of men reporting high or low gender role conflict to either emotion-focused or thought-focused therapy, through the use of a counselling video, influences subsequent preference for type of therapy, and to examine the overall influence of exposure to therapy, through the use of a counselling

video, on the subsequent preferences for therapies for men, both in general and in high and low gender role conflict, and (2) to analyse the role of coping as a mediator of the relationship between gender role conflict and preferences for therapies.

Stage Three Aims

The third stage aims to provide an in-depth examination of traditional men's perspectives on therapy and on particular issues inherent in living the experience of depression: seeking help for depression, the barriers to seeking help, and their views on how to make psychological services more appealing.

The three stages are the result of adopting the notion "methodological pluralism": that different types of research questions determine the appropriateness of the research methods (Barker et al., 1994). For example, while correlational methods are the best way to approach questions in which the goal is to describe the relationship between naturally-occurring phenomena, qualitative methods are the best for research questions that focus on experience and meaning. The present study adopted this approach in an attempt to match the different aspects of the phenomenon in question by relevant methods.

The aims of the current study are described in detail in the following three chapters; each chapter represents a stage of the three stages.

CHAPTER 2

MASCULINITY AND PREFERENCE FOR THERAPY

The current chapter covers the methodology, results, and discussion of the first stage of the research, which, as reported in Chapter One, examines the relation between gender role conflict and therapy preferences for depression, so as to determine whether gender role conflict influences preference for type of therapy that men (scoring high and low on GRCS) choose. This is in response to calls for much needed research on the relation between gender role conflict and therapy or counselling (e.g. Cournoyer & Mahalik, 1995) as such research might provide practitioners with more specific clues about men's preferences, beliefs and expectations about therapy, especially in light of the finding that clients' therapy preferences seem to have practical implications in relation to therapeutic outcomes (e.g. Furnham & Wardley, 1990 & 1991). Investigating the issue of gender role conflict and preferences for therapeutic conditions is important and needed, since, as most researchers recognise (Glass et al., 2001; Grenavage & Norcross, 1990; Stiles et al., 1986), these affect both the utilisation and success of mental health services. Another reason is that the literature on the relationship between various types of client preferences to therapy is sparse (Glass et al., 2001), particularly in relation to gender role conflict. By examining the relationship between gender role conflict (GRC) and therapy preferences, this stage of the study aims to answer a series of questions. Firstly, do men who score high on the gender role conflict scale prefer biomedical/medical therapies for depression more than men who score low on the gender role conflict scale? This prediction is built on the theory that high gender role conflict men avoid emotional expressiveness (Bem, 1974, 1977) because it is considered feminine (O'Neil, 1981a, 1981b, 1982), and gender role conflicted men fear and avoid what is considered feminine, or unmanly. Secondly, do

men who score low on the gender role conflict scale prefer counselling therapies for depression (e.g. existential, humanistic and cognitive therapies) more than men who score high on the gender role conflict scale? Thirdly, are there differences among the four subscales of the gender role conflict scale (1-success, power, and competition; 2-restrictive emotionality; 3-restrictive affectionate behaviour between men; and 4-conflicts between work and family relations), in relation to preferences for biomedical therapies? Fourthly, is scoring high or low on gender role conflict related to preferences for therapeutic conditions, or any of its four components, namely, accessibility, length of therapy, modality of therapy and therapist's characteristics? And if so, how?

The design of this first stage of the research is a simple correlational design. The predictor is gender role conflict (high and low, and four subscales). The criterion is the preference for therapy (involving therapeutic techniques: behavioural, cognitive, biomedical and psychoanalytic; as well as therapeutic conditions: accessibility, modality, length of therapy and the characteristics of the therapist).

METHOD

Participants

Three hundred and ninety seven community-based men, age ranged between 18 and 45 years, were recruited using posters and information sheets from the Sydney metropolitan area. 281 men were aged 18-30 years and 170 men were aged between 31-45 years. Although the participants are Australians citizens, they are of different ethnic backgrounds. The strongest contributors to the sample are the Asian participants (46%), followed by the respondents of European background (36%), Middle Eastern (11.1%) and then Latino (4%). The percentage of participants from other ethnic groups was minor and varied between one per cent (Pacific Islands) and 0.3% (Aboriginal Australians).

The participants included university students (both undergraduate and graduate), as well as working adults who were recruited from universities (University of Western Sydney, University of Sydney and Macquarie University) and other occupational groups (Telstra, Sky news, Everwerington, and others). 12.1% of the participants have secondary education, 49.6 % have post secondary education, 32.2% of the respondents have passed at least one year at the university, and 4.8% have postgraduate education. 70.5% of the respondents are employees and 29.5% are full time students. 43.9% of the employees are blue collar workers (unskilled, semi skilled, or skilled) while the rest (56.1%) are white collar workers (clerical, administration, management, professionals). The participants were all physically healthy, only a small number of participants (3.5%) acknowledged having health problems. This included heart problems (1%), followed by cancer (0.8%), then asthma, diabetes, and eye problems (0.5% each) and blood pressure (0.3%). In relation to mental health, although the study did not specifically recruit man who had experienced mental disorders, in particular depression, 71% reported having experienced some sort of depression, 15.4% were not sure whether they had experienced depression or not, and only 12.8% said that they had had no previous experience with depression. Only 11.3% of the respondents confirmed seeking some sort of help for depression. See appendix J, for substantial information about the demographics of the participants in the present study.

Instruments

The Gender Role Conflict Scale (GRCS; O'Neil et al., 1986)

GRCS measured the level of gender role conflict in men (the degree to which the traditional male gender role interferes with the well-being of men and those with whom they interact). The GRCS contains 37 items (Appendix A). Each item consists of a

statement that the participant responds to on a 6-point Likert-type scale, with responses ranging from "strongly agree" to "strongly disagree." O'Neil et al. (1986) found that the GRCS loaded on four factors: 1. restrictive emotionality (RE), 2. success, power, and competition (SPC), 3. restrictive affectionate behaviour among men (RABBM) and 4. conflict between work and family relations (CBWF). These four gender role conflict patterns have been consistently found by researchers in ongoing construct validity studies of the GRCS. Internal consistency reliabilities scores in previous research ranged from .75 to .85 and test-retest reliabilities ranged from .72-.86 for each factor (Good et al., 1995; O'Neil, Good, Holmes, 1995).

Preferences for Therapies

A combination of two questionnaires was used, one focused on techniques and the other focused on therapeutic conditions. The preferences for therapeutic techniques questionnaire (Furnham & Wardley, 1991) presents 22 therapies (psychotherapy, systematic desensitisation, assertiveness training, rational-emotive therapy, thought-stopping therapy, non-directive therapy, existential therapy, Gestalt therapy, aversion therapy, implosion therapy, token economies, behaviour contracting, modelling/role playing, chemotherapy, electroconvulsive therapy, group therapy, biofeedback, hypnosis, megavitamin therapy, psychodynamic therapy, primal scream therapy and psychosurgery), with descriptions of the various therapies that a person might consider in an attempt to get help for psychological disorders.

For each therapy the respondent is asked to place a number between 1 and 9 to indicate how likely he would be to choose the therapy. 1=extremely unlikely; 9= extremely likely (Appendix B). The questionnaire is not validated or standardised, as it was designed by Furnham and Wardley (1991) as an inventory of the available therapies. The

questionnaire was previously used by Furnham and Wardley (1991) and by Heaven and Furnham (1994).

Nine individual questions that were posed by the researcher were included to examine participants' preferences for therapeutic conditions. These covers two sets of questions: The first set of questions covers three issues related to therapy characteristics, in particular therapies' modality, length and accessibility; and the second set of questions covers four issues related to the characteristics of the therapist, namely, age, gender, race and experience level (Appendix B). Under characteristics of the therapy, each topic (modality, length and accessibility) consists of several options that the participant ranks them in order of preference. For example, in the matter of accessibility the options are, constancy or regularity of therapy (e.g. weekly or monthly appointments), affordability, accessible hours, and not to be kept in the waiting room is fourth. As for length of therapy the options are brief therapy, long therapy and none specified therapy. For preferences for therapy modality the options are individual therapy, and other modalities, such as family or group therapy.

In the analysis, only the first ranked preference of each participant was used due to the ordinal nature of this data. While under the characteristics of the therapist, each topic (age, gender, race and experience level) consists of several options that the participant is asked to select only one characteristic he considers important and later on to rank the four topics (age, gender, race and experience level) in order of importance. The options that the participants have under each item of the characteristics of the therapist section are as follow: For the age of the therapist the options are, prefer the therapist to be older than them, prefer the therapist to be of their age or younger or consider the age of the therapist as not important. For gender of the therapist the options are, prefer a male therapist only, prefer a female therapist only, or prefer to have mixed therapists or collaborative

therapists (two therapists one is male and the other is female). As for the race or ethnicity of the therapist the options are, prefer white therapist, prefer therapist of mixed racial ancestry or Métis or prefer to have a therapist of visible ethnicity (to be able to tell what the therapist's ethnicity is), or race is not important. The experience of the therapist the options are, prefer an experienced therapist, prefer a therapist in training, prefer a mixed therapist (experienced but still in training) or consider the therapist's experience as not important. The current study investigated the preferences for therapeutic conditions, for both therapy and therapist characteristics, not only because they meet with purpose of the current study, but also because as most researchers recognise (Glass et al., 2001; Grenavage & Norcross, 1990; Stiles et al., 1986), these affect both the utilisation and success of mental health services.

The Attitudes toward Seeking Professional Psychological Help Scale (ATSPPH; Fischer & Turner, 1970)

Fischer and Turner developed this scale to assess the propensity of an individual to seek psychotherapeutic assistance. The ATSPPH scale consists of 29 statements, which the participant rates on a 4-point Likert-type scale, ranging from "agree" to "disagree." The ATSPPH scale as originally constructed consists of four subscales measuring need, stigma, openness, and confidence. ATSPPH is reliable, its internal consistency is high ($r=.83$). ATSPPH discriminated significantly on an empirical ("known-groups") basis, between those who have sought professional help and those who have not (for males, $p<.001$; for females, $p<.0001$). The ATSPPH overall scale score was used by Good, Dell, and Mintz (1989) in their study of the relationship between men's gender role conflict and attitudes towards seeking psychological help (Appendix C).

Demographic Information

This was designed to gather information from participants concerning age, ethnicity, social status, sexual orientation, economic status, education and profession as well as previous experience with depression and presence of any physical health and seeking help (Appendix D).

Procedure

Recruitment for the first part of the project was based on posters and information sheets (Appendix E), distributed in different organisations and institutions. The participants were informed as to the nature of the research being conducted prior to their consent to participate in the study (Appendix H). The posters and sheets invited men to participate in a study investigating what men think about the psychological services and what kind of therapy they prefer for depression. Furthermore the advertisement advised the participants about the procedures and the questionnaires involved in this study, how the results will be used, their rights and how to participate. And finally the men were advised about a second stage study and they were instructed what are the requirements of participations in the second stage. After they had stated that they were satisfied and understood the nature of their participation, each participant was given or mailed a sealed packet. The packet contained the measures, information and consent forms, as well a separate sheet to fill in with their contact details if they were willing to take part in a further study. Furthermore, they were reminded that there were no right or wrong answers. The completed forms were returned to the researcher in person or by mail in prepaid plain, non-identifying envelopes.

The materials in the questionnaire battery were distributed according to the following order:

1. Gender Role Conflict Scale
2. Seeking Professional Help
3. Preferences for Therapies
4. Demographic Information
5. Information and Consent Forms

Finally, the participants were invited to take part in a second study and were advised that those who agree to take part in both studies will automatically enter a draw on three prizes (1st AU \$500, 2nd AU \$300 and 3rd AU \$ 200). The measures and papers in each packet had a specific sequence number. The sequence number was used to retrieve the results of the participants who took part in the second part of the study (Appendix E and F). The procedures and use of draw prizes received full ethics approval.

RESULTS

For simplification, the presentation of the statistical analysis is divided into three sections. The first section presents the results of the preliminary analyses; the second section presents the results of the main analyses, while the third section presents the results of the supplementary analyses.

I. The Preliminary Analyses

The preliminary analysis examines the main components of the current stage. First, it examines the psychometric properties of the gender role conflict scale factors (O'Neil, 1981a; O'Neil et al., 1985; O'Neil et al., 1986). This is an important step, necessary to establish the validity of the results of the current study, because the gender role conflict scale is relatively recent, and there is a lack of information about the consistency of GRC internal factors across diverse samples of men from various racial, ethnic and socioeconomic groups from different countries. Australia is among those where the test

has not yet been validated (Heppner, 1995). Secondly, the preliminary analysis determines high and low gender role conflict groups. Thirdly, it examines the relationship between gender role conflict and the demographic variables of age, marital status, economic status, education, occupation, ethnicity, and presence of physical problems – with particular attention to the critical variable of age. This is important and necessary to establish the validity of the results of the current study, because in the literature review of previous research, in Chapter One, attention was drawn to the lack of information about gender role conflict across diverse samples of men from various racial, ethnic and socio-economic groups, as well as across different age groups. Finally, the preliminary analyses examine the preferences for therapeutic techniques (cognitive, behavioural, cognitive, and psychoanalytic) and conditions (accessibility, modality, length of therapy and the characteristics of the therapist)

A. Psychometric Properties of the Gender Role Conflict Scale

1. Means, Standard Deviations, Pearson's Correlations and GRCS

Means, Standard Deviations, Pearson's Correlations were calculated between gender role conflict (GRC) total score and the four sub scales (SPC; RE; RABBM; CBWFR) using an alpha level of .01. Scatterplots suggested that the assumptions of correlation were satisfactory and within acceptable limits. As can be seen in the correlation matrix shown in Table 2.1, all items reported significant positive correlations with the GRC total score: 1-SPC $r = .855, \rho < .01$; 2-RE $r = .855, \rho < .01$; 3- RABBM $r = .884, \rho < .01$; and 4-CBWFR $r = .535, \rho < .01$. Inter-item correlations among the four subscales all were positive: SPC X RE $r = .609, \rho < .01$; SPC X RABBM $r = .655, \rho < .01$; SPC X CBWFR $r = .279, \rho < .01$; RE X RABBM $r = .760, \rho < .01$; RE X CBWFR $r = .348, \rho < .01$; CBWFR

X RABBM $r = .369, \rho < .01$ (Table 2.1). The results exhibit a general convergence of the subscales with each other.

Table 2.1

Means, Standard deviations and Correlations among GRC Total Scores and Subscales

		GRC-TOTAL	SPC	RE	RABBM	CBWFR
GRC- TOTAL	Pearson Correlation					
SPC	Pearson Correlation	.855(**)				
RE	Pearson Correlation	.869(**)	.609(**)			
RABBM	Pearson Correlation	.884(**)	.655(**)	.760(**)		
CBWFR	Pearson Correlation	.535(**)	.279(**)	.348(**)	.369(**)	
Mean		139.14	50.31	35.93	30.58	22.3
Std. Deviation		24.85	10.09	8.17	7.32	4.93

NB. GRC= Gender Role Conflict; SPC= Success, Power and Competition; RE= Restrictive Emotionality; RABBM= Restricted Affectionate Behaviour Between Men; CBWFR= Conflict Between Work and Family Relations.

** Correlation is significant at the 0.01 level (1-tailed and 2-tailed).

2. High and Low GRCS

To determine high and low gender role conflict groups, and in order to have a clear separation of the two groups which will enhance the reliability of the results (Preacher et al., 2005), the GRC sample was dichotomised based on the upper (75th) and lower (25th) percentiles, excluding the middle 50 percent or the Median following Preacher et al. (2005). The outcome of the analysis is high GRC ≥ 158.50 and low GRC ≤ 121 . (Table 2.2)

Table 2.2

Percentiles of GRC Total Scores

	N	Percentiles		
		25th	50th (Median)	75th
GRC- TOTAL	397	121	143	158.5

NB. GRC= Gender Role Conflict

The results of GRC dichotomisation indicated that 99 participants could be categorised as high gender role conflict ($M=169.90$, $SD=7.2$) and 101 participants categorised as low gender role conflict ($M=105.70$, $SD=11.21$). 197 participants were excluded from analysis (See Table 2.3).

Table 2.3

Means and Standard Deviations of High and Low GRC and Subscales based on the upper (75) and lower (25) percentiles

High or Low GRC based on the Median Split		GRC- TOTAL	SPC	RE	RABBM	BWFR
High	Mean	169.9	59.81	45.4	39.12	25.56
	N	99	99	99	99	99
	Std. Deviation	7.28	5	4.07	3.41	3.91
Low	Mean	105.7	37.76	27.06	22	18.87
	N	101	101	101	101	101
	Std. Deviation	11.21	6.76	5.52	3.67	4.77

NB. GRC= Gender Role Conflict; SPC= Success, Power and Competition; RE= Restrictive Emotionality; RABBM= Restricted Affectionate Behaviour Between Men; CBWFR= Conflict Between Work and Family Relations.

B. Demographics and Gender Role Conflict Scale

The present study examined the relationship between gender role conflict and the demographic variables of age, marital status, income, education, occupation, ethnicity, and presence of physical problems – with particular attention to the critical variable of age. The findings indicated the presence of significant relations between GRC and income and occupation, as well as between a number of GRC subscales and age.

Gender role conflict was found to differ significantly across two socioeconomic groups, those of income, $F(3, 396) = 8.57$, $p \leq .001$ and occupation $F(2, 396) = 12.35$, $p \leq .001$ (See Table 2.4). Post Hoc tests revealed that a high gender role conflict score was attained by those who earn more than \$AU 30,000 in comparison to those whose income is less than AU \$10,000. Furthermore a high gender role conflict score was attained by white

collar occupations, notably administrative occupations, in comparison to blue collars and students (See Table 2.5).

Table 2.4
One-way ANOVA for Gender Role Conflict and Demographics

Demographics* GRC Total		df	Mean Square	F	Significance
Age	Between Groups	1.00	856.15	1.39	0.24
	Total	396.00			
Marital Status	Between Groups	2.00	252.35	0.41	0.67
	Total	396.00			
Sexual Orientation	Between Groups	1.00	1013.86	1.64	0.20
	Total	396.00			
Occupation	Between Groups	2.00	7214.02	12.35	0.00
	Total	396.00			
Income	Between Groups	3.00	5007.86	8.57	0.00
	Total	396.00			
Education	Between Groups	2.00	764.06	1.24	0.29
	Total	396.00			
Race or Ethnic Group	Between Groups	3.00	790.93	1.28	0.28
	Total	396.00			
Do you have any physical problems?	Between Groups	1.00	560.28	0.91	0.34
	Total	396.00			

NB. GRC = Gender Role Conflict

Table 2.5
Means and Standard Deviations of Gender Role Conflict Scores for Income and Occupation

GRC TOTAL * Income and Occupation		Mean	N	Std. Deviation
Income	Less Than \$AU 10.000	128.52	83.00	24.85
	\$AU 10.000-\$AU 30.000	136.22	72.00	22.40
	\$AU 30.000-\$AU 50.000	143.94	205.00	24.25
	Greater Than \$AU 50.000	142.08	37.00	25.46
	Total	139.14	397.00	24.85
Occupation	Blue collar	137.13	123.00	22.01
	White collar	146.15	157.00	24.54
	Student	131.85	117.00	25.78
	Total	139.14	397.00	24.85

NB. GRC = Gender Role Conflict

Results revealed that both age groups (18-30 years and 31-45 years) of men experienced a moderate amount of gender role conflict. Unlike the results of Cournoyer & Mahalik (1995), and in accordance with the results of Stillson et al. (1991), this study found no

significant differences between the two age groups (18-30 and 31-45) on gender role conflict levels (high or low). However, and in accordance with the results of Cournoyer and Mahalik (1995) and Theodore and Llodry (2000), the results of the current study found that the two age groups differed on gender role conflict types, or on gender role conflict subscales: SPC $F(1, 396)=18.91, \rho \leq .001$ and CBWFR $F(1, 396)=\rho \leq .001$. No significant age differences were found for restrictive emotionality (RE) and restrictive affectionate behaviour between men (RABBM). Men aged 31-45 yrs. significantly experienced less conflict ($M =46.98$) than did younger men aged 18-30 yrs. on the success, power, and competition factor ($M =51.71$), and more conflict on the conflict between work and family relations ($M =22.30$) than young men ($M =21.36$). Descriptive statistics of gender role conflict in relation to age are shown in Table 2.6.

Table 2.6
Means and Standard Deviations of Gender Role Conflict Sub-scales for Men
Aged 18-30 and 31-45

	Age Group	N	Mean	Std. Deviation
SPC	18-30	280	51.71	10.56
	31-45	117	46.98	8.01
	Total	397	50.32	10.1
RE	18-30	280	36.01	8.51
	31-45	117	35.75	7.34
	Total	397	35.93	8.17
RABBM	18-30	280	31.01	7.39
	31-45	117	29.58	7.1
	Total	397	30.59	7.32
CBWFR	18-30	280	21.37	5.15
	31-45	117	24.56	3.51
	Total	397	22.31	4.94

NB. GRC = Gender Role Conflict; SPC = Success, Power and Competition;
 RE = Restrictive Emotionality; RABBM= Restricted Affectionate Behaviour Between Men;
 CBWFR= Conflict Between Work and Family Relations

C. Preferences for Therapeutic Techniques

Means and standard deviations for preferences for the various therapeutic techniques (22 types) were calculated (Table 2.7). The results indicated that the most highly rated were psychological therapies, psychotherapy ($M= 6.96$), followed by existential therapy ($M=5.36$). The highest rated biomedical therapy was chemotherapy ($M= 4.98$), which, though it is highly rated, was still low in comparison to the psychological therapies in general. The range for the most highly rated therapies is eight.

Table 2.7

Means, standard Deviations for Various Therapies

Therapies	N	Range	Mean	Std. Deviation
Psychotherapy	397	8	6.96	1.82
Existential Therapy	397	8	5.36	1.88
Chemotherapy	397	8	4.99	2.24
Systematic Desensitisation	397	8	4.50	2.20
Thought Stopping Therapy	397	8	4.49	2.17
Hypnosis	397	8	4.48	2.22
Group Therapy	397	8	4.42	1.84
Non-Directive Therapy	397	8	3.90	1.97
Rational Emotive Therapy	397	8	3.75	2.40
Assertiveness Training	397	8	3.57	1.81
Biofeedback	397	7	3.49	2.14
Gestalt Therapy	397	8	3.36	1.88
Mega-Vitamin Therapy	397	7	3.28	2.09
Psychodynamic Therapy	397	8	3.23	1.85
Implosion Therapy	397	8	3.19	1.85
Modeling Role Playing	397	8	2.72	1.69
Behaviour Contracting	397	8	2.69	1.77
Token Economies	397	8	2.57	1.61
Aversion Therapy	397	8	2.51	1.67
Primal Scream Therapy	397	8	1.92	1.46
Psychosurgery	397	8	1.69	1.31
Electroconvulsive Therapy	397	8	1.54	1.19
Valid N (listwise)	397			

To determine the mean scores of the four therapeutic groups (cognitive, behavioural, psychoanalytic and biomedical therapies) scales of equal length were constructed according to Heaven and Furnham's (1994) instructions about scoring preferences for this

questionnaire. First the 3 items with the highest means were selected from each of the four types of therapies (Table 2.7). Cognitive therapy had the highest three means on psychotherapy ($M=6.69$, $SD=1.81$), group therapy ($M=4.41$, $SD=1.83$) and thought stopping therapy ($M=4.49$, $SD=2.16$). Psychoanalytic therapy had the highest three means on existential therapy ($M=5.36$, $SD=1.88$), hypnosis ($M=4.48$, $SD=2.22$) and non-directive therapy ($M=3.90$, $SD=1.97$). Behavioural therapy had the highest three means on systematic desensitisation ($M=4.50$, $SD=2.20$), assertiveness training ($M=3.56$, $SD=1.81$), and biofeedback ($M=3.48$, $SD=2.1$). Biomedical therapy had the highest three means on chemotherapy ($M=4.98$, $SD=2.24$), megavitamin therapy ($M=3.28$, $SD=2.09$), and psychosurgery ($M=1.68$, $SD=1.31$). Then the mean scores for the four therapeutic groups were calculated, based on the scores of the participants. The mean scores for each therapeutic group were cognitive therapy $M=15.87$ ($SD=7.87$), psychoanalytic therapy $M=13.73$ ($SD=4.17$); behavioural therapy $M=11.54$ ($SD=4.63$), and biomedical therapy $M=11.50$ ($SD=4.19$). Results are presented in Table 2.8

Table 2.8
Means of All the Therapies in Order of Preference

	N	Mean	Std. Deviation
Cognitive Therapies	397	15.8715	3.87704
Psychoanalytic Therapies	397	13.7355	4.17944
Behavioural Therapies	397	11.5441	4.63204
Biological Therapies	397	11.5013	4.19272

In order to determine the significance of difference between the means of the four therapies, within-subjects repeated ANOVA was conducted $F(21, 375)$, $p < 0.001$. Results of ANOVA are summarised in Table 2.9. Contrasts for the comparison of means using Tukey's test revealed that the mean scores on all of the four therapies scales differed significantly from each other (all $p < .001$). The participants drew clear distinctions between the various forms of psychotherapy.

Table 2.9

ANOVA: Significance of Difference between the Means of the Various Therapies

		df	Mean Square	F	Significance
Cognitive therapy is the main factor	Behavioural Therapies	21	131.82	8.63	.000
	Biomedical Therapies	21	68.1	4.62	.000
	Psychoanalytic Therapies	21	50.6	3.24	.000
	Total	396			
Psychoanalytic therapy is the main factor	Behavioural Therapies	21	165.06	12.3	.000
	Biomedical Therapies	21	88.5	6.5	.000
	Cognitive Therapies	21	56.47	4.44	.000
	Total	396			
Behavioural therapy is the main factor	Biomedical Therapies	21	85.83	6.33	.000
	Cognitive Therapies	21	86.45	7.98	.000
	Psychoanalytic Therapies	21	161.18	17.88	.000
	Total	396			
Biomedical therapy is the main factor	Cognitive Therapies	21	43.26	3.22	.000
	Psychoanalytic Therapies	21	94.38	7.17	.000
	Behavioural Therapies	21	102.96	6.1	.000
	Total	396			

D. Preferences for Therapeutic Conditions

1. Therapy Characteristics

The analysis of preferences for therapy characteristics covered the issues of accessibility, length, and modality of therapy and revealed the following:

a. Accessibility

The descriptive statistics of the participants' first ranking of the ordinal data revealed that in the matter of accessibility, constancy or regularity of therapy (e.g. weekly or monthly appointments) comes first, affordability second, accessible hours third and not to be kept in the waiting room is fourth (Table 2.10).

b. Therapy Length

The descriptive analysis of the preferred length of therapy demonstrated that the first choice is brief therapy, second choice is what the participants perceive as long therapy and the last choice is not specified (Table 2.10).

c. Therapy Modality

The descriptive analysis of preferences for therapy modality demonstrated that men's first choice is individual therapy, second choice is other modalities, such as family or group therapy (Table 2.10).

Table 2.10
Frequency and Percent of Therapy Characteristics

Therapy Characteristics		Frequency	Percent
Accessibility	Constant	216	54.41
	Affordable	103	25.94
	Accessible Hours	57	14.36
	Not to be kept in the waiting room	21	5.29
Length	Brief	307	77.33
	Long	69	17.38
	Not Specified	21	5.29
Modality	Individual	375	94.45
	Other: Family or Group Therapy	22	5.54

d. Preference for Therapy Characteristics in General

The analysis of the participants' ranking for the three main constituents of therapy characteristics, namely accessibility, length and modality, revealed that the modality of therapy (e.g. individual or group therapy) comes first, accessibility second, and length of therapy third. (Table 2.11)

Table 2.11
Overall Preference for Therapy Characteristics

Therapy Characteristics	Frequency	Percent
Modality	231	58.19
Accessibility	122	30.73
Length	44	11.08
Total	397	100

2. Therapist Characteristics

The analysis of the therapist’s characteristics covered the issues of age, gender, race and experience level and lead to the following:

a. Age of the therapist

Fifty-eight percent of the men reported that age of the therapist is not important, 35% prefer the therapist to be older than them, and 5.7 % prefer the therapist to be of their age or younger (Table 2.12).

b. Therapist’s gender

Around Sixty-eight percent of the participants reported that the therapist’s gender is not important, 22.17% prefer a male therapist only, 6.3% prefer to have mixed therapists or collaborative therapists (two therapists one is male and the other is female) and only 3.78% prefer a female therapist (Table 2.12).

c. Therapist’s Race or Ethnicity

Eighty-three percent of the men considered the therapist’s ethnicity as not important, 11.1% prefer white therapist, 3.5% prefer therapist of mixed racial ancestry or Métis (e.g. A person of mixed Native American and French-Canadian ancestry), 2.3% prefer to have a therapist of visible ethnicity (to be able to tell what the therapist’s ethnicity is).Results are presented in Table 2.12.

d. Therapist's Experience Level

Seventy-six and a half percent of the participants prefer an experienced therapist, 19.9% considered the therapist's experience as not important, 2% prefer a mixed, and 3.5% prefer a therapist in training. Results are presented in Table 2.12.

Table 2.12

Frequency and Percent of Therapist Characteristics

Therapist Characteristics		Frequency	Percent
Therapist Age	Not Important	232	58.44
	Older	142	35.77
	Same Age or Younger	23	5.79
	Total	397	100
Therapist Gender	Not Important	269	67.76
	Male Only	88	22.17
	Mixed Therapist- One Female and One Male	25	6.3
	Female Only	15	3.78
	Total	397	100
Therapist Race or Ethnicity	Not Important	330	83.12
	White Only	44	11.08
	Mixed Race	14	3.53
	Visible Ethnic Group	9	2.27
	Total	397	100
Therapist Experience Level	Experienced	304	76.57
	Not Important	79	19.9
	In Training	14	3.53
	Total	397	100

II. Main Analyses

This section now turns to the main analyses. It presents the investigation of the relation between gender role conflict and men's preferences for therapies (both techniques and conditions).

A. Gender Role Conflict and Preference for Therapeutic Techniques

In order to examine the relationship between GRC levels (high and low) and its four subscales, and preference for therapeutic techniques, first analyses of the relationship between GRC levels (high and low) and preference for therapeutic techniques were conducted, then the analyses were repeated for the GRC four subscales.

1. High and Low Gender Role Conflict and Preference for Therapeutic Techniques

A dependent *t* test was conducted on the mean of preference for type of therapy scores under the two conditions of high and low gender

The high and low gender role conflicted men's preferences for the four therapeutic techniques (cognitive, behavioural, biomedical, and psychoanalytic) were analysed using dependent *t* test. Alpha was set at .05. The assumptions of normality were met. The result indicated a statistically significant difference between GRC levels (high and low) and preference for biomedical therapy, $t(98) = 7.56, p \leq .001$. The mean for biomedical therapies in the condition of high GRC 14.20 ($SD = 3.70$) was higher than that of low GRC 10.01 ($SD = 4.24$). High and low gender role conflicted men do not differ in their preferences for counselling therapies for depression whether cognitive, $t(98) = 1.14, p > .254$, psychoanalytic, $t(98) = -.404, p > .687$ or behavioural therapy, $t(98) = .755, p > .452$ (See Table 2.13). Furthermore, the analysis revealed that high gender role conflict rated cognitive therapy first 16.76 ($SD = 4.06$), psychoanalytic 14.32 ($SD = 5.41$), biomedical therapies 14.20 ($SD = 3.70$), and behavioural therapy third 12.61 ($SD = 4.40$). For low gender role conflict men rated cognitive therapy 16.11 ($SD = 3.68$), psychoanalytic therapies second 14.62 ($SD = 3.71$), behavioural third 11.98 ($SD = 5.24$) and biomedical fourth 10.09 ($SD = 4.26$). (See Table 2.13).

Table 2.13

**Paired Samples Statistics and T-Test:
Overall Preferences for Therapies of High and Low GRC**

High and Low GRC Preferences for Therapies			Mean	N	S.D	Paired Differences		t	df	Significance (2-tailed)
						Mean	S.D			
High GRC Preferences for Therapies	Pair 1	Behavioural	12.62	99.00	4.41	-1.59	4.97	-3.18	98.00	0.002
		Biomedical	14.20	99.00	3.71					
	Pair 2	Behavioural	12.62	99.00	4.41	-4.15	6.17	-6.69	98.00	0.000
		Cognitive	16.77	99.00	4.06					
	Pair 3	Behavioural	12.62	99.00	4.41	-1.71	4.48	-3.79	98.00	0.000
		Psychoanalytic	14.32	99.00	5.42					
	Pair 4	Biomedical	14.20	99.00	3.71	-2.57	5.76	-4.43	98.00	0.000
		Cognitive	16.77	99.00	4.06					
	Pair 5	Biomedical	14.20	99.00	3.71	-0.12	5.27	-0.23	98.00	0.820
		Psychoanalytic	14.32	99.00	5.42					
	Pair 6	Cognitive	16.77	99.00	4.06	2.44	7.08	3.43	98.00	0.001
		Psychoanalytic	14.32	99.00	5.42					
Low GRC Preferences for Therapies	Pair 7	Behavioural	11.98	101.00	5.25	1.97	5.54	3.57	100.00	0.001
		Biomedical	10.01	101.00	4.26					
	Pair 8	Behavioural	11.98	101.00	5.25	-4.14	4.18	-9.94	100.00	0.001
		Cognitive	16.12	101.00	3.68					
	Pair 9	Behavioural	11.98	101.00	5.25	-2.64	4.44	-5.98	100.00	0.000
		Psychoanalytic	14.62	101.00	3.71					
	Pair 10	Biomedical	10.01	101.00	4.26	-6.11	4.01	-15.32	100.00	0.000
		Cognitive	16.12	101.00	3.68					
	Pair 11	Biomedical	10.01	101.00	4.26	-4.61	4.72	-9.83	100.00	0.000
		Psychoanalytic	14.62	101.00	3.71					
	Pair 12	Cognitive	16.12	101.00	3.68	1.50	3.51	4.28	100.00	0.000
		Psychoanalytic	14.62	101.00	3.71					
High VS. Low GRC Preferences for Therapies	Pair 13	High GRC * Behavioural	12.616	99	4.41	0.55	7.19	0.76	98.00	0.452
		Low GRC * Behavioural	12.071	99	5.26					
	Pair 14	High GRC * Biomedical	14.202	99	3.71	4.19	5.51	7.57	98.00	0.000
		Low GRC * Biomedical	10.01	99	4.25					
	Pair 15	High GRC * Cognitive	16.768	99	4.06	0.65	5.60	1.15	98.00	0.254
		Low GRC * Cognitive	16.121	99	3.72					
	Pair 16	High GRC * Psychoanalytic	14.323	99	5.42	-0.27	6.72	-0.40	98.00	0.687
		Low GRC * Psychoanalytic	14.596	99	3.74					

GRC = Gender Role Conflict
S.D = Standard Deviation

2. Gender Role Conflict Subscales and Preference for Therapeutic Techniques

To examine the relationship between the four sub-scales of gender role conflict scale (SPC; RE; RABBM; CBWFR), and preference for therapies, in particular biomedical therapy, analyses of variance (ANOVA) were conducted between the gender role conflict scale's four sub-scales (SPC; RE; RABBM; CBWFR) and the four therapeutic techniques (cognitive, behavioural, biomedical, and psychoanalytic). ANOVA test with alpha set at .05 revealed the presence of significant differences between the four subscales of gender role conflict and the four therapies (Table 2.14). The relationships between SPC and the four therapies were all significant: behavioural $F(43, 396) = 2.66, \rho \leq .001$; biomedical $F(43, 396) = 2.78, \rho \leq .001$; cognitive $F(43, 396) = 1.98, \rho \leq .001$; and psychoanalytic $F(43, 396) = 1.89, \rho \leq .001$. Furthermore, the relationships between RE and the four therapies were all significant, positive relationships: behavioural $F(39, 396) = 2.92, \rho \leq .001$; biomedical $F(39, 396) = 3.57, \rho \leq .001$; cognitive $F(39, 396) = 1.88, \rho \leq .001$; and psychoanalytic $F(39, 396) = 3.26, \rho \leq .001$. Moreover, the relationships between RABBM and the four therapies were all significant, positive relationships: behavioural $F(33, 396) = 2.68, \rho \leq .001$; biomedical $F(33, 396) = 4.63, \rho \leq .001$; cognitive $F(33, 396) = 4.49, \rho \leq .001$; and psychoanalytic $F(33, 396) = 2.36, \rho \leq .001$. Similarly the relationships between BWFR and the four therapies were all significant, positive relationships: behavioural $F(23, 396) = 4.01, \rho \leq .001$; biomedical $F(23, 396) = 2.63, \rho \leq .001$; cognitive $F(23, 396) = 3.11, \rho \leq .001$; and psychoanalytic $F(23, 396) = 2.99, \rho \leq .001$.

Table 2.14

One-way ANOVA and Contrasts for Subscales of Gender Role Conflict and Preference for Therapeutic Techniques

GRC Subscales * Therapy			df	Mean Square	F	Sig.
SPC	Behavioural Therapy	Between Groups	43	48.399	2.663	0.000
		Linear Term	1	0.421	0.023	0.879
	Biomedical Therapy	Between Groups	43	40.932	2.778	0.000
		Linear Term	1	542.941	36.849	0.000
	Cognitive Therapy	Between Groups	43	26.926	1.982	0.000
		Linear Term	1	7.930	0.584	0.445
	Psychoanalytic Therapy	Between Groups	43	30.085	1.888	0.001
		Linear Term	1	24.556	1.541	0.215
RE	Behavioural Therapy	Between Groups	39	52.637	2.916	0.000
		Linear Term	1	63.235	3.503	0.062
	Biomedical Therapy	Between Groups	39	50.116	3.574	0.000
		Linear Term	1	533.778	38.061	0.000
	Cognitive Therapy	Between Groups	39	25.977	1.878	0.002
		Linear Term	1	3.413	0.247	0.620
	Psychoanalytic Therapy	Between Groups	39	46.535	3.256	0.000
		Linear Term	1	7.660	0.536	0.465
RABBM	Behavioural Therapy	Between Groups	33	50.376	2.676	0.000
		Linear Term	1	40.042	2.127	0.146
	Biomedical Therapy	Between Groups	33	62.493	4.631	0.000
		Linear Term	1	1104.349	81.829	0.000
	Cognitive Therapy	Between Groups	33	52.270	4.488	0.000
		Linear Term	1	80.663	6.926	0.009
	Psychoanalytic Therapy	Between Groups	33	37.028	2.360	0.000
		Linear Term	1	51.647	3.292	0.070
CBWFR	Behavioural Therapy	Between Groups	23	73.271	4.013	0.000
		Linear Term	1	65.842	3.606	0.058
	Biomedical Therapy	Between Groups	23	42.203	2.628	0.000
		Linear Term	1	258.636	16.104	0.000
	Cognitive Therapy	Between Groups	23	41.672	3.112	0.000
		Linear Term	1	1.583	0.118	0.731
	Psychoanalytic Therapy	Between Groups	23	46.851	2.993	0.000
		Linear Term	1	120.327	7.686	0.006
	Total		396			

NB. GRC= Gender Role Conflict; SPC= Success, Power and Competition; RE= Restrictive Emotionality; RABBM= Restricted Affectionate Behaviour between Men; CBWFR= Conflict between Work and Family Relations.

Contrasts comparisons using linear polynomial indicated that the four sub-scales of gender role conflict, are all high indicators of preference for biomedical therapies: SPC $F(1, 396) = 36.84, \rho \leq .001$; RE $F(1, 396) = 38.06, \rho \leq .001$; CBWFR $F(1, 396) = 16.10, \rho \leq .001$, with restriction of affectionate behaviour between men (RABBM) the highest

indicator of preference for biomedical therapies among them all, $F(1, 396) = 81.82, \rho \leq .001$. Furthermore, the data suggest that restriction of affectionate behaviour between men (RABBM) is a high indicator of preference for cognitive therapies, $F(1, 396) = 6.29, \rho < .001$. Furthermore, conflict between work and family relation (CBWFR) is a high indicator of preference for psychoanalytic therapies, $F(1, 396) = 7.68, \rho \leq .001$. Behavioural therapy is not related to any of the four subscales. This indicated that all gender role conflicted men, whether their gender role conflict is associated with 1-success, power, and competition; 2-restrictive emotionality; 3-restrictive affectionate behaviour between men; or 4-conflicts between work and family relations, tend to prefer biomedical therapies. Preference for cognitive therapy is limited to those who score high on restrictive affectionate behaviour between men, while preference for psychoanalytic therapy is limited to those who score high on conflicts between work and family relations. Linear contrast results are presented in Table 2.14.

B. Gender Role Conflict and Preferences for Therapeutic Conditions

To examine the question of whether gender role conflict is related to preferences for therapeutic conditions, the analysis consisted of cross tabulation and two way chi-square analysis of the therapeutic conditions, both therapy and therapist characteristics, for high and low GRC groups. The results revealed the following:

1. Therapy Characteristics

The analysis of the men's preferences regarding accessibility, length, and modality of therapy revealed the following:

a. Accessibility

With α set at .05, a two way chi-square revealed a significant relationship between high and low gender role conflicted men in the matter of accessibility. The proportions of high and low gender role conflict were different for the four different areas of accessibility, $\chi^2(3, N=200) = 14.57, \rho \leq .002$. The first preference frequencies are shown in Table 2.15. While there was not a great deal of difference in proportions of high and low GRC in relation to their first preference for the constancy or regularity of therapy (e.g. weekly or monthly appointments), the great differences were found between the two groups of men in relation to not to be kept in the waiting room. As it can be seen from Table 2.15, 100% of low gender role conflicted men who ranked this as their most important accessibility issue prefer not to be kept in the waiting room, while it was not rated as the most important accessibility issue for any of the high gender role conflicted men.

b. Therapy Length

Conducting a two way chi-square, with α set at .05, revealed significant differences in the order of preference for length of therapy between high and low gender role conflicted men. The proportions of high and low gender role conflict were different for the three different lengths of therapy, $\chi^2(2, N=200) = 13.27, \rho = .001$. The frequencies are shown in Table 2.15. The greatest difference was in the proportions of high to low GRC in relation to long therapy, it can be seen from Table 2.15 that around 75% of those who would consider long therapy were high gender role conflicted men.

Table 2.15

**First Preference of High and Low Gender Role Conflict in Relation to the
Three Main Constituents of the Therapy Characteristics**

			High and Low Gender Role Conflict		Total
			High	Low	
Accessibility	Accessible Hours	Count	11	17	28
		% within Accessibility	39.3%	60.7%	100.0%
		% of Total	5.5%	8.5%	14.0%
	Constant	Count	59	54	113
		% within Accessibility	52.2%	47.8%	100.0%
		% of Total	29.5%	27.0%	56.5%
	Affordable	Count	29	19	48
		% within Accessibility	60.4%	39.6%	100.0%
		% of Total	14.5%	9.5%	24.0%
	Not to be kept in the waiting room	Count	0	11	11
		% within Accessibility	.0%	100.0%	100.0%
		% of Total	.0%	5.5%	5.5%
Total		Count	99	101	200
		% within Accessibility	49.5%	50.5%	100.0%
		% of Total	49.5%	50.5%	100.0%
Length of Therapy	Brief	Count	68	85	153
		% within Length Of Therapy	44.4%	55.6%	100.0%
		% of Total	34.0%	42.5%	76.5%
	Long	Count	28	9	37
		% within Length Of Therapy	75.7%	24.3%	100.0%
		% of Total	14.0%	4.5%	18.5%
	Not Specified	Count	3	7	10
		% within Length Of Therapy	30.0%	70.0%	100.0%
		% of Total	1.5%	3.5%	5.0%
Total		Count	99	101	200
		% within Length Of Therapy	49.5%	50.5%	100.0%
		% of Total	49.5%	50.5%	100.0%
Modality of Therapy	Individual	Count	94	94	188
		% within Modality Of Therapy	50.0%	50.0%	100.0%
		% of Total	47.0%	47.0%	94.0%
	Other: Family or Group Therapy	Count	5	7	12
		% within Modality Of Therapy	41.7%	58.3%	100.0%
		% of Total	2.5%	3.5%	6.0%
Total		Count	99	101	200
		% within Modality Of Therapy	49.5%	50.5%	100.0%
		% of Total	49.5%	50.5%	100.0%

c. Therapy's Modality

Conducting a two way chi-square, with α set at .05, revealed no significant differences between high and low gender role conflicted men in relation to the modality therapy whether it was individual therapy or other $\chi^2 (1, N=200) = .31, \rho = .76$. It can be seen from Table 2.15 that both groups of men (high and low on GRC) have almost similar preferences regarding the modality of therapy.

d. Preference for Therapy Characteristics in General

With α set at .05, a two way chi-square revealed a significant relationship between high and low gender role conflict and the participants' ranking for the three main constituents of therapy characteristics, namely accessibility, length and modality. The proportions of high and low gender role conflict were different for two different constituents of therapy characteristics, namely accessibility and modality $\chi^2 (2, N=200) = 9.10, \rho = .01$. The first Preference of high and low gender role conflict in relation to the three main constituents of the therapy characteristics are shown in Table 2.16.

Table 2.16
First Preference of High and Low Gender Role Conflict in Relation to the Three Main Constituents of the Therapy Characteristics

			High and Low Gender Role Conflict		Total
			High	Low	
Therapy Characteristics	Modality	Count	50	70	120
		% within Therapy Characteristics	41.7%	58.3%	100.0%
		% of Total	25.0%	35.0%	60.0%
	Length	Count	12	12	24
		% within Therapy Characteristics	50.0%	50.0%	100.0%
		% of Total	6.0%	6.0%	12.0%
	Accessibility	Count	37	19	56
		% within Therapy Characteristics	66.1%	33.9%	100.0%
		% of Total	18.5%	9.5%	28.0%
Total	Count	99	101	200	
	% within Therapy Characteristics	49.5%	50.5%	100.0%	
	% of Total	49.5%	50.5%	100.0%	

2. Therapist Characteristics

The analysis of the therapist's characteristics covered the issues of age, gender, race and experience level and lead to the following:

a. Age of the therapist

Conducting a two way chi-square, with α set at .05, revealed no significant differences between high and low gender role conflicted men in relation to the age of the therapist $\chi^2(2, N=200) = .52, \rho = .77$. It can be seen from Table 2.17 that both groups of men (high and low on GRC) have almost similar preferences for the therapist's age.

Table 2.17
First Preference of High and Low Gender Role Conflict in Relation to the Age of the Therapist

			High and Low Gender Role Conflict		Total
			High	Low	
Therapist Age	Same Age or Younger	Count	4	5	9
		% within Therapist Age	44.4%	55.6%	100.0%
		% of Total	2.0%	2.5%	4.5%
	Older	Count	38	34	72
		% within Therapist Age	52.8%	47.2%	100.0%
		% of Total	19.0%	17.0%	36.0%
	Not Important	Count	57	62	119
		% within Therapist Age	47.9%	52.1%	100.0%
		% of Total	28.5%	31.0%	59.5%
Total	Count	99	101	200	
	% within Therapist Age	49.5%	50.5%	100.0%	
	% of Total	49.5%	50.5%	100.0%	

b. Therapist's gender

With α set at .05, a two way chi-square revealed a significant relationship between high and low gender role conflict and the matter of preference for therapist's gender. The proportions of high and low gender role conflict were different for the matter of gender, $\chi^2(3, N=200) = 14.76, \rho = .002$. The frequencies are shown in Table 2.18. It can be seen from Table 2.20 that though the issue of gender is almost equally not important for both

high and low GRC men, both groups of men prefer to have a male therapist. And while a 0% of high gender role conflict men would like to have a female therapist only, around 92% of high gender role conflict men accepted to have mixed therapists or collaborative therapists (two therapists one is male and the other is female).

Table 2.18
First Preference of High and Low Gender Role Conflict in Relation to Therapist Gender

			High and Low Gender Role Conflict		Total
			High	Low	
Therapist Gender	Female Only	Count	0	5	5
		% within Therapist Gender	.0%	100.0%	100.0%
		% of Total	.0%	2.5%	2.5%
	Male Only	Count	21	21	42
		% within Therapist Gender	50.0%	50.0%	100.0%
		% of Total	10.5%	10.5%	21.0%
	Mixed Therapist- One Female and One Male	Count	12	1	13
		% within Therapist Gender	92.3%	7.7%	100.0%
		% of Total	6.0%	.5%	6.5%
	Not Important	Count	66	74	140
		% within Therapist Gender	47.1%	52.9%	100.0%
		% of Total	33.0%	37.0%	70.0%
Total	Count	99	101	200	
	% within Therapist Gender	49.5%	50.5%	100.0%	
	% of Total	49.5%	50.5%	100.0%	

c. Therapist's Race or Ethnicity

With α set at .05, a two way chi-square revealed no significant differences between high and low gender role conflicted men in relation to the race or ethnicity of the therapist $\chi^2(3, N=200) = 5.37, p = .14$. It can be seen from Table 2.19 that for both groups of men (high and low on GRC) race or ethnicity is not rated as important.

Table 2.19

First Preference of High and Low Gender Role Conflict in Relation to the Race or Ethnicity of the Therapist

			High and Low Gender Role Conflict		Total
			High	Low	
Therapist Race or Ethnicity	White Only	Count	6	9	15
		% within Therapist Race or Ethnicity	40.0%	60.0%	100.0%
		% of Total	3.0%	4.5%	7.5%
	Mixed Race	Count	7	1	8
		% within Therapist Race or Ethnicity	87.5%	12.5%	100.0%
		% of Total	3.5%	.5%	4.0%
	Visible Ethnic Group	Count	2	3	5
		% within Therapist Race or Ethnicity	40.0%	60.0%	100.0%
		% of Total	1.0%	1.5%	2.5%
	Not Important	Count	84	88	172
		% within Therapist Race or Ethnicity	48.8%	51.2%	100.0%
		% of Total	42.0%	44.0%	86.0%
Total	Count	99	101	200	
	% within Therapist Race or Ethnicity	49.5%	50.5%	100.0%	
	% of Total	49.5%	50.5%	100.0%	

d. Therapist's Experience Level

With α set at .05, a two way chi-square revealed no significant differences between high and low gender role conflicted men in relation to the therapist's level of experience $\chi^2(2, N=200) = 3.84, \rho = .14$. It can be seen from Table 2.20 that both groups of men have a high preference for experienced therapists.

Table 2.20

First Preference of High and Low Gender Role Conflict in Relation to the Experience Level of the Therapist

			High and Low Gender Role Conflict		Total
			High	Low	
Therapist Experience Level	Experienced	Count	75	72	147
		% within Therapist Experience Level	51.0%	49.0%	100.0%
		% of Total	37.5%	36.0%	73.5%
	In Training	Count	6	2	8
		% within Therapist Experience Level	75.0%	25.0%	100.0%
		% of Total	3.0%	1.0%	4.0%
	Not Important	Count	18	27	45
		% within Therapist Experience Level	40.0%	60.0%	100.0%
		% of Total	9.0%	13.5%	22.5%
Total	Count	99	101	200	
	% within Therapist Experience Level	49.5%	50.5%	100.0%	
	% of Total	49.5%	50.5%	100.0%	

Based on all of the above, the therapist’s experience seems to lead the order of preference of the therapist’s characteristics (only 22.5% of participants said not important), followed by age (59% of participants said not important), then gender (70% of participants said not important), and finally race (86% of participants said not important).

III. The Supplementary Analyses

The supplementary analyses explored the attitude of the participants in the current study toward seeking help, hypothesising that gender role conflict is associated with negative attitudes toward seeking psychological help, and that the restriction of emotions is negatively related to all aspects of seeking professional help. This was to substantiate previous results about men’s attitude toward seeking help by using a broader sample, in an Australian context. Furthermore, the supplementary analysis re-examined the relationship between GRC levels (high and low), and preference for therapeutic techniques (previously examined in the Main Analysis of the current study), controlling

for the participants attitudes toward seeking psychological help as a covariate, hypothesised as a contributing variable with GRC.

A. Attitudes toward Seeking Professional Psychological Help and Gender Role Conflict

To test the hypothesised confound between gender role conflict and attitudes toward seeking psychological help, Pearson's correlations were conducted between the continuous data of gender role conflict (GRC; total score, and its four subscales: 1-restrictive emotionality; 2-success, power, and competition; 3-restrictive affectionate behaviour among men and 4-conflict between work and family relations) as the predictor variable and attitude toward seeking professional help (ATSPH; total score and its subscales: 1-stigma; 2-interpersonal openness; 3-recognition of need for psychological help; 4-confidence in mental health practitioner) as the criterion variable. GRC scores were negatively and significantly correlated with general attitudes toward seeking professional psychological help ($r = -.277, \rho < .001$). Furthermore, GRC scores were negatively correlated to all of ATSPPH subscales, at a significant level in the case of stigma ($r = -.128, \rho < .01$) and interpersonal openness ($r = -.398, \rho < .001$). All of the subscales of GRC were negatively and significantly correlated to ATSPPH total score (See Table 2.21). The correlation of the factors of GRC to those of ATSPPH showed significant variations. Stigma was negatively and significantly correlated to all of the GRC factors, except the factor of success, power and competition (SPC) ($r = -0.013, \rho = .78$). Interpersonal openness was negatively and significantly correlated to all of the GRC factors, except the factor of conflict between work and family relationship (CBWFR) ($r = -0.052, \rho = .30$). Recognition of need for psychological help was negatively and significantly correlated to just one factor of GRC, the factor of restriction of emotions

(RE) ($r = -.185, \rho < .001$). Confidence in mental health practitioners was only significantly correlated to the factor of conflict between work and family relationship (CBWFR) ($r = -.181, \rho < .001$) (Table 2.21).

Table 2.21
Correlation of Gender Role Conflict Factors and the Attitudes Toward Seeking Professional Psychological Help

	GRC Total	ATSPPH Total	SPC	RE	RABBM	CBWFR
GRC Total						
ATSPPH Total	-.27(**)					
Recognition of Need for Psychological Help	-0.07	.62(**)	0.03	-.18(**)	-0.08	0
Stigma	-.12(*)	.76(**)	-0.01	-.19(**)	-.13(**)	-.09(*)
Interpersonal Openness	-.39(**)	.54 (**)	-.38(**)	-.32(**)	-.42(**)	-0.05
Confidence in Mental Health Practitioner	-0.06	.68 (**)	0	-0.04	-0.02	-.18(**)

Note.GRC=Gender Role Conflict; SPC= Success, Power and Competition; RE= Restrictive Emotionality; RABBM= Restricted Affectionate Behaviour Between Men; CBWFR= Conflict Between Work and Family Relations. ATSPPH= Attitude Toward Seeking Professional Psychological Help

B. Attitudes toward Seeking Professional Psychological Help as Covariate in the Relationship Between High and Low GRC and Preference for Therapeutic Techniques

Due to the significant correlation between GRC and attitudes toward seeking professional psychological help, indicating a potential confound, analyses of covariance (ANCOVA) were conducted as a precaution. The covariate analyses examined the relationship between GRC levels (high and low) and preference for therapeutic techniques, while controlling participants' attitudes toward seeking psychological help as a covariate. The predictor variable is gender role conflict (high and low). The criterion variable is the preference for therapeutic techniques, namely behavioural, cognitive, biomedical and psychoanalytic, and attitudes toward seeking psychological help is a covariate.

The ANCOVA results found that controlling for attitudes toward seeking psychological help influenced the participants' preferences only for behavioural therapy. The covariate (ATSPPH) was significantly related to preferences for behavioural therapy, $F(1, 199) = 39.51, \rho \leq .001$, and after controlling for ATSPPH, there was a significant unique main effect of high and low GRC, $F(1, 199) = 11.51, \rho \leq .001$. For biomedical therapy, the covariate (ATSPPH) was not significantly related to preferences, $F(1, 199) = .020, \rho = .889$, when ATSPPH was controlled, there was a significant main effect of high and low GRC, $F(1, 199) = 45.55, \rho = .00$. The covariate (ATSPPH) was significantly related to preferences for psychoanalytic therapy, $F(1, 199) = 27.20, \rho \leq .001$, but it was not related to preferences for cognitive therapy. When the covariate (ATSPPH) was controlled, there was no significant effect of high and low GRC for cognitive $F(1, 199) = 1.38, \rho = .24$, and psychoanalytic therapy $F(1, 199) = 2.54, \rho = .113$. (See Table 2.22)

Table 2.22
Covariate analyses for the relationship between High and Low GRC and Preference for Therapeutic Techniques, while Attitudes Toward Seeking Psychological Help is the covariate

Dependent Variable	Source	df	F	Significance
Behavioural Therapy	ATSPPH Total	1	39.51	.000
	High and Low GRC	1	11.51	.001
	Corrected Total	199		
Biomedical Therapy	ATSPPH Total	1	.020	.889
	High and Low GRC	1	45.55	.000
	Corrected Total	199		
Cognitive Therapy	ATSPPH Total	1	.054	.817
	High and Low GRC	1	1.37	.240
	Corrected Total	199		
Psychoanalytic Therapy	ATSPPH Total	1	27.20	.000
	High and Low GRC	1	1	.113
	Corrected Total	199		

Note. GRC= Gender Role Conflict; ATSPPH= Attitude Toward Seeking Professional Psychological Help.

Comparison of the means scores of high and low GRC on the four therapies, while controlling participants' attitudes toward seeking psychological help as a covariate revealed that men who score high on the gender role conflict scale prefer biomedical

therapies ($M= 14.04$) more than men who score low on the gender role conflict scale ($M=9.66$). Furthermore men who score high on the gender role conflict scale prefer behavioural therapies ($M=13.06$) more than men who score low on the gender role conflict scale ($M= 12.17$). But high and low gender role conflicted men do not differ in their preferences for the other counselling therapies for depression namely, cognitive (M of high GRC = 16.48; M of low GRC =16.16) and psychoanalytic therapies (M of high GRC = 14.76; M of low GRC =14.54). Descriptive statistics are shown in Table 2.23.

Table 2.23
Means of the Four Therapies in Relation to High or Low Gender Role Conflict after Controlling for the Covariate Attitudes toward Seeking Professional Psychological Help

Dependent Variable	High or Low GRC	Mean
Behavioural Therapy	High	13.06
	Low	12.17
Biomedical Therapy	High	14.04
	Low	9.66
Cognitive Therapy	High	16.48
	Low	16.16
Psychoanalytic Therapy	High	14.76
	Low	14.54

Based on modified population marginal mean.

DISCUSSION

For simplifying the discussion of the results, the discussion is divided into three sections. The first section discusses the results of the preliminary analyses, examining the psychometric properties of the gender role conflict scale and preferences for therapeutic techniques and conditions. The second section discusses the results of the main analyses, examining gender role conflict and therapy preferences. The third section discusses the results of the supplementary analyses, examining attitudes toward seeking professional psychological help in relation to gender role conflict and preference for therapeutic techniques.

I. Discussion of the Preliminary Analyses

A. Psychometric Properties of the Gender Role Conflict Scale

The examination of the psychometric properties of the gender role conflict scale (O'Neil, 1981a; O'Neil et al., 1985; O'Neil et al., 1986) was an important first step in the current project, because the scale is relatively recent and because in Australia, validation of the test has not been previously conducted sufficiently. The current analysis of the GRCS verified stability and internal consistency. The four GRCS subscales were also found to be valid.

The correlation analysis indicated that success, power and competition (SPC), restriction of emotionality (RE), and restricted affectionate behaviour between men (RABBM), were stronger contributors to GRC total score than conflict between work and family relations (CBWFR). The findings in general are consistent with Good et al. (1995) and Cournoyer and Mahalik's (1995) findings. One possible explanation of this is the strong association between the GRCS subscales and depression, in particular SPC and depression. Gender role conflict has been consistently found to be associated with measures of clinical depression in college students and in adult, non-student samples. A recent study (Kelley, 2001), that sampled 188 adult men who completed the GRCS and the Beck Depression Inventory, reported that while SPC has a strong association with depression, that relationship is more significant when a measure of hopelessness is introduced. Success, power, competition, income, and hopelessness were found to be the most powerful predictors of clinical depression among Kelley's sample of adult men. The low intercorrelations in the correlation analysis raised concerns about the subscale of conflict between work and family relation (CBWFR). These findings are consistent with those of Good and Mintz (1990), Good et al. (1995) and Llewellyn-Smith (1999). However, it is

worth mentioning that in comparison to the previous studies, the intercorrelations of CBWFR with all the other subscales were positive. Possible explanations for such results are sampling issues: (a) previous studies have mostly used undergraduate men who typically have neither begun their careers nor started their families; (b) previous studies that have included undergraduate as well middle aged men (Llewellyn-Smith, 1999) had a small sample of middle aged men in comparison to the younger undergraduate samples.

The GRC mean score found in the present study ($M=139.14$, $SD= 24.85$) was considerably higher than scores obtained from adult men in the United States of America (Highest $M= 133.94$) (O'Neil, 1997). Similarly to Llewellyn-Smith (1999), it may be speculated that Australian men have a more strict definition of their gender role in comparison to men from North America; however more Australian studies are needed than the available studies (e.g. Gough, 1999; Harris, 1997; Heath, 2005; Llewellyn-Smith, 1999; Mahalik et al., 2001; McAnulty, 1996; Monk & Ricciardelli, 2003; Theodore, 1998; Theodore & Lloyd, 2000; Wall & Walker, 2002) to draw a general conclusion. Consequently, further research is needed to examine the issue of gender role in Australia. Equally, more research is needed about the issue of gender role conflict in various countries since, as was reported in the literature review, gender role conflict is based on socialisation and culturally prescribed gender-roles (Leafgren, 1990; O'Neil, 1982, 1990; Pleck, 1981 & 1995), but most of the research in relation to gender role conflict conducted to date has been based in the USA (Heppner, 1995).

B. Demographics and Gender Role Conflict Scale

The present study result regarding the association between high gender role conflict score and high income and occupation contrasts with the findings of Manosevitz (1971) and Stillson et al. (1991) who found lower income working class individuals score high in the

matter of gender issues. One possible explanation for the present results is that the degree of conflict individuals experience and their socioeconomic status may be mediated by the relationship between the individuals' gender role and whether or not their socioeconomic status matches their traditional gender role beliefs. For example, the results of several studies (e.g., Chusmir & Koberg, 1988, 1989; Bem & Lenney, 1976; Koberg & Chusmir, 1989; Luhaorg & Zivian, 1995), found that individuals whose gender role and socioeconomic situation match, experience less gender role conflict than individuals whose gender role and socioeconomic situation do not match. The amount of gender role conflict experienced was related to the degree of correspondence between an individual's masculinity score and the concentration of males or females in one's occupation. For example, in predominantly male occupations, women reported much more gender role conflict than men, and in predominantly female occupations, men reported much more gender role conflict than women.

It is possible that being a man in "a man's world" becomes easier the more assertive, independent, self-reliant, etc., a man is. In a subsequent study, however, Koberg and Chusmir (1991) found that employment in an occupation dominated by the opposite sex was not related to gender role conflict for either males or females. They suggested that these individuals may have rejected stereotyped gender roles, which is consistent with the reasoning that the relationship between gender role and occupation may mediate the degree of conflict experienced. Thus, the gender role conflict reported by the individuals in the present study may be related to a complex interaction of their gender, gender role, and socioeconomic status.

However, the impact of socioeconomic variables, particularly income, needs to be investigated more carefully, because the relationship of these variables to GRC still uncertain. There also remain unresolved methodological problems in relation to the

proper standards in measuring the socio-economic variables, and the available research is very limited (Luhaorg & Zivian, 1995; Manosevitz, 1971; Stillson et al., 1991).

As for the current study findings that men aged 31-45 yrs. significantly experienced less conflict than did younger men aged 18-30 yrs. on the success, power, and competition factor, and more conflict than young men on the conflict between work and family relations (CBWFR), the results suggest that a young man's perception of masculinity may be a driving or motivating force in striving for success and achievement (Levinson et al., 1978; Theodore & Llody, 2000). The workplace is the arena in which many young men struggle to establish their identity, and where they measure their success and their failures (Erikson, 1982). As men age, they invariably have new responsibilities in addition to work, such as family. For example, in an Australian study of working men, Fallon (1996) found that 70% reported serious concerns about work and family conflicts. Sixty percent of men said that family concerns were affecting their work plans and career goals. Some men were prepared to sacrifice promotions and transfers to spend more time with their family. It was concluded that the conflict between work and family commitments places demands upon men.

The finding that there are no significant age differences regarding RE and RABBM in the current study tends to rule out a developmental-stage theory for those two gender role conflict subscales as suggested by some researchers (Cournoyer & Mahalik, 1995; Levinson et al, 1978; Ripple et al., 1982; Wink & Helson, 1993). In other words, it is possible to conclude that restriction of emotions and avoiding male intimacy are male traits that do not change with age. The finding also questions the view that as men age they shift "in the direction of expressing more stereotypically feminine aspects of their personalities and becoming more nurturant" (Cournoyer & Mahalik, 1995, p. 12). It has been argued that when a man is young, he is said to "burn out his masculine resources"

(Cournoyer & Mahalik, 1995; Levinson et al., 1978; O'Neil, 1982; O'Neil & Egan, 1992), whilst in the second half of his adult life, around the age of 30, a man becomes less concerned with striving and ambition, and instead turns inwardly for more intrinsic motivations such as the enjoyment of the process, the quality of the experience, emotional connectedness, etc. (e.g., Cournoyer & Mahalik, 1995; D. F. Levinson, Darrow, Klein, Levinson, & McKee, 1978; Neugarten, 1965). These findings are not supported by the current study, although as the research was cross sectional, rather than longitudinal, firm conclusions cannot be drawn about change across the lifespan in individual men.

C. Preferences for Therapeutic Techniques and Conditions

Regarding therapeutic techniques, the respondents differentiated between various categories of therapies, namely, cognitive, behavioural, psychoanalytic and biomedical. Psychotherapy, existential therapy and chemotherapy were most favoured while primal scream therapy, psychosurgery and electroconvulsive therapy were least favoured. These results reflect to some extent the sorts of therapies frequently associated with depression, which suggest that people's general beliefs in relation to the efficacy of treatment or therapy could be the best predictors of their preferences. However, it is not clear whether the preferences are related to personality factors or reflect current trends in what is positioned as good treatment in the media and in self-help texts, or other reasons. It is not clear whether the participants' preferences for therapies in the current study are really specific to depression or they are general preferences that apply to any sort of psychological diseases or disorders e.g. manic-depressive illness, mania, anxiety, or others. It is not clear to what extent the fact that respondents had had no experience with seeking help or therapy may have affected the results. Thus, it is important to examine the origin of people's preferences for therapy more thoroughly, and future research should

investigate prior experience with seeking help for in relation to depression and to other diseases.

As for therapeutic conditions, the results indicated that in the matter of accessibility preferences, the constancy of therapy comes first, affordability second, accessible hours third and not to be kept in the waiting room fourth. In the matter of preferred length of therapy, brief therapy is the most favoured, followed by long therapy. In relation to therapy's modality, the first choice is individual therapy, second choice is family or group therapy. The overall ranking for the three main constituents of therapy characteristics, namely accessibility, length and modality shows that modality is first in importance, accessibility is second and length of therapy is third.

As for the therapist's characteristics, the therapist's experience seems to lead the order of preference, followed by age, then gender, and finally race and ethnicity. All in all, the findings suggest that the participants seem to focus on issues of professional traits more than on the demographic traits of the therapists; this is consistent with studies such as that by Goldberg and Tidwell (1990), which found that therapist's demographics were not highly important in clients' preferences. The current study suggests that agency administrators and therapists should pay more attention to their clients' preferences and to accommodating them as much as clinically possible. Clients who receive a treatment from a therapist that they consider experienced and skilled, and in the same time they receive a treatment that they believe in and prefer may be more likely to engage in therapy and to comply with and continue in treatment (Glass, Arnkoff, & Shapiro, 2001). It is also important to formulate service policies to enhance the accessibility conditions, particularly constancy of therapy, and to emphasise the employment of brief individual therapy, with the ultimate goal of providing quality services for the patient.

II. Discussion of the Main Analyses

A. Preferences for Therapeutic Techniques and Gender Role Conflict

A central aim of the present study was to investigate the relation between gender role conflict (high and low and its four factors) and therapy preferences for depression, so as to determine whether gender role conflict influences preference for type of therapy that men choose. The results of analyses of variance for high and low GRC, revealed that men who score high on the gender role conflict scale prefer biomedical therapies more than men who score low on the gender role conflict scale. However both groups of men rated psychoanalytic, behavioural and cognitive therapies, almost the same. This may be explained to a certain extent by the “dysfunction- producing” model of Pleck (1981), O’Neil et al (1986), and Eisler and Skidmore (1987), and particularly the idea of fear of femininity, and one of the undercurrent sources of gender role conflict in men (O’Neil, 1981a, 1981b, 1982). Adherence to the traditional male gender role, as various researchers propose (Good, Dell, & Mintz, 1989; Good & Sherrod, 2001 Robertson, 2001; Robertson & Fitzgerald’s, 1992), may be a source of hesitation in using mental health services even if the men want to seek help or might have certain therapeutic or counselling preferences. This is because men, in particular men who adhere to the traditional male gender role, may have a stereotypical view of counselling as entirely affective and requiring emotional expressiveness (Wisch et al., 1995), qualities which are traditionally deemed feminine (O’Neil, 1982; O’Neil et al., 1986) and contradict what is optimally masculine. Therefore, depressed men who are high on gender role conflict may try to “mask” their depression (Real, 1997) to avoid the stigma of “feminine” emotionality and also the stigma of mental illness, and at the same time to make themselves feel better, may rely on medication and biomedical therapies. The empirical

research supporting this view indicates that failing to adhere to the masculine role ideals, usually leads to a feeling of psychological strain and shame (Blazina & Watkins, 1996; Good & Mintz, 1990; Good et al., 1995; Sharpe & Heppner, 1991). This is because men internalise their conceptions of masculinity from their culture, and socialisation encourages men to attempt to live up to cultural standards of masculinity (Pleck, Sonenstein & Ku, 1993). The fear and rejection of the feminine and the qualities deemed feminine (O'Neil, 1982; O'Neil et al., 1986), define what is masculine, and guides the development of masculine gender roles through assessing and then rejecting those gender-specific behaviours considered traditionally as feminine. All in all, the preference for medical related therapies are the participants' choices, but those choices might be based on what the participants know from the media or from self help texts, or inaccurate or false information related to the stigma associated with mental illness (Real, 1997; Lam, 2001) that traditional men try to avoid (Good et al., 2001; Mahalik et al., 1995; O'Neil, 1996; Real, 1997). Or as Robertson (2001) explained, "Traditional counselling requires men to set aside much of their masculine socialisation simply to get through the door and ask for help" (p. 148). However they were certainly not based on previous experience with counselling because none of the participants had had any experience of counselling. It seems that men in the present study do not struggle in relation to what type of counselling and/or psychotherapy to seek or choose, but they do have difficulties in initiating the help-seeking process, particularly the men who are high on gender role conflict. The challenges for men, both high and low GRC, often start with the issue of the negative social messages that they receive for seeking help in the first place.

Overall, restrictive affectionate behaviour between men (RABBM), which reflects how men are socialised to have difficulties expressing feelings and emotions to other men,

seems to be the highest indicator of preference for both biomedical and cognitive therapies, while high conflict between work and family relation (CBWFR) which reflects the degree to which men struggle with balancing work, school, and family relationships because of competing socialised roles, seems to be the highest indicator of preference for both biomedical and psychoanalytic therapies. In the present study, both the gender role conflict factors of 1) success, power and competition (SPC), which reflects the degree to which men are socialised to focus on personal achievement, obtaining power, or evaluating themselves in comparison to others, and 2) restriction of emotions (RE) which reflects the degree to which men are taught to use caution in dealing with emotions, their own and those of others, confirmed the finding of previous research of being correlated with negative attitudes towards help-seeking (Robertson & Fitzgerald, 1992; Blazina & Watkins, 1996; and Blazina & Marks, 2001) and counselling therapies, but the present study found that both SPC and RE are highly correlated to preference of biomedical therapy. This may be explained by the finding of previous research that men's unhealthy behaviour and/or psychopathology is related to struggles with gender role conflict, in particular, success, power and competition (SPC), and 2) restriction of emotions (RE) (e. g. , Hayes & Mahalik, 2000; O'Neil, et al. , 1995) and shame (e. g. , Jennings & Murphy, 2000; Wright, O'Leary & Balkin, 1989).

The results of this study have several implications, in particular with regard to counselling practice. General practitioners or therapists can assess preferences at the beginning of therapy and could usefully consider the level and type of gender role conflict (eg. SPC, RE, RABBM and CBWFR) experienced by men and be responsive to these issues. Raymond Lam (2001) suggested that therapists should educate their clients about therapeutic techniques before starting therapy, because this can help the mental health services consumer make more informed choices, and client-therapist matches can

be facilitated. Chambless, Tran, and Glass (1997) suggested cognitive-behaviour therapists need to boost clients' expectancy of benefit from treatment, take time to build a rationale for treatment and its credibility before beginning a behaviour change program. Such rationales for treatment given by the therapist early in therapy can be reassuring, lead clients to feel that their problem is not unique, that there is a credible and effective treatment available, and inspire confidence that some change will be experienced. Recently researchers have suggested (Lam, 2001; Ward et al., 2000) that practitioners should refer clients expressing a strong preference for a particular form of counselling to counsellors of that affiliation, or postpone interventions that would be difficult for the client to accept, until the client is comfortable and engaged in the process. In the present research the participants who were high on GRCS preferred biomedical therapies. The men's preference for biomedical seems to be related to the issue of socialisation and the negative social messages that they receive for seeking help in the first place. Just to get through the door and ask for psychological assistance men need to set aside much of their masculine socialisation (Robertson, 2001, p. 148).

B. Preferences for Therapeutic Conditions and Gender Role Conflict

In general, and consistent with studies such as that by Goldberg and Tidwell (1990), the current study findings suggest that both groups of men (high or low on GRCS), seem to focus on issues of professional traits more than on the demographic traits of the therapists. The current study suggests that agency administrators and therapists may need to strengthen therapists' skills and knowledge about male clients' preferences and men's issues, especially about men's tendencies to conceal vulnerability, a tendency that seems to have misled some medical practitioners and counsellors to under-diagnose men's depression (Potts et al., 1991). Those involved in the academic training of male interns,

might do well to educate themselves on male gender role issues. This would allow them to identify gender role conflict issues in themselves and in their students because “male counsellors themselves are not immune to the effects of their gender role socialisation” (Wisch & Mahalik, 1999, p57). In addition, their understanding of a traditional male socialisation may be important to their being able to mentor, supervise, and train male counsellors to recognise and overcome the potential limitations placed on them by this gender role socialisation. It is maybe helpful to determine what the client perceives as helpful and engaging in the initial client assessment, including active inquiry into the client history of helpful relationships. Similarly, in this process the client’s expectations regarding the helping relationship should be determined. Therapists could also explicitly ask their clients what do they want and what they do not want from therapy. For example, often clients report that they do not want a silent therapist or a therapist who dwells exclusively on childhood. It may be important to let the client know that therapy can attend to at least some of the client’s preferences (Arnkoff et al., 1987; Glass & Arnkoff, 1982). It is also important to formulate service policies to enhance the accessibility conditions, particularly constancy and affordability of therapy, and to emphasise the employment of brief individual therapy, with the ultimate goal of providing quality services for the patient. Maybe it would also be helpful to consider changing the names of counselling services, as Robertson and Fitzgerald (1992) suggested. Changing the name of services, might help traditional men with strong masculine attitudes to take advantage of them more freely. Rather than “personal counseling”, Robertson and Fitzgerald (1992) suggested "classes," "workshops," and "seminars" as potential name substitutes.

III. Discussion of the Supplementary Analyses

A. Attitudes toward Seeking Professional Psychological Help and Gender Role Conflict

As was hypothesised, and consistent with previous studies (Berger et al., 2005; Blazina & Marks, 2001; Blazina & Watkins, 1996; Good et al., 1989; Good & Wood, 1995; Robertson & Fitzgerald, 1992; Wisch & Mahalik, 1995), the present study found that higher levels of gender role conflict are associated with negative attitudes toward seeking psychological help, and restriction of emotions was negatively related to all aspects of seeking professional help. GRCS was found to predict negative views of two patterns of seeking help, specifically stigma and interpersonal openness. These findings can be explained in the context of the growing body of research that connects gender-role conflict with psychological maladjustment, which includes avoiding seeking help because of fears of stigma and vulnerability (Blazina, 1997; Blazina & Marks, 2001; Blazina & Watkins, 2000; Courmoyer & Mahalik, 1995; Davies et al., 2001; Good et al., 1989, 1990, 1995 & 1996; Nadler et al., 1984; O'Neil et al., 1981, 1986 & 1995; O'Neil, 1990; Real, 1997; Wisch et al., 1995).

Similarly to the findings of Blazina and Watkins (1996) and Blazina and Marks (2001), the present study found that the most prominent aspect of gender role conflict in predicting the general attitude toward seeking help was restriction of emotions, with restriction of emotions being negatively related to all the aspects of seeking professional help. Furthermore, confirming the results of Blazina and Watkins (1996), the present study found that two patterns of gender role conflict, specifically restriction of emotions (RE) and success, power and competition (SPC), highly predict a negative attitude toward seeking professional help, possibly due to the fear of mental health stigma and the

avoidance of admitting the need for psychological help. What is added to the literature by the present study is that SPC, RABBM and CBWFR predict avoiding seeking professional help, possibly because of disliking interpersonal openness, and that CBWFR predicts a negative attitude toward seeking professional help, possibly due to distrust of mental health practitioners. These results may be explained by the fact that gender-role conflicted men are not all the same, and it cannot be assumed or taken for granted that those who score high on gender role conflict are a homogeneous sample, and will have the same attitudes. Thus these results correspond with a view previously expressed within the gender role conflict literature, which posits that men who are considered or regarded as traditional should not be seen as a homogeneous group by counsellors, because there are various factors associated with gender role conflict, masculinity and male identity (Levant, 1996, 1997; Philpot et al., 1997; Wade, 1998). This is not only because such a view denies the influence of the various patterns within the phenomenon of gender role conflict, but also because it minimises and negates the other factors of a person. Such factors might be the person's racial background and ethnicity (Thorn & Sarata, 1998), sexual orientation (Schwartzberg & Rosenberg, 1998), age (Simon, 1996), and socioeconomic status (Jolliff & Home, 1996), all of which can have significant influence on men's identity. However, to adequately confirm this theoretical view and the results of the present study, more research is needed to look at gender role conflict systemically across different groups, and using various research techniques, such as interviews, longitudinal studies, experimental designs and others. Such studies will no doubt improve knowledge about masculinity and gender role conflict across different demographic groups. Such studies will also benefit the mental health system's understanding of men's help seeking.

B. Attitudes toward Seeking Professional Psychological Help as Covariate in the Relationship Between High and Low GRC and Preference for Therapeutic Techniques.

The re-examination of the relationship between GRC levels (high and low) and preference for therapeutic techniques (previously examined in the Main Analysis of the current study), while controlling for the participants' attitudes toward seeking professional psychological help (ATSPPH) for a covariate and as a possible source of error variance, revealed that the effect of high and low GRC for preference for therapies remained the same as before controlling for ATSPPH, except for behavioural therapy. The change of both groups of men's (high and low GRC) ratings for behavioural therapy after controlling for their negative attitude towards seeking professional help may be explained to a certain extent by what Mahalik and Cournoyer (2000) recently described as cognitive errors that may occur among gender-role conflicted men, or what Blazina and Watkins (2000) described as a form of dichotomous thinking or a psychological use of splitting. Cognitive errors or dichotomous thinking occurs because of a struggle that people high on gender role conflict have between what they think or need and what society thinks or wants from them. Adherence to the traditional male gender role, as various researchers propose (Good, Dell, & Mintz, 1989; Good & Sherrod, 2001; Robertson, 2001; Robertson & Fitzgerald's, 1992), may be a source of hesitation in using mental health services, even if the men want to seek help, or have certain therapeutic preferences. All in all, it seems that in the present study both men who are high and those who are low on gender role conflict have similar counselling and/or psychotherapeutic preferences, but the men who are high on gender role conflict have more difficulty in initiating the help-seeking process, particularly in regards to behavioural therapy. The higher willingness of men who scored high on gender role conflict in comparison to men

who scored low on gender role conflict in relation to preference for behavioural therapy after controlling for attitude toward seeking professional help could be explained by the difference between the men's experience of depression across groups. Though the current study did not measure the levels of depression research has continuously found high scores on the gender role conflict scale (GRCS) to be related to higher levels of depression in men (Good & Mintz, 1990; Good & Wood, 1995), and higher avoidance of seeking help from professionals, or support from family or friends (Cochran, 2001; Good & Sherrod, 2001; Mahalik et al., 1995; Real, 1997), in comparison to those who score low on GRC.

CONCLUSION

In general, the findings of the current research enrich the literature about men's gender role conflict, its properties, its association with age, socioeconomics, seeking professional help, and its relation to preferences for therapy, the latter being of particular importance, since no studies have been previously carried out on therapy preferences and GRCS. The findings of the current study suggest that there is a relation between gender role conflict and preferences for therapeutic techniques and conditions with men who score high on the gender role conflict scale having a stronger preference for biomedical therapies than men who score low on the gender role conflict scale. However, more research is needed about gender role conflict, both in general and in relation to therapy, to support and validate the current findings. Such studies will promote the mental health system's understanding of men's help seeking and of their choice of therapy, and there is no doubt such studies will benefit the knowledge of men and therapy, which is needed to encourage a change of men's attitudes toward therapy and enable depressed men to be helped. Implications are discussed in last chapter of this study - Chapter Five.

CHAPTER 3

THE ROLE OF MASCULINITY IN RELATION TO PREFERENCE FOR TYPE OF THERAPY AND COPING

This chapter addresses the methodology, results, and discussion of the second stage of the research, which, as reported in Chapter One, aims to examine two main issues, firstly whether exposure of men reporting high or low gender role conflict to either emotion-focused or thought-focused therapy, through the use of a counselling video, influences subsequent preference for type of therapy, and to examine the overall influence of exposure to therapy on the subsequent preferences for therapies for men, both in general and in high and low gender role conflict. Secondly to analyse the role of coping as a mediator of the relationship between gender role conflict and preferences for therapies.

As noted earlier, this is in response to Wisch et al.'s (1995) call to explore how gender role conflict interacts with the emotional content of therapy in influencing men's attitudes towards therapy and a variety of other orientations. The present investigation will address a sequence of specific questions: Does the exposure of men reporting high and low gender role conflict to emotion- focused or thought-focused therapy, through the use of a counselling video, influence subsequent preference for type of therapy? What are men's overall preferences for therapies pre and post exposure? What are the preferences for therapies of men reporting high and low gender role conflict in general, and post exposure to emotion- focused or thought-focused counselling? It is hypothesised that men reporting high gender role conflict exposed to an emotion- focused or thought-focused counselling video will prefer biomedical therapies more than men reporting low gender role conflict who are exposed to an emotion-focused or thought-focused counselling, because

biomedical therapies does not involve emotional expressiveness as much as the counselling therapies do. As outlined in Chapter Two, this prediction is built on the theory that high gender role conflict men avoid emotional expressiveness (Bem, 1974, 1977) because it is considered feminine (O'Neil, 1981a, 1981b, 1982), and gender role conflicted men fear and avoid what is considered feminine, or unmanly. Thus the focus on emotion, in a counselling session, whether behavioural, cognitive or psychoanalytic, may interact with gender role conflict (Wisch et al, 1995) producing a preference for biomedical intervention and avoidance of counselling therapies.

According to Heppner (1995) and Llewellyn-Smith (1999), the validation of the gender role conflict model relies on reducing dependence on simple correlational designs and on exploring more complex relationships, including the role of mediating variables, especially the impact of coping as a mediator between gender role conflict and related issues such as therapy preferences. Therefore, a further aim of the current study is to analyse whether coping acts as a mediator of the relationship between gender role conflict and preferences for therapies. The study will answer three key questions of the proposed mediation model: Is gender role conflict associated with men's choice of coping strategies (emotion-focused coping, problem-focused coping and avoidance coping)? Is gender role conflict associated with men's preference for therapy (biomedical, behavioural, cognitive or psychoanalytic)? Does the choice of coping strategy predict and account for the relationship between gender role conflict and the preference for type of therapy?

To examine the first main question, whether exposure of men reporting high or low gender role conflict to either emotion-focused or thought-focused therapy, through the use of a counselling video, influences subsequent preference for type of therapy, a

multivariate analysis of variance (MANOVA) is employed using degree of gender role conflict (high vs. low) and type of the experimental session (emotion-focused or thought-focused) as the independent variables, and using scores on therapy preferences (cognitive, behavioural, biomedical and psychoanalytic) post watching the counselling video as the dependent variables. Furthermore, two separate dependent-samples *t* tests are employed: one to compare men's preferences for therapies pre and post exposure, and another compare high and low gender role conflict men preferences for therapy following exposure.

To examine the second main question of this stage of the research, namely the role of coping as a mediator between gender role conflict and preferences for therapy techniques (cognitive, behavioural, biomedical or psychoanalytic), multi-collinear mediation design is employed. Employing multi-collinear mediation design is conditional on the significance of the association between the three main factors, namely, gender role conflict, coping strategies and therapy preferences. The independent variable is the gender role conflict total score, the mediators are the continuous scores for each coping strategy (emotional, avoidance and task coping), and the dependent variables, known as the criterion in mediator designs, are the continuous scores for each therapy technique (cognitive, behavioural, biomedical or psychoanalytic).

METHOD

Participants

One hundred and forty-two men accepted and took part in this second study, a sub-sample of 397 men that had taken part in the first study. Eighty three men (58% of the participants) were aged 18-30, and 59 men (42% of the participants) were aged between 31-45 years. The sample consisted of 68 Asian, 41 European, 22 Middle Eastern, 5 Latino, 4 Pacific Islanders,

1 Aboriginal and 1 Indian. The sample was made up of 13% students and 87% full time workers. Initially, 168 men took part in the second study but 26 participants were disqualified because they left more than one question unanswered, leaving the final sample at 142.

Instruments

The Gender Role Conflict Scale (GRCS; O'Neil et al., 1986)

GRCS measured the level of gender role conflict in men (the degree to which the traditional male gender role interferes with the well-being of men and those with whom they interact). See questionnaire details in instruments section of the first stage of the study pp.47-48 and in Appendix A.

Preferences for Therapies Questionnaire (Furnham & Wardley, 1991)

The questionnaire presents 22 therapies with descriptions of the various therapies that a person might consider in an attempt to get help for psychological disorders. See questionnaire details in instruments section of the first stage of the study pp. 48-50 and in Appendix B.

Multidimensional Coping Inventory (MCI)

The MCI is a 48-item inventory which was designed to specifically evaluate three very different and frequently conflicting coping strategies: emotion oriented, task oriented or avoidance. Participants are to indicate on a 5 point Likert scale ranging from 1 (Not at all) to 5 (very much) the frequency of utilising these strategies when encountering “difficult, stressful or upsetting situations.” For the three types of coping, higher scores represent engagement in that kind of coping strategy more often (see Appendix G). Repeated testing reports high internal consistency and reliability (Cronbach's alpha ranging from

.74 to 7.3, Endler & Parker, 1990). The MCI was selected for the current study due to evidence supporting its psychometric characteristics, ease of scoring and its relevance to examine the research aims.

Experimental Manipulation

Videotapes of Counselling Sessions

These were based on the ones developed and used by Wisch, Mahalik, Hayes & Nutt (1995) to study the impact of gender role conflict and emotion-focused or thought-focused counselling techniques on psychological help seeking in men. The study is reported in the literature review of current research (see p. 41). The videotapes, as described by these researchers (Wisch, Mahalik, Hayes & Nutt, 1995. p 82) were:

“Two 10-minute videotapes of mock counseling sessions using male actors to portray the counselor (44-year-old male counseling psychology doctoral student) and the client (21-year-old male Master’s student)”.

In both videotapes, the client presents the same concerns, which are vocational and personal issues. The client reports that he is starting his senior year of undergraduate study and he needs help determining a post-graduation career path. Furthermore, he reports strong pressure from his parents and female partner to pursue various options, which has left him indecisive and in need of guidance. The client talks about his concerns by focusing on his behaviours and the behaviours of the significant others affecting him.

Once the client has finished describing his concerns, the counsellor responds by probing for more information. Once the counsellor starts to probe, the two tapes start to differ in terms of emotion versus thought content. But the general content of both videotapes remains the same (e.g. general discussion of the vocational problem, followed by

discussion of conflict with parents, then conflict with female partner, and concluding with a counsellor intervention regarding conflict).

In the affective tape, the counsellor responds by focusing on the client's emotions (e.g., "Let's talk for a minute about your parents. What kind of feelings come up when you deal with them?"), and the client responds by reporting emotions (e.g., "Whenever my dad comes up with an idea for me for a career, it makes me feel even more overwhelmed and depressed than before."). In the thought-focused videotape, the counsellor responds by focusing on the client's thoughts (e.g., "Let's talk for a minute about your parents. What kind of messages to yourself come up when you deal with them?"), and the client responds by reporting thoughts (e.g., "Whenever my dad comes up with an idea for me for a career, I think about how impossible it is.").

The videotapes of counselling sessions were selected for the current study due to its validity and reliability (Wisch, Mahalik, Hayes & Nutt, 1995. p 83), and its relevance in relation to the examination of the current research aims.

Procedure

Volunteers from the first study who agreed to take part in the second study were randomly assigned to one of the two conditions (emotion-focused or thought-focused), and contacted to schedule a time for the experimental session. At the experimental session, participants first gave informed consent (Appendix H and I). Then they were asked to fill out the multidimensional coping inventory. Next, the researcher introduced the session by giving a short verbal introduction indicating that the session focuses on vocational and personal problems. Then the researcher played either the emotion or thought focused videotape. Post viewing the tape, participants were invited to complete the therapy preferences questionnaire and were then debriefed. Furthermore participants

were invited to participate in a further interview study and were informed that those who meet the criteria of the third stage and accept to participate were to be given \$AU 50 for expenses. The procedures and paid amount for expenses received full ethics approval (Registration No. HEC 01/153, Appendix K).

RESULTS

In order to simplify the presentation of the statistical analysis, the results section is divided into two sections. The first section presents the results of the preliminary analyses; the second section presents the results of the main analyses.

I. The Preliminary Analyses

To determine high and low gender role conflict groups for stage two, the sample was dichotomised based on the upper (75th) and lower (25th) percentiles, and excluding the middle 50 percent as reported by Preacher et al. (2005). The outcome of the analysis is high $GRC \geq 153.25$ and low $GRC \leq 122.00$. The results of GRC dichotomisation indicated that 35 participants were high GRC ($M=168.42$, $SD=7.7$) and 38 participants were low GRC ($M=113$, $SD=10.96$). Sixty-nine participants were excluded because they are in the middle (See Table 3.1). The re-determination of high and low gender role conflict categorisation for stage two was conducted in order to take into account the change of the number of participants in this stage.

Table 3.1

Means and Standard Deviations of High and Low GRC and Subscales based on the upper (75) and lower (25) percentiles

High or Low GRC based on the Median Split		GRC-Total	SPC	RE	RABBM	BWFR
Excluded	Mean	140.26	50.74	36.69	30.97	21.85
	N	69	69	69	69	69
	Std. Deviation	7.72	5.85	3.11	4.15	3.49
High	Mean	168.42	60.74	45.54	35.45	26.68
	N	35	35	35	35	35
	Std. Deviation	10.96	5.04	6.33	2.54	3.12
Low	Mean	113.00	40.44	29.78	21.55	21.21
	N	38	38	38	38	38
	Std. Deviation	9.17	5.076	2.74	2.17	5.057
Total	Mean	139.90	50.45	37.02	29.55	22.87
	N	142	142	142	142	142
	Std. Deviation	21.84	9.09	6.96	6.16	4.45

NB. GRC= Gender Role Conflict; SPC= Success, Power and Competition; RE= Restrictive Emotionality; RABBM= Restricted Affectionate Behaviour Between Men; BWFR= Conflict Between Work and Family Relations.

II. Main Analyses

The main analysis is divided into two sections. The first section investigates whether exposure of men reporting high or low gender role conflict to emotion-focused or thought-focused therapy influences preference for type of therapy. The second section inspects whether coping acts as a mediator of the relationship between gender role conflict and preferences for therapies.

A. The Influence of Exposure to Emotion-Focussed or Thought-focused Therapy on Preference for Type of Therapy for High and Low Gender Role Conflict

To examine whether exposure of men reporting high or low gender role conflict to emotion-focused or thought-focused therapy influenced preference for type of therapy, a multivariate analysis of variance (MANOVA) was performed on therapy preferences (cognitive, behavioural, biomedical and psychoanalytic) post watching the counselling video. Gender role conflict (high GRC vs. low GRC) and counselling techniques

(emotion-focused or thought-focused) were the independent variables and scores on therapy preferences (cognitive, behavioural, biomedical and psychoanalytic) only post watching the counselling video were the dependent variables. Box's test for homogeneity of covariance matrices revealed that there is homogeneity $F = 1.50, \rho > .083$.

With alpha set at .05, the multivariate tests of significance indicated the presence of significant group differences. Pillai's criterion indicated the presence of significant group differences for high and low gender role conflict $F = 14.00, \rho \leq .000, \eta^2 = .459$, and for the interaction of high and low gender role conflict with emotion-focused or thought-focused $F = 42.17, \rho \leq .000, \eta^2 = .710$. No significant group differences for emotion-focused or thought-focused exposure $F = 1.49, \rho = .215, \eta^2 = .083$. Table 3.2 summarises the multivariate tests of significance. However, it should be noted that conducting multivariate tests of significance while retaining $\alpha = .05$ as a potential limitation associated with the exploratory design of the study.

Table 3.2

Multivariate Tests

Effect		Value	F	Sig.	Partial Eta Squared
Counselling Video: Emotional and Cognitive	Pillai's Trace	0.083	1.490	0.215	0.083
GRC: High and Low	Pillai's Trace	0.459	14.004	0.000	0.459
Counselling Video * GRC	Pillai's Trace	1.419	42.176	0.000	0.710

NB. GRC= Gender Role Conflict.

With $\alpha = .05$ the tests of between-subjects effects indicated that both the main effects of GRC and the interaction of high and low gender role conflict with emotion-focused or thought-focused were found to be significant. Table 3.3 summarises tests of between-subjects effects. The results indicated that there was a significant effect for high and low gender role conflict for biomedical therapy $F = 37.52, \rho = .00, \eta^2 = .948$, cognitive therapy $F = 4.87, \rho = .03, \eta^2 = .066$, behavioural therapy $F = 12.19, \rho = .00, \eta^2 = .150$, and

psychoanalytic therapy $F = 5.79, \rho = .01, \eta^2 = .077$. There was significant effect for emotion-focused or thought-focused counselling video for psychoanalytic therapy $F = 4.91, \rho = .030, \eta^2 = .066$, but not for cognitive therapy $F = 2.82, \rho = .097, \eta^2 = .039$, behavioural therapy $F = 2.49, \rho = .199, \eta^2 = .035$, or biomedical therapy $F = 1.96, \rho = .659, \eta^2 = .003$. However, the results revealed there was a significant effect for the interaction of high and low gender role conflict with emotion-focused or thought-focused counselling video for cognitive therapy $F = 4.04, \rho = .04, \eta^2 = .974$, psychoanalytic therapy $F = 6.13, \rho = .01, \eta^2 = .972$, biomedical therapy $F = 37.54, \rho = .00, \eta^2 = .948$, and behavioural therapy $F = 12.35, \rho = .00, \eta^2 = .915$. All in all, it seems that exposure of men reporting high or low gender role conflict to emotion-focused or thought-focused therapy influenced preference for type of therapy.

Table 3.3

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Model	Behavioural	9029.906	4.000	2257.477	192.757	0.000	0.918
	Biomedical	7299.179	4.000	1824.795	316.501	0.000	0.948
	Cognitive	18522.582	4.000	4630.645	687.989	0.000	0.976
	Psychoanalytic	20382.799	4.000	5095.700	641.376	0.000	0.974
Counselling Video: Emotional and Cognitive	Behavioural	29.199	1.000	29.199	2.493	0.119	0.035
	Biomedical	1.132	1.000	1.132	0.196	0.659	0.003
	Cognitive	19.001	1.000	19.001	2.823	0.097	0.039
	Psychoanalytic	39.012	1.000	39.012	4.910	0.030	0.066
GRC: High and Low	Behavioural	142.823	1.000	142.823	12.195	0.001	0.150
	Biomedical	216.331	1.000	216.331	37.522	0.000	0.352
	Cognitive	32.838	1.000	32.838	4.879	0.031	0.066
	Psychoanalytic	46.010	1.000	46.010	5.791	0.019	0.077
Counselling Video: Emotional and Cognitive * GRC: High and Low	Behavioural	9000.705	2.000	4500.352	381.616	0.000	0.915
	Biomedical	7294.513	2.000	3647.256	643.387	0.000	0.948
	Cognitive	18492.814	2.000	9246.407	1328.438	0.000	0.974
	Psychoanalytic	20339.972	2.000	10169.986	1221.717	0.000	0.972

NB. GRC= Gender Role Conflict.

To examine the question: “what are the preferences for therapies for men reporting high and low gender role conflict post exposure to emotion-focused or thought-focused

counselling”, and the hypothesis that men reporting high gender role conflict exposed to emotion-focused or thought-focused counselling will prefer biomedical therapies more, than men reporting low gender role conflict who are exposed to emotion-focused or thought-focused counselling because biomedical therapies does not involve emotional expressiveness as much as the counselling therapies do, Post Hoc pairwise comparisons were conducted among the four cells mean of gender role conflict (high GRC vs. low GRC) and counselling techniques (emotion-focused or thought-focused) using Tukey test. Descriptive statistics are shown in Table 3.4. The results supported the hypothesis and revealed significant differences, with men in the high GRC/emotion-focused condition and men in the high GRC/thought-focused condition preferring biomedical therapies more than men in the low GRC/emotion-focused condition and men in the low GRC/thought-focused condition. Although not hypothesised, examination of the mean differences indicated that men in the high GRC/thought-focused condition preferred behavioural therapies significantly more than men in the low GRC/emotion-focused condition and men in the low GRC/thought-focused condition. Also examination of the means differences indicated that men in the high GRC/thought-focused condition preferred psychoanalytic therapies more than men in the low GRC/ emotion-focused condition, and that men in the low GRC/ thought-focused condition preferred cognitive therapies more than men in the high GRC/emotion-focused condition and men in the high GRC/ thought-focused condition.

Table 3.4

**The Means and Standard Deviations of Therapy Preference Post watching
the counselling video by Gender Role Conflict and Session Focus**

		N	Mean	Std. Deviation
Behavioural Post Counselling Video	High GRC x Cognitive Counselling Video	20	13.05	2.82
	High GRC x Emotional Counselling Video	15	11.73	3.26
	Low GRC x Cognitive Counselling Video	22	10.18	4.16
	Low GRC x Emotional Counselling Video	16	8.94	3.11
	Total	73	11.01	3.69
Biomedical Therapies Post Counselling Video	High GRC x Cognitive Counselling Video	20	11.55	2.31
	High GRC x Emotional Counselling Video	15	11.73	2.69
	Low GRC x Cognitive Counselling Video	22	8.50	2.48
	Low GRC x Emotional Counselling Video	16	7.81	2.10
	Total	73	9.85	2.92
Cognitive Therapies Post Counselling Video	High GRC x Cognitive Counselling Video	20	16.05	1.79
	High GRC x Emotional Counselling Video	15	14.20	2.73
	Low GRC x Cognitive Counselling Video	22	16.59	2.84
	Low GRC x Emotional Counselling Video	16	16.38	2.94
	Total	73	15.90	2.69
Psychoanalytic Therapies Post Counselling Video	High GRC x Cognitive Counselling Video	20	18.40	3.23
	High GRC x Emotional Counselling Video	15	16.40	2.82
	Low GRC x Cognitive Counselling Video	22	16.27	2.96
	Low GRC x Emotional Counselling Video	16	15.31	1.89
	Total	73	16.67	2.99

NB. GRC= Gender Role Conflict.

To examine the overall influence of exposure to therapy on the subsequent preference for type of therapy for men, both in general and in high and low gender role conflict, two separate dependent-samples *t* tests were conducted.

The first dependent-samples *t* test was conducted for men's preferences for therapies (behavioural, cognitive, psychoanalytic and biomedical) under two conditions, pre-exposure and post-exposure to the counselling videos. Table 3.5 presents the descriptive statistics and *t* test. With alpha set at .05 the results indicated that there was a significant increase in the men's rating for biomedical therapy, $t(141) = 2.70, p = .008$, and psychoanalytic therapy $t(141) = 3.84, p < .001$ post-exposure, but there was not any significant changes in the attitudes of the participants toward behavioural therapy, $t(141) = 1.23, p > .27$ and cognitive therapy $t(141) = -2.71, p > .78$.

Table 3.5

**Paired Samples Statistics and T-Test:
Overall Preferences for Therapies Pre- and Post- Exposure to Counselling Videos**

Preferences for Therapies Post- and Pre- Exposure to Counselling Videos			Mean	S.D	Paired Differences		t	df	Sig.
					Mean	S.D			
Preferences for Therapies Post- Exposure to Counselling Videos	Pair 1	Behavioural Post-Exposure	9.92	3.32	0.32	3.56	1.08	141.00	0.280
		Biomedical Post-Exposure	9.60	2.90					
	Pair 2	Behavioural Post-Exposure	9.92	3.32	-5.24	3.79	-16.47	141.00	0.000
		Cognitive Post-Exposure	15.16	2.97					
	Pair 3	Behavioural Post-Exposure	9.92	3.32	-5.27	3.24	-19.40	141.00	0.000
		Psychoanalytic Post-Exposure	15.20	3.18					
	Pair 4	Biomedical Post-Exposure	9.60	2.90	-5.56	4.29	-15.47	141.00	0.000
		Cognitive Post-Exposure	15.16	2.97					
	Pair 5	Biomedical Post-Exposure	9.60	2.90	-5.60	3.93	-16.97	141.00	0.000
		Psychoanalytic Post-Exposure	15.20	3.18					
	Pair 6	Cognitive Post- Exposure	15.16	2.97	-0.04	3.48	-0.12	141.00	0.904
		Psychoanalytic Post-Exposure	15.20	3.18					
Preferences for Therapies Pre- Exposure to Counselling Videos	Pair 7	Behavioural Pre-Exposure	9.66	3.41	0.63	3.41	2.19	141.00	0.030
		Biomedical Pre-Exposure	9.04	2.82					
	Pair 8	Behavioural Pre-Exposure	9.66	3.41	-5.55	3.98	-16.62	141.00	0.000
		Cognitive Pre-Exposure	15.21	2.65					
	Pair 9	Behavioural Pre- Exposure	9.66	3.41	-4.78	3.13	-18.19	141.00	0.000
		Psychoanalytic Pre-Exposure	14.44	3.59					
	Pair 10	Biomedical Pre-Exposure	9.04	2.82	-6.18	4.11	-17.90	141.00	0.000
		Cognitive Pre-Exposure	15.21	2.65					
	Pair 11	Biomedical Pre-Exposure	9.04	2.82	-5.41	3.87	-16.66	141.00	0.000
		Psychoanalytic Pre-Exposure	14.44	3.59					
	Pair 12	Cognitive Pre-Exposure	15.21	2.65	0.77	3.95	2.31	141.00	0.022
		Psychoanalytic Pre-Exposure	14.44	3.59					
Preferences for Therapies Pre- and Post- Exposure to Counselling Videos	Pair 13	Behavioural Post-Exposure	9.92	3.32	0.26	2.51	1.24	141.00	0.217
		Behavioural Pre-Exposure	9.66	3.41					
	Pair 14	Biomedical Post-Exposure	9.60	2.90	0.56	2.49	2.70	141.00	0.008
		Biomedical Pre-Exposure	9.04	2.82					
	Pair 15	Cognitive Post-Exposure	15.16	2.97	-0.05	2.16	-0.27	141.00	0.786
		Cognitive Pre-Exposure	15.21	2.65					
	Pair 16	Psychoanalytic Post-Exposure	15.20	3.18	0.75	2.34	3.84	141.00	0.000
		Psychoanalytic Pre-Exposure	14.44	3.59					

* Significant at the 0.05 level (2-tailed).

The change in rating significantly affected the order of preference for therapies for all men. Before exposure cognitive therapy was the first preference ($M=15.21$, $SD=2.65$), psychoanalytic therapy second ($M=14.44$, $SD=3.59$), behavioural therapy third ($M=9.66$, $SD=3.41$) and biomedical therapy fourth ($M=9.04$, $SD=2.82$). Following exposure both

psychoanalytic ($M=15.20$, $SD=3.18$) and cognitive therapy ($M=15.16$, $SD=2.97$) became the first preference, while both behavioural therapy ($M=9.92$, $SD=3.32$) and biomedical therapy ($M=9.60$, $SD=2.90$) became the second preference.

The second dependent-samples t test was conducted for men's preferences for therapies (behavioural, cognitive, psychoanalytic and biomedical) post exposure to therapy under two conditions, high and low gender role conflict. Table 3.6 presents the descriptive statistics and t test for the above analyses. With alpha set at .05 the results indicated a statistically significant difference between both groups of men for preferences for therapies, biomedical therapy, $t(34) = 5.42$, $\rho \leq .001$, behavioural therapy, $t(34) = 2.88$, $\rho = .007$, cognitive therapy $t(34) = -2.59$, $\rho = .014$, and psychoanalytic therapy $t(34) = 2.21$, $\rho = .034$. Comparison of means revealed that high gender role conflict men rated psychoanalytic therapy ($M=17.5$, $SD=3.18$), behavioural ($M=12.5$, $SD=3.04$) and biomedical therapy ($M=11.6$, $SD=2.44$) significantly more than low gender role conflict men. However low GRC men rated cognitive therapy ($M=16.6$, $SD=2.93$), higher than high gender role conflict men ($M=15.3$, $SD=2.39$). The significant differences between both groups of men were reflected in the order of preference for therapies within each group. Post-exposure high gender role conflict men ranked preference for psychoanalytic therapy first ($M=17.54$, $SD=3.18$), cognitive therapy second ($M=15.26$, $SD=2.39$), while both behavioural therapy ($M=12.49$, $SD=3.04$) and biomedical therapy ($M=11.63$, $SD=2.44$) third, with $t(34) = 1.63$, $\rho = .113$. Low gender role conflict men, post exposure, ranked cognitive ($M=16.50$, $SD=2.85$) and psychoanalytic ($M=15.87$, $SD=2.58$) therapies equally as a first preference, with $t(37) = 1.23$, $\rho = .0228$, behavioural ($M=9.66$, $SD=3.76$) as a second preference and biomedical ($M=8.21$, $SD=2.33$) therapies as a third preference.

Table 3.6

**Paired Samples Statistics and T-Test:
Overall Preferences for Therapies of High and Low GRC Post-Exposure to Counselling Videos**

High and Low GRC Preferences for Therapies Post-Exposure to Counselling Videos			Mean	S.D	Paired Differences		t	df	Sig.
					Mean	S.D			
High GRC Preferences for Therapies Post-Exposure to Counselling Videos	Pair 1	Behavioural Post-Exposure	12.49	3.04	0.86	3.12	1.63	34.00	0.113
		Biomedical Post-Exposure	11.63	2.44					
	Pair 2	Behavioural Post-Exposure	12.49	3.04	-2.77	3.26	-5.02	34.00	0.000
		Cognitive Post-Exposure	15.26	2.39					
	Pair 3	Behavioural Post-Exposure	12.49	3.04	-5.06	2.68	-11.17	34.00	0.000
		Psychoanalytic Post-Exposure	17.54	3.18					
	Pair 4	Biomedical Post-Exposure	11.63	2.44	-3.63	3.51	-6.12	34.00	0.000
		Cognitive Post-Exposure	15.26	2.39					
	Pair 5	Biomedical Post-Exposure	11.63	2.44	-5.91	3.60	-9.72	34.00	0.000
		Psychoanalytic Post-Exposure	17.54	3.18					
	Pair 6	Cognitive Post- Exposure	15.26	2.39	-2.29	3.15	-4.29	34.00	0.000
		Psychoanalytic Post-Exposure	17.54	3.18					
Low GRC Preferences for Therapies Post-Exposure to Counselling Videos	Pair 7	Behavioural Post-Exposure	9.66	3.76	1.45	3.88	2.30	37.00	0.027
		Biomedical Post-Exposure	8.21	2.33					
	Pair 8	Behavioural Post-Exposure	9.66	3.76	-6.84	3.15	-13.39	37.00	0.000
		Cognitive Post-Exposure	16.50	2.85					
	Pair 9	Behavioural Post-Exposure	9.66	3.76	-6.21	4.03	-9.50	37.00	0.000
		Psychoanalytic Post-Exposure	15.87	2.58					
	Pair 10	Biomedical Post-Exposure	8.21	2.33	-8.29	3.24	-15.78	37.00	0.000
		Cognitive Post-Exposure	16.50	2.85					
	Pair 11	Biomedical Post-Exposure	8.21	2.33	-7.66	3.01	-15.70	37.00	0.000
		Psychoanalytic Post-Exposure	15.87	2.58					
	Pair 12	Cognitive Post- Exposure	16.50	2.85	0.63	3.17	1.23	37.00	0.228
		Psychoanalytic Post-Exposure	15.87	2.58					
High VS. Low GRC Preferences for Therapies Post-Exposure to Counselling Videos	Pair 13	High GRC * Behavioural Post-Exposure	12.5	3.04	2.66	5.46	2.88	34.00	0.007
		Low GRC * Behavioural Post-Exposure	9.83	3.86					
	Pair 14	High GRC * Biomedical Post-Exposure	11.6	2.44	3.46	3.85	5.32	34.00	0.000
		Low GRC * Biomedical Post-Exposure	8.17	2.36					
	Pair 15	High GRC * Cognitive Post-Exposure	15.3	2.39	-1.31	3.00	-2.59	34.00	0.014
		Low GRC * Cognitive Post-Exposure	16.6	2.93					
	Pair 16	High GRC * Psychoanalytic Post-Exposure	17.5	3.18	1.71	4.58	2.21	34.00	0.034
		Low GRC * Psychoanalytic Post-Exposure	15.8	2.63					

* Significant at the 0.05 level (2-tailed).

B. Coping as a Mediator between Gender Role Conflict and Therapy Preferences

To examine whether the coping strategies mediate the relationship between gender role conflict and preferences for therapy techniques (cognitive, behavioural, biomedical or psychoanalytic), the analyses were performed using a series of three multiple regression equations in accordance with Baron and Kenny (1986), Holmbeck (1997) and Kenny's (2003) rules for mediation analysis. All mediation analyses were conducted with the results on preferences for therapies, the three coping strategies scores (task, emotional and avoidance) and gender role conflict prior to the exposure. Means, standard deviations and intercorrelations between the mediating analyses measures are presented in Table 3.7.

Table 3.7
Means, Standard Deviations and Intercorrelations between, the Mediating Analyses' Measures

	GRC	Emotional Coping	Task Coping	Avoidance Coping	Behavioral Therapy	Biomedical Therapy	Cognitive Therapy	Psychoanalytic Therapy
Emotional Coping	-0.11							
Task Coping	0.44**	-0.03						
Avoidance Coping	-.366**	0.24**	-0.36**					
Behavioural Therapy	0.33**	0.03	0.57**	-0.32**				
Biomedical Therapy	0.67**	-0.01	0.45**	-0.19**	0.41**			
Cognitive Therapy	-0.16	-0.13	-0.16	0.03	0.15	-0.13		
Psychoanalytic Therapy	0.32**	0.22**	0.36**	-0.38**	0.60**	0.29**	0.22**	
Mean for variables in columns	139.91	48.41	48.44	51.68	9.66	9.04	15.21	14.44
SD for variables in columns	21.84	6.32	7.98	7.70	3.41	2.82	2.65	3.59

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

The first multiple regression equations tested the relationship between gender role conflict (as a predictor) and the three coping strategies (as the criterion). The three separate regressions, one for each of the three coping strategies, revealed that task coping ($\beta = .449, \rho < .001$) and avoidance coping ($\beta = -.366, \rho < .001$) are significantly related to GRC. As emotion coping was not significantly related to GRC ($\beta = -.11, \rho > .10$), in accordance with Baron and Kenny (1986), it was dropped from the further analysis. Table 3.8 present the coefficients of the three separate coping strategies regressions

Table 3.8
Coefficients of the Three Separate Regressions for Gender Role Conflict and the Three Coping Strategies

Model		Standardized Coefficients	t	Sig.
		Beta		
Regression 1	(Constant)		17.75	0.00
	GRC	-0.366	-4.65	0.00
	Dependent Variable: Avoidance Coping			
Regression 2	(Constant)		15.46	0.00
	GRC	-0.118	-1.41	0.16
	Dependent Variable: Emotional Coping			
Regression 3	(Constant)		6.53	0.00
	GRC	0.449	5.94	0.00
	Dependent Variable: Task Coping			

*GRC= Gender Role Conflict

The second multiple regression equations tested the relationship between gender role conflict (as a predictor) and the four types of therapies (as the criterion). The four separate regressions, one for each of the four therapies, revealed that preferences for behavioural therapy ($\beta = .32, \rho < .001$), biomedical therapy ($\beta = .66, \rho < .001$) and psychoanalytic therapy ($\beta = .32, \rho < .001$) are positively significantly related to GRCS, while cognitive therapy ($\beta = -.164, \rho = .05$) is significantly negatively related to GRCS. Table 3.9 present the coefficients of the four separate regressions for GRC and the four therapies.

Table 3.9

Coefficients of the Four Separate Regressions for Gender Role Conflict and the Four Therapies

Model		Standardized Coefficients	t	Sig.
		Beta		
Regression 1	(Constant)		1.425	0.156
	GRC	0.328	4.103	0.000
	Dependent Variable: Behavioural Therapies			
Regression 2	(Constant)		-2.602	0.010
	GRC	0.666	10.560	0.000
	Dependent Variable: Biomedical Therapies			
Regression 3	(Constant)		12.583	0.000
	GRC	-0.164	-1.973	0.051
	Dependent Variable: Cognitive Therapies			
Regression 4	(Constant)		3.657	0.000
	GRC	0.135	1.560	0.121
	Dependent Variable: Psychoanalytic Therapies			

*GRC= Gender Role Conflict

In the third multiple regression equations the two coping strategies that were left from stage one, avoidance coping and task coping, plus GRCS were entered at the same time as independent variables, on each of the four therapies (behavioural, biomedical, cognitive and psychoanalytic therapies) isolated. Table 3.10 present the coefficients of the four separate regressions for GRC, coping and the four therapies.

The results showed that biomedical therapy is the only therapy that is significantly related to GRC ($\beta = .58, \rho < .001$). The other three therapies were not related to GRC, with behavioural ($\beta = .58, \rho = .467$), cognitive ($\beta = -.133, \rho = .170$), and psychoanalytic therapy ($\beta = .135, \rho = .121$).

As for the relation between the therapies and coping, the results revealed that preference for psychoanalytic therapy is significantly related to both task coping ($\beta = .20, \rho < .001$) and avoidance ($\beta = -.25, \rho < .001$), while preferences for biomedical therapy and behavioural therapy are only significantly related to task coping. Cognitive therapy was not related to any of the two coping strategies, avoidance coping ($\beta = -.058, \rho = .52$), and

task coping ($\beta = -.11, \rho < .22$). In accordance with Baron and Kenny (1986) avoidance coping was dropped from the analyses with biomedical ($\beta = .12, \rho > .09$), behavioural ($\beta = -.12, \rho = .12$), and cognitive ($\beta = -.058, \rho = .52$) therapies. The results of regression coefficient (β) of GRC and therapy after inclusion of coping are reported in Table 3.11

Table 3.10
The Coefficients of the Four Separate Regressions for Gender Role Conflict, Task Coping Avoidance Coping and the Four therapies

Model		Standardized Coefficients	t	Sig.
		Beta		
Regression 1	(Constant)		0.239	0.811
	GRC	0.058	0.729	0.467
	Task Coping Before Video	0.503	6.349	0.000
	Avoidance Coping Before Video	-0.120	-1.578	0.117
	Dependent Variable: Behavioural Therapies			
Regression 2	(Constant)		-3.494	0.001
	GRC	0.609	8.633	0.000
	Task Coping Before Video	0.220	3.124	0.002
	Avoidance Coping Before Video	0.116	1.708	0.090
	Dependent Variable: Biomedical Therapies			
Regression 3	(Constant)		7.013	0.000
	GRC	-0.133	-1.379	0.170
	Task Coping Before Video	-0.118	-1.227	0.222
	Avoidance Coping Before Video	-0.058	-0.630	0.529
	Dependent Variable: Cognitive Therapies			
Regression 4	(Constant)		3.657	0.000
	GRC	0.135	1.560	0.121
	Task Coping Before Video	0.209	2.407	0.017
	Avoidance Coping Before Video	-0.258	-3.104	0.002
	Dependent Variable: Psychoanalytic Therapies			

Table 3.11
The Results of Regression Coefficients (β) of Gender Role Conflict and Therapy Relationship After Inclusion of Coping Strategies

Dependent Variable	Independent Variables	Standardized Coefficients Beta (β) of Direct Effect
Behavioural Therapy	GRC	0.08
	Task Coping	0.53 **
Biomedical Therapy	GRC	0.58 **
	Task Coping	0.19 **
Psychoanalytical Therapy	GRC	0.14
	Task Coping	0.21 **
	Avoidance Coping	-0.26 **

* Significant at the 0.05 level (2-tailed).

In the final stage, in accordance Baron and Kenny (1986), Holmbeck (1997) and Kenny's (2003) rules for mediation analysis the Beta's (β) before and after the inclusion of the mediating variables were compared and the indirect effect of coping on therapy preference was calculated. The results are reported in Table 3.12

Table 3.12
Regression Coefficients of Gender Role Conflict and Therapy Relationship Before and After Inclusion of Coping Strategies

Criterion	Predictor	Total Effect β	Mediator Variable	Direct Effect β (GRC Direct Effect)	Indirect Effect ^a
Behavioural Therapy	GRC	0.32**	Task Coping	.08	.24**
Biomedical Therapy	GRC	0.66**	Task Coping	.58 **	.08**
Psychoanalytical Therapy	GRC	0.32**	Task Coping and Avoidance	.14	.18**

^a Significance levels for indirect effect calculated using Sobel's equation (1982).

** $\rho < .05$

Taken as a whole, the mediation analysis suggests that coping strategies mediate the relationship between gender role conflict and therapy preference (See Table 3.12). GRC exerted significant indirect effects on the preference for behavioural therapy through task coping. Similarly GRC exerted significant indirect effects on the preference for psychoanalytic therapy through task coping and avoidance coping. GRC exerted significant indirect effects on the preference for biomedical therapies through task coping. However the main direct effect of GRC, without going through coping, remained a significant strong predictor of preference for biomedical therapies. The direct effect of GRC of preference for biomedical therapies was stronger than going through task coping (See Table 3.12)

DISCUSSION

For this second study, the discussion is divided into two sections. The first section discusses how exposure of men reporting high or low gender role conflict to either emotion-focused or thought-focused therapy through the use of a counselling video influences subsequent preference for type of therapy. The second section considers the role of coping as a mediator between gender role conflict and preferences for therapy.

I. The Influence of Exposure of Men Reporting High or Low Gender Role Conflict to Emotion-focused or Thought-focused Therapy on the Preference for Type of Therapy.

The second study examined whether the therapy preferences of men reporting greater and lesser conflict about gender roles changed post viewing two different approaches of counselling (emotional or cognitive). Consistent with Wisch et al. (1995), the data of the present study supported the hypothesis that the interaction between emotion/thought focused therapy and gender role conflict would affect the participants' preferences for therapies. The analysis of variance revealed that there was a significant effect for the interaction of high and low gender role conflict with emotion-focused or thought-focused counselling video for biomedical therapy, cognitive therapy, behavioural therapy, and psychoanalytic therapy. Men reporting high on gender role conflict who are exposed to either emotion-focused or thought-focused counselling video preferred biomedical therapies more than men reporting low on gender role conflict who are exposed to the same conditions. Furthermore, men high on gender role conflict exposed to thought-focused counselling video preferred behavioural and psychoanalytic therapies

significantly more than men reporting low on gender role conflict who are exposed to emotion-focused or thought-focused counselling video. The focus on thoughts in a counselling session seems to positively influence men with high gender role conflict preferences toward counselling and psychological help more than the focus on emotions in a counselling. It could be concluded that, for men experiencing high gender role conflict, seeing other men (the client and counsellor in the videotape) talking about feelings and expressing emotions, which are considered to be related to femininity (O'Neil, 1981a, 1981b, 1982) produced enough discomfort to make them prefer biomedical intervention than men with less gender role conflict. These findings also endorse previous findings that adherence to the traditional male role is linked to less willingness to seek psychological help (Good, Dell, & Mintz, 1989; Nadler, Maler & Friedman, 1984; Robertson & Fitzgerald, 1992) because of fears of stigma, emotional self-disclosure (Williams & Myer, 1992) and vulnerability (Blazina, 1997; Blazina & Marks, 2001; Blazina & Watkins, 2000; Cournoyer & Mahalik, 1995; Davies et al., 2001; Good et al., 1989, 1990, 1995 & 1996; Nadler et al., 1984; O'Neil et al., 1981, 1986 & 1995; O'Neil, 1990; Real, 1997; Wisch et al., 1995). Because gender role conflict and the emotional content of sessions influenced preferences for therapies, one may conclude that avoiding emotions in counselling, and emphasising thoughts instead, may make the traditional man more comfortable with counselling and more positive toward psychological therapies in general. Men high on gender role conflict, who may have a stereotypical view of counselling as entirely emotionally-focused, might be convinced to seek help if they were aware of other types of therapy that are more consistent with their emotional style. Such approaches might include behavioural counselling which focuses on skill development more than on emotional expression. Otherwise, as was reported by Mahalik and Kivlighan (1988), bibliotherapy may be more appealing to men who

experience gender role conflict. However, more research is needed to explore the relation between gender role conflict and preference for therapy, and their relationship to variables such as the content of counselling sessions.

II. Coping as a Mediator between Gender Role Conflict and Therapy Preferences

A key feature of the present study was to explore whether coping strategies mediate the relationship between gender role conflict and therapy preferences. The present study is the third study to examine the role of coping as a mediator in relation to gender role conflict, after the contradictory results of the studies of Bergen (1996) and Llewellyn-Smith (1999). However, the present study is the first to address the role of coping as a mediator in relation to gender role conflict and therapy preferences. Therefore the findings are preliminary and require further confirmation. The findings of the present study support the hypotheses that coping mediates the relationship between gender role conflict and therapy preferences.

The first step of the mediation model examined the relationship between gender role conflict and coping strategies. The means revealed that the participants relied mostly on avoidance, then on task coping and finally on emotional coping. Regression analysis revealed that task coping is positively related to GRCS total and avoidance coping is negatively significantly related to GRCS, while emotional coping did not record a significant relationship with GRC. The finding that there is a link between “particular coping dispositions” and gender role conflict supports Llewellyn-Smith’s (1999) conclusions that “individuals coping repertoire mediates the relationship between gender role stress and wellbeing”, and does not support Bergen’s (1996) conclusion that no

relationship exists between coping strategies of men experiencing gender role conflict and their wellbeing.

The similarity of the results of the present study to those of Llewellyn-Smith, and their conflict with those of Bergen's, may be related to the fact that the present study made use of similar methodologies and concepts to those of Llewellyn-Smith. For example, similarly to Llewellyn-Smith, and in contrast to Bergen, who relied on a small homogeneous sample of middle class college students, the present study involved a broad general population sample of various age groups, numerous occupations and different income statuses. Furthermore, consistent with Llewellyn-Smith (1999), and in contrast to Bergen who used the isolated context of situation vignettes to assess gender role conflict, assuming gender role conflict is a situation-specific stressor, the present study assessed traditional gender role conflict according to O'Neil et al.'s (1986) view, which considers gender role conflict levels (high and low) and attitudes as beyond situations and contexts. GRC is considered to be a global cognitive schema, through which the world is perceived, and not situation-specific as Bergen (1996) conceives it. Examining coping strategies following the global schema approach, instead of Bergen's isolated context, allowed the full examination and detection of the connection between gender role conflict and coping strategies in the current study, as it did in Llewellyn-Smith's.

However, the present study's findings that task coping is positively related to GRC, that avoidance coping is negatively but significantly related to GRC, and emotion coping does not have any relation with GRC, contradicts Llewellyn-Smith's (1999) findings, which emphasised the existence of a significant positive relationship between GRC and both emotion coping and avoidance coping, and a negative association with task coping. Although the data contradict this aspect of Llewellyn-Smith's, the results of the present

study are consistent with the findings of Endler and Parker (1990a) who used the same questionnaire as that used in both Llewellyn-Smith's and the current study, and found that men engage in task coping more than avoidance coping or emotional coping. As well, they found that for men and women, emotion-oriented coping was strongly related to neuroticism. In men, neuroticism was also related to avoidance-oriented coping. This needs to be investigated further in the future.

The significant positive relationship between men who are high on gender role conflict and task coping, and the absence of any relationship between men who are high on gender role conflict and emotional coping supports Eisler's (1995) view that male gender role socialisation restricts traditional men's coping repertoires, and consequently, supports the view of O'Neil (1981a, 1981b, 1982) that emotional expressiveness and the avoidance of emotions is positioned as a must in men, particularly traditional men, because it is unmanly (Blazina & Watkins, 1996; Good & Mintz, 1990; Good et al., 1995; Leafgren, 1990; O'Neil, 1981a, 1981b, 1982, 1990; O'Neil & Good, 1997; O'Neil et al., 1986; Pleck, 1981 & 1995; Real 1997; Sharpe & Heppner, 1991). Thus consistent with various previous research studies, the men in the present study seem to have chosen coping strategies less emotional, ruminative or "feminine", as described by many researchers (e.g. Boyd-Wilson et al., 2000; Chino & Funabiki, 1984; Compas et al., 1993; Funabiki et al., 1980; Kleinke, Staneski & Mason, 1982; Nolen-Hoeksema, 1987, 1990 & 1991; Pearlin & Schooler, 1978).

The unexpected result was the negative but significant relation between GRC and avoidance coping. Most research done on masculinity and coping has found that the self-preoccupation characteristic of depressives, in general, increases the likelihood of avoidance coping strategies (Endler & Parker, 1990b), more so in males than females (Billings & Moose, 1981 & 1984; Endler & Parker, 1990b; Felsten, 1998; Pearlin &

Schooler, 1978). The explanation is that most of those studies, with few exceptions (Llewellyn-Smith, 1999), examine the relationships between masculinity, coping and depression, or compare the results of males and females in relation to coping and depression. Only Llewellyn-Smith (1999) and Bergen (1996) investigated the association between gender or gender role conflict and coping predispositions in cases of depression. This could be theoretically limiting particularly when the possible impact of the various potential causes is taken into consideration. However, the current results indicate that gender role conflict and coping are certainly worthy of further research.

The last stage of the mediation model investigated the relation between the therapies and coping. The results revealed that task coping was the dominant predictor of choosing all three preferred therapies (biomedical, psychoanalytic and behavioural), while avoidance coping was found to predict a preference for psychoanalytic therapies. The dominance of task coping in predicting the various therapies, in particular the counselling therapies more than the biomedical therapies, is significant and encouraging, though it was not expected. Task oriented coping is known to aim towards change or to regulate the source of stress and to be related to positive results, such as lowered depression, in comparison to avoidance and emotion-focused coping (Aldwin & Revenson, 1987; Billings & Moos, 1981; 1984; Bowman & Stern, 1995; Endler et al., 1994; Endler & Parker, 1990a; 1990b; 1994; Folkman & Lazarus, 1985; Jung, 1993; Ptacek et al., 1992; Sigmon et al., 1995; Vollrath et al., 1994; Zeidner, 1994). The choice of any of the counselling therapies, considered to be a constructive means to deal with depression, definitely reflects the effect of a constructive coping strategy such as task coping or problem-focused coping (Endler & Parker, 1990b).

CONCLUSION

In summary, the results of the present study indicated that exposure to therapy using counselling videos changed the therapeutic preferences for men in general, and for men reporting high or low gender role conflict. After exposure to therapy all of the men rated psychoanalytic and biomedical therapies higher than before. And the exposure using counselling videos changed the preferences for therapies for men reporting high and low gender role conflict. Furthermore, the interaction of high and low gender role conflict with emotion-focused and thought-focused therapy affected the participants' subsequent preferences for therapies. Men reporting high gender role conflict who were exposed to either an emotion-focused or a thought-focused counselling video preferred biomedical therapies more than men reporting low gender role conflict who are exposed to the same conditions. However, men high on gender role conflict exposed to a thought-focused counselling video preferred behavioural and psychoanalytic therapies significantly more than men reporting low gender role conflict who were exposed to an emotion-focused or a thought-focused counselling video.

Coping was found to mediate the relations between gender role conflict and therapy preferences, and consistent with Lazarus and Folkman (1984), coping was an important predictor of adjustment. Though adjustment was not directly measured in the current study, the importance of coping as a predictor of adjustment could be inferred from the results which revealed that task coping, which was considered a useful and sensible coping strategy, was significantly related to the three practical and convenient therapies, biomedical, behavioural and psychoanalytical, while emotional coping that relied on feelings more than on practicality was not related to any of the therapies.

CHAPTER 4

TRADITIONAL MEN'S PERSPECTIVE ON THERAPY AND ON ISSUES INHERENT IN LIVING WITH DEPRESSION.

The present chapter presents the third stage of the current research, which uses in-depth interviews plus interpretive phenomenological analysis to investigate the experience of depression in previously depressed traditional men, the barriers to seeking help, and their views on how to make psychological services more appealing. This qualitative study was conducted in an attempt to gain a detailed description of depression and its related dimensions including therapy and coping from the point of view of traditional men and to assist in meeting the needs of men, in particular depressed men.

As argued earlier in Chapter One (pp.46) the study is undertaken in response to the recognised need for complex methodologies (Davidson-Katz, 1991), and for qualitative research that could be useful for discovering additional dimensions or new perspectives in relation to gender role conflict (Heppner, 1995). As was indicated in the literature review, with the notable exception of Terrence Real (1997), the issue of depression and therapy preferences in depth and qualitatively from the point of view of men, has been mostly ignored and there has been no qualitative component to empirical research studies on gender role conflict.

METHOD

Participants

The participants were eight men from the sample that took part in the first and second stage of the current research and who indicated willingness to take part in in-depth

interviews. The criteria for selection were: scoring high on the gender role conflict scale, having had previous experience with depression, and having not sought help. The selection was based on findings of previous research that have often indicated that adherence to the traditional male role is linked to poorer psychological health (Cournoyer & Mahalik, 1995; Davis, 1988; Good & Mintz, 1990; Sharpe & Heppner, 1991), and at the same time, have indicated that traditional men are less willing than non traditional men and women to seek out and accept psychological treatment (Berger et al., 2005; Blazina & Marks, 2001; Chamarow, 1978; Cheatham, Shelton, & Ray, 1987; Good et al., 1995; Haffner, 1983; Marks, 2001; Rice, 1978; Sher, 1979; Wisch, Mahalik, Hayes, & Nutt, 1995).

A sample size of eight was deemed appropriate, as a qualitative research of this nature requires in depth analysis of interviews and the analysis technique used -Interpretative Phenomenologist Analysis (see analysis section), is deemed best with small samples: one case study or at most 10 participants (Smith, 1995). Furthermore, according to many qualitative researchers, a few interviews, such as ten or less, can provide information as valid as several hundred responses to a structured opinion poll (Potter & Weatherell, 1987).

The Participants Pen Portraits

The pen-portraits of the respondents are constructed from the data provided from each interview, to help explain and contextualise some of the issues emerging from the discussions. The eight participants are all single young adult Australian men from eight different cultural or ethnic backgrounds: Chinese, English, Indian, Irish, Korean, Lebanese, Polish and Vietnamese. The pen portraits of the participants, whose names have been changed to assure their anonymity and confidentiality, are as follows:

Albert is a 19-year-old single Chinese-Australian university student. He is living with his parents: father, mother and two younger siblings, a boy and a girl, both of them are still in school. He complained of going through periods where he feels depressed and stressed out since childhood years, but he does not know why and he does not want to seek help.

Bill is a 21-year-old single Korean-Australian university student. He is living with his parents: father, mother and one younger brother still in school. He described his family as very supportive. He reported going through periods where he feels sad and depressed without an obvious reason. Bill is very conservative and prefers to keep his problems to himself because he thinks that the best person to consult is the person who has the problem.

Carl is a 28-year-old single Vietnamese-Australian worker. He started a university degree in architecture and then dropped out because he needed to support his family. He works as a work scheduler in a telecommunication company. Carl is the youngest of two sisters and two brothers. He lives at his own place with his father, mother, a single sister who works as a bar tender, a married brother who works as a mechanic and his brother's wife and their son. His other brother and sister are married and live in their own homes. He described his family as very supportive. He reported that the first time he came into depression was at age of fourteen, after his mother had a stroke and she was taken to hospital. This period prevented him from focusing on his studies and he relied on his older brother and sister for advice, for guidance and for strength. He has never considered seeking help for his depression though he complained of still going through periods of depression every now and then.

Daniel is 23-year-old Lebanese-Australian. He is a third year computer science student, and is living with his parents and two brothers. He describes his relationship with his family as ordinary, but he finds it hard to talk to them or share some of his concerns with them due to cultural reasons. He reported going through periods of depression more than once, but he never sought help for his depression. Furthermore, Daniel advised that depression might be hereditary in his family because one of his brothers was diagnosed with depression and is seeking help.

Edward is a 26-year-old Indian-Australian. He stopped his studies at school at year ten. He works as a work scheduler in a telecommunication company. He is living in Sydney on his own, away from his family in Adelaide. Edward has one brother and two sisters all of them are married and live in Adelaide. Edward reported that the first time he came into depression was at age 23, after he broke-up with his girlfriend. This period prevented him from sleep, prevented him focusing on his work and disturbed his eating and sleeping habits. Edward advised that he moved from Adelaide to Sydney to distance himself from what was reminding him of his girlfriend and consequently to alleviate depression, but his depression did not leave him and got worse because of loneliness, homesickness as well as the feelings of anxiety about the fate of his old parents. He has considered returning back and/or seeking help but he never has.

Fredric is a 23-year-old Polish-Australian. He is doing a university degree in philosophy. He is the only child of two working parents. He loves his parents, but he does not feel they have a close relation. At the same time he suggested that his family is the cause of most of his depression because they do not believe in him and they just want him to finish school and lead an ordinary life. Fredric started experiencing depression at the age of 18, after he felt that he failed to achieve his supreme goal to be a professional basketball

player. He explained that when his dream stopped, he felt that he lost his identity, he felt sad and helpless. To alleviate his sadness he started slipping into smoking, drinking and drugs, but that led him to fail his last year at school and to feel more depressed. Fredric decided to follow his parent's advice and to continue his studies and have a life similar to theirs. Fredric is still depressed and he believes that source of his depression is that he has not made the right decision to the question of whether he should be himself or he should "bastardise" him-self and be something that pleases his parents.

George is a 22-year-old. He defines himself as an Irish-Catholic Australian. He is a second year graphic design student, and full time temporary employee at a telecommunication company. He lives in shared accommodation with one of his friends. George's parents separated when he was 13 years old. His father is 58 years old; he works in the field of construction and he lives with his new wife and her two young daughters from a previous marriage. George's mother is 55 years old; she works as a receptionist in one of Sydney's hospitals, and she lives with two of her daughters. George has three sisters and one brother and he is the fourth in order. His older sister, a 32-year-old, is married and lives with her husband in Sydney. His brother, a 28-year-old, is single and works in the field of construction in Ireland. His second sister, a 25-year-old, is single, she works as a fashion designer and lives with her mother. His youngest sister, is 18 years old, still in school and lives with her mother. George describes his relationship with his family as unstable. George has a girlfriend; she is a 20-year-old East-European university student, she is doing a business degree in one of Sydney's universities. According to George they are passionate about each other, but their relationship is "volatile". George complained of going through periods where he feels depressed, though not every time with the same severity. These periods prevent him from studying or sleeping properly, he

eats more than usual and continuously feels sad and angry. He advised that his first episode of depression was at age of thirteen after his parents separated, and he had to move and live with his father away from his mother and sisters. His second episode was at age of 17 when his step mother and father decided that he should move out and find his own place. His last and most severe episode of depression was a couple of months before the present interview, after his girlfriend went back to her country to spend summertime with her family, and he found himself lonely without friends, without money and without work. George never sought help for his depression.

Harry is a 26-year-old English-Australian. He has a high school diploma, and works as an administrative employee in a telecommunication company. He lives in his own house with his girlfriend, whom he is planning to marry. His father is 59 and works in a bank; his mother is 54 and is a homemaker. He has two sisters, a 28-year-old sister who is married, and a 22-year-old sister who is working in banking. He described his relationship with his family as ordinary. His first experience with depression was at age of 21, when he broke up with his first girlfriend. During this period, which lasted for six months, he was continuously feeling sad, worried, upset, tired, angry and irritated; he had stomach pain, he could not eat or sleep, and he was always crying whenever he was on his own. He did not want to seek help or talk about it, all he needed was company. He still feels depressed every now and then, but it is nothing in comparison to his first experience.

Instruments

The main instrument in this third stage was semi-structured interviews that varied in duration from 1 to 2 hours depending on the interviewee level of comfort and willingness to talk and respond to the questions. The ordering of questions was less important than

establishing rapport with the respondent, and the interviewer was free to search interesting areas that arose and to follow the respondents' interests or concerns (Smith, 1995). All the interviews were audio taped and transcribed verbatim. The interview schedule was guided by the following questions (The questions were extracted from a pilot study led by the researcher with two depressed people- a male who scored high on the gender role conflict scale and a female (low on the gender role conflict scale).

The Guiding Questions of the Interview

- 1-I would like to know how you have managed to get through the depression experience. What are the things you did during your experience of depression that you find helpful and you recommend for people suffering from depression?
- 2-Who were your greatest supporters through these times?
- 3-What's your advice for people dealing with depressed people?
- 4- What are the reasons that did/would have prohibited you from referring yourself to a psychologist/psychiatrist?
- 5- What is the major reason that would have made you seek help?
- 6-What kind of therapy would you have wanted to seek but did not seek? And why have you chosen that therapy in particular? Why did you not seek it?
- 7-What elements of counselling for depression need to be changed to make it more appealing? (Emotion /thoughts)
- 8-Can you describe how that would influence your attitude toward therapy?
- 9- What do you know now that you wish you'd known or been told concerning depression? And concerning therapy?
- 10-If you were to have a depression state now, what things might you do differently?

Procedure

Men who accepted to take part in the interview study were contacted to determine a date and time that suited them. At the interview session, the participants were informed as to the nature of the research being conducted prior to their consent to participate in the study. They were informed that their participation was voluntary and that they may withdraw from the study at any time without explanation.

After they had stated that they were satisfied and understood the nature of their participation, each participant was given information and consent-forms. Furthermore, they were reminded that the information they were providing was for research purposes only. As well they were asked permission for audio-taping. After that, the interview meeting proceeded.

The duration of the interview/s was one to two hours and that was relative to two conditions:

1. Covering all the issues on the agenda.
2. Participants' convenience.

At the end of the interview participants were offered AU\$50 as a "per diem", to cover expenses.

Analytic Strategy

Interpretive Phenomenological Analysis (IPA) guided the process of interview analysis, using the procedures outlined by Smith et al. (1995 & 1999). The aim was to create a comprehensive account of themes which have significance within the original texts. Therefore, connections were made from the dialogue, rather than from a preexisting theoretical position. NVivo 2 software (QSR Int, 1999-2002) was employed in coding the interviews after they were transcribed.

Following IPA techniques, transcripts were analysed individually in sequence, by coding, categorizing, (contrasting, aggregating, and ordering of classification schemes) and concept-formation-development, leaving IPA as the identification of emergent themes and then major themes. The themes were then grouped into related groups or clusters. Master lists of themes were then collected for each interview, which led to the development of a table of themes for each individual. The interviewees' tables of themes were compared and collected together as sub-themes within higher order categories, entitled super-ordinate themes. Through the various stages of the analysis, the transcripts were continuously re-assessed and re-examined to ensure that themes and sub-themes were related to each other, with certain themes being dropped and others expanded. All themes were represented by extracts from the transcribed interviews. The themes were not only chosen for their frequency, but as well for various other reasons, such as the value of particular passages which highlighted the themes, and how the theme helped explain other aspects of the interviewee's story (Smith et al., 1999, p. 226).

Interpretative Phenomenological Analysis (e.g., Smith 1996, 1999; Smith et al., 1997) was used as a means of analysis in this study because it concurs with the aim of the present study to explore in depth a participant's view, perception or account of the topic under investigation as well to examine the association of verbal report, behaviour and cognition, without discounting potentially key themes, which arise due to their frequency within the text. In the present study, IPA allowed the interviewer to examine how, when men experiencing gender role conflict talk about their experience of depression and therapy, their talk (verbal report) reflects their actions (behavioural) and thinking (cognition) about manhood, and how it affects their experience (behaviourally and cognitively) of depression and therapy.

Interpretative Phenomenological Analysis (IPA) is eclectic, it has a belief in, and concern with, the chain of connection between verbal report, cognition (as in social cognition), and behaviour, using qualitative examination of the text outcome (as in discourse analysis). IPA emphasises subjective perception and the importance of individual interpretation respectively. IPA states, “Access is both dependent on, and complicated by, the researcher’s own conceptions which are required in order to make sense of that other personal world through a process of interpretative activity” (Smith, 1996, p. 264).

IPA is considered very useful and is widely used in the field of health psychology. Recent investigations have focused on chronic pain and chronic illness (Osborn, 2002; Reynolds, 2002); reproductive health (Chadwick & Liao, 2002; Todorova, 2002); dermatological health (Collins & Nicholson, 2003); psychological distress including self-harm and attempted suicide (Alexander, 2002; Crocker, 2002). IPA has also been employed to study people with psychosis, with a focus on delusions (Rhodes & Jakes, 2000), recovery (Thornhill & Clare, 2002), treatment strategies for hallucinations (Coupland, 2002; Newton, 2002), and stigma in schizophrenia (Knight et al., 2003). These studies have provided insight into the experience of psychosis, informed clinical intervention (Newton, 2002), and highlight the potential of IPA in exploring life experiences and social exclusion.

RESULTS AND DISCUSSION

Five super-ordinate themes, which were primarily phenomenological in composition were drawn from the analysis, (I) Causes of Depression, (II) Coping with Depression, (III) Seeking Professional Help, (IV) Barriers to Help Seeking, and (V) What Depressed Men Need to Open Up. The five super-ordinate themes are all related to the current research aim which is to gain a detailed description of depression and its related dimensions including therapy and coping from the point of view of traditional men and to assist in meeting the needs of men, in particular depressed men. Endorsement of all super-ordinate themes was demonstrated within each participant text. The implications of the results of the third study are presented with the implications of the previous two studies in the conclusion chapter; this to secure the harmony of the implications and interpretations as well as to prevent repetition.

I. Causes of Depression

This section of the chapter outlines the psychological and social factors or stressors that the men who scored high on the gender role conflict scale, the traditional men, proposed as explanation for what caused, or predisposed them to, depression. The super-ordinate theme of Causes of Depression emerged from the participants accounts of their experience with depression

A. Psycho-social Stressors

1. Anxiety

In accordance with previous studies (e.g. Davis & Walsh, 1988) that found that anxiety was positively related to gender role conflict, the traditional men in the present study

stated that they were always anxious. They said that “Worrying” about anything was one of the reasons for their depression.

Harry

But before am worry heaps, about things. So I don't know if you wanna call it depression or worry but I worry about every little thing ... You heard me, like I said before I worry about things. If I didn't worry, and new things will carry on and things will still be good as ever or better. You know? (Section 2, Paragraph30 and 150)

Similar results for men and women in general have been found in other studies (e.g., Barbee, 1998). Worrying, anxiety and depression frequently coexist, so much so that patients, females and males, with both depression and anxiety are the rule rather than the exception (Barbee, 1998). There are no definite answers as to the question of why anxiety and depression are interrelated, but researchers have reported that long term consequences of anxiety and depression are evident at the same anatomical site, the hippocampus (McEwen, 1998; Sheline, 1996). Studies of the hippocampus revealed it to be smaller in patients with post traumatic stress disorder (McEwen, 1998) and in patients with recurrent depression (Sheline, 1996).

2. Social Loss

According to the American Psychiatric Association (1998), social loss during adult life (such as loss of a spouse) is a major psychological cause of depression. However, there is a significant interaction between emotional reliance and social loss regarding its effects on depression severity. The stronger the emotional reliance, attachment or love of someone, the stronger the social loss is felt when this someone is detached from the life of the relying person and the more severe is depression (Overholser, 1990). As was mentioned in the literature review, men who are separated or divorced are most likely to kill themselves, probably because depression is more common and more severe in this

group (Nolen-Hoeksema & Larson, 1999). A prospective study by Davis, Nolen-Hoeksema, and Larson (1998) did find that making sense of a loss 6 months after it had happened predicted less distress at that time, as did finding benefit from the loss.

In accordance with the above studies, some of the participants in the present study gave accounts of depression in relation to different social losses, for example when somebody had gone away from their lives, or a friend left to live abroad. But the most severe form of social loss was positioned as the loss of their relationships with their most significant loved ones, such as their girl friend or a parent who became seriously ill. In many cases, the experience of depression was positioned as so extreme that “it torn [me] apart in every field.” A number of participants said that it took them more than six months to recover from their depression.

Edward

I’m depressed because somebody’s gone away, or because a friend is going overseas... You know that I had an incident before (broken with girl friend), and I was seriously very depressed when I came from Adelaide to Sydney... what I realised em, the problem I came through before, in my relationship, it torn me apart, in every field: my heart, my thoughts, my feelings, my emotions, took food away from mouth; I wasn’t able to eat, never felt thirsty, always had problems on my mind, always really depressed. And it went on for something like 13-14 months. You know how underweight I was when I was running around in Ashfield (previous work location) you know those things (Section 2, Paragraph 16- 21 and Section 13, Paragraph 139)

Davis, Nolen-Hoeksema, and Larson (1998) found that what facilitated a shorter recovery time was losing hope that the social loss was going to be reversed, as well as rationalising their loss six months after it had happened. The following extracts from two interviewees, Carl and Harry, illustrate this:

Carl

Well the first time I've come into depression and it's probably the major time, when my mother went into hospital. You know that she had the stroke and she was taken to the hospital. At the time I was young, I was about, probably about fourteen, fifteen. I got quite depressed over that, and that made me unable to concentrate on work, on sorry on studying or what I have then... And it took a bit of time to get back from it and getting my head back into studies and to homework and you know to get through it and concentrate. It took a bit of time but you just have to try and to live as normal as possible and yeah face, face the facts, it's happened, look forward. And I was quite depressed over that time, and it affected me with my studies and with me going out as well. Socially I didn't want to do anything, I didn't really want to go out, and I locked myself up for a period of time then. But yeah, finally I got over that (Section2 paragraph 4-5)

Harry

The main way I have ever dealt with...Would be the break up with my first girlfriend. And took about say...probably six months of just thinking straight like what I can do everything in the book how I can get her back and stuff like that, which was fine but once I started to wear off and I knew that there's no chance to getting her back... (Section 2, Paragraph 4)

Thus, like many others, the traditional men in the current study gave accounts of getting depressed because of social loss, and the stronger their emotional reliance or attachment, the more they perceive their social loss as bitter, which can lead to a harder and longer experience of depression.

3. Unemployment

Leaving work, for any reason, is a common and stressful problem. Studies show that up to 1 in 7 men who become unemployed will develop a depressive illness in the next 6 months (Royal College of Psychiatrists, 1998). This is much more than would be expected in females or employed men. In fact, after divorce (a form of social loss), unemployment is the most likely thing to push a man into a serious depression (Caplan et al., 1989; Royal College of Psychiatrists, 1998; Vinokur et al., 1991). Many studies have reported that work is a preventive measure against depression (Caplan et al., 1989; Morin & Chalfoun, 2003; Vinokur, et al., 1991). This isn't surprising, as work is often one of

the main things that gives a man his sense of worth and self-esteem (Francis-Cheung & Grey, 2002; Royal College of Psychiatrists, 1998). Of course, if a man gets depressed, he may well find it harder to get another job, which may make his depression worse (Caplan et al., 1989; Royal College of Psychiatrists, 1998). One of the participants in this study experienced stress of unemployment and he reported it was a strong factor in making him feel depressed.

George

(Deep sigh) I do get sometimes depressed, ahhhhhhhhhh, (silence for 12 seconds), (sighing). I guess, ahhhh, the last time I felt depressed... It was after the uni break and I wasn't caring to study at first this year. And.... I wasn't working at the time. And was also living at my friends' house with (stop the sentence). I was generally at home by myself most of the time, which was (silence for 6 seconds). I don't know (silence for 8). No it went pretty bad sad because also because of financial difficulties I were having at the time. I had no money. And that caused a bit of depression. (Section 1, Paragraph 5).

4. Financial Hardship

Another factor that is related to unemployment and is known for its effect as a stressor in depression is financial hardship. Having problems meeting basic needs on a daily basis can be extremely stressful and may be particularly problematic for people's psychological well-being. For example, stress resulting from problems meeting basic needs (e. g. food, clothing, and transportation) has been found to be a stronger predictor of depressive mood than income level (Ennis et al., 2000; Miranda & Green, 1999). It may be that low levels of household income result in problems meeting basic needs, which more directly puts people at risk of depression.

In the present study some of the participants revealed that they did get depressed when they were having financial difficulties. Extracts from two interviewees illustrate this:

Edward

Depression is derived from what happens, what consequences were faced whether you had emotional loss, you had a financial loss, you have this, you have that....Finance has played a big part of the stress in my life, you know? And often that I've come about it, money is a big factor... (Section 12, Paragraph 129 & Section 5, Paragraph 83)

George

No it went pretty bad because... also because of financial difficulties I were [sic] having at the time. I had no money. And that caused a bit of depression (Section 1, Paragraph 5).

For the interviewees, money was positioned as a cause in their depression, not because they are “money crazy” or they think money can bring happiness, but simply because they could not sustain themselves.

Edward

Finance has played a big part of the stress in my life, you know? And often that I've come about it, money is a big factor. Not really a big factor in happiness, but it plays a major part. Because you are able to afford things that you want and to keep yourself going and avoid the thought of not being able to afford things (Section 5, Paragraph 83)

Edward

Money wise, money is.... money is a... Em, money plays a good part in everybody life, you know what I mean?
Not saying that I'm money crazy, because I'm not. You know and I know that money is not everything. It gets you a lot of things, but it can't get you happiness. And unfortunately, money can't get you the happiness to overcome depression (Section 2, Paragraphs 29-30).

So, financial problems or financial hardship can be very stressful and may put traditional men, as is the case with anybody else, at risk of depression.

5. Failure

Frost, Heimberg, Holt, Mattia, and Neubauer (1993) found that concern over mistakes and failure reflected a maladaptive evaluative concern about perfectionism. Also, it was found that among all the perfectionism related sub-scales, failure is the one most strongly

related to depression (Frost et al., 1993). Furthermore, failure was found to be related to adjustment such as compulsiveness, self-esteem, procrastination (Frost et al., 1993, 1990). Those who have a tendency to interpret mistakes as failures, tend to believe that one will lose the respect of others when one fails (Dunkley et al., 2000 & 2003).

In accordance with previous studies about failure and depression, the present study found that traditional man gave accounts of suffering from depression after a failure to achieve certain goals e.g. “failure at school.” And the depression was positioned as strongest in cases where the man failed after he had previously been totally successful and happy. The extract from Fredric illustrates this:

Fredric

I guess the worst time, I was high, I was absolutely like megalomania: [I] ran from school, do whatever and all the countless number of friends, I didn't have to try, I didn't have to put any effort in anything. And then when that was gone, I failed at school, that's when the unhappiness came because I was so high and then that stopped (Section 6, Paragraph 34)

If we consider that, culturally, men are socialised to adhere to the traditional norms of masculinity and to fear being unsuccessful, or vulnerable, because a male's success is the glory of the family (O'Neil, 1990, &1995; Shepard, 2002), then it should be expected that traditional men will get depressed when they perceive themselves as failures (Beck et al., 1979).

6. Lack of Social Support

The relationship between social support and health has received a great deal of research attention in health psychology and behavioural medicine (Martin et al., 1994; Stone et al., 1999). Social support is an important factor in immune, endocrine, and cardiovascular functioning; recovery from illness and injury; and health maintenance (Helgeson & Cohen, 1996; Uchino et al., 1996). The precise means by which social support contributes

to health and the factors that moderate and mediate this relationship are not yet completely understood (Stone et al., 1999; Vitaliano et al., 2001). Social support may benefit health by buffering stress, influencing affective states, and/or changing behaviours (Cohen, 1988); direct effects may occur with hormonal and neuro-endocrine influences on the immune system, and indirect effects may occur through lifestyle and health behaviours (Connell et al., 1994), or other aspects of social and psychological functioning (e. g., depression; DiMatteo et al., 2000; Goodenow et al., 1990). Social support also influences the ability to adjust to and live with illness (Helgeson & Cohen, 1996). Assistance and support from friends and family have been found to be effective in both physical and mental health by encouraging optimism and self-esteem, buffering the stresses of being ill, reducing patient depression, improving sick-role behaviour, and giving practical assistance (Connell et al. , 1994; Shumaker & Hill, 1991; Wallston et al., 1983). Conversely, deficits in social support increase the risk for many illnesses and disorders, including depression (Monroe, 1983; Windle, 1992). This study indicates that deficiency in social support leads to depression in traditional men. The deficiency is on two levels, family cohesion and living arrangements.

a. Family Cohesion

Family cohesiveness (including warmth, acceptance, family emotional health, and closeness) (Uchino et al., 1996) has a positive relation with avoidance of stressors, depression and health in general (DiMatteo, 2004; Goodenow et al., 1990; Shumaker & Hill, 1991). The mere presence of the family or other people does not matter as much as the quality of relationships with them (DiMatteo, 2004). Patients with depression are found more in families with higher conflict, and depression is lower if there is no conflict (Lewinsohn et al., 1994; Windle, 1992).

The findings of this research provide support for the assertion that deficits in social support increase the risk of depression (Monroe, 1983; Windle, 1992), and suggest that deficits in parental support may be more damaging than deficits in any other forms of social support (e.g. Stice et al., 2004). According to some of the interviewees the family or problems with the family, was the major cause of their depression. One of the interviewees described the issue as follows:

Researcher

Who were your greatest supporters through these times?

Fredric

Good friends, I guess (slowly and cutting: as if reluctant) family in away. Probably family, probably, is the most common cause of depression...
(Section 4, Paragraph 16)

The interpretation of the traditional men's answers regarding deficit in parental support and the increasing risk of depression was positioned as three different sorts of problems, namely: family indifference, family rejection and family pressures.

Family indifference. According to Enns, Cox, and Clara (2002) any form of harsh parenting (e. g., critical parenting, parental over-protection, and parental lack of care) leads to depression.

In the present study the traditional men reported that they felt they were not close enough to their families. Supporting previous research findings (Uchino et al., 1996) they reported wanting to be close to their parents, but the parents were blocking the closeness or cohesiveness of the family through being unsupportive and indifferent since they were young. This indifference or lack of care and non-encouragement was reported to have led to depression in the traditional men, supporting previous research findings (Enns et al., 2002). The following extract from Fredric illustrates it:

Fredric

One of my problems is that I didn't feel like I was close to my family because they just did what they did and I was out here, I want to be great. All these people believed in me and my parents were just like that "nothing, no, no, finish school" heh, "you are gonna go to a job" eh (Section 14, Paragraph 136).

This sort of indifference was reported to continue even when the men were depressed and needed support. According to some respondents their parents did not notice that they were depressed. However the respondents expressed doubts that this was the case. They said that their parents were acting as if blind to their depression because they were always indifferent:

George

They wouldn't have known any difference any way. They wouldn't have known anything different in me. Even if they'd known they might still act the same. No matter, feeling one way or another. My dad I don't see him that often. But even my mum she is, she is sort of blind to it anyway. So (silence for 13 sec) or she acts like towards it. (Section 1, Paragraphs 138-139).

Though this sort of parenting is harsh (Enns et al., 2002), it could be related to the cultural expectations of masculinity (Good et al., 1990, O'Neil, 1990; Real, 1997). Society, including the parents, keeps sending to men the message that they should as men keep struggling and should not expect help (Real, 1997). Even when the man is depressed the family of traditional men may follow the same policy, partially colluding with the social and cultural expectations of masculinity and partially protecting the male ego from shame (Real, 1997). The severity of such treatment is not necessarily the same in all families and nor does it always take such dysfunctional forms, but in general, boys and men are raised according to the standards of masculinity of their culture. In contrast, studies that have dealt with issues of social support and gender indicated that when dealing with stressful situations, females are more apt to give and receive social support than males are

(Frydenberg & Lewis, 1991). So family indifference and withheld support because of cultural expectations of masculinity could be a source in depression of men.

Family rejection. Theoretically, the perception of being accepted and valued in one's interpersonal environment promotes esteem, confidence, and efficacy, which preserves an individual from depression (Stice et al., 2004). Since this condition of acceptance was not available for some of the participants in the present study, they reported that this led them to feel odd, as not belonging to, and rejected by, the family. They said such feelings have shaken their confidence in themselves and in their parents, and led them to being an easy target for depression. As one participant put it:

George

Sometimes through like feeling ,ehhhhhhhh, in a way rejected by my parents. And feeling like the odd one out from my family, like feeling depressed from my family. And not being, some feeling not being treated the same as the rest of my brothers and sisters. Annnnd. When I stop and think about it, it gets me down. But, eh (silence for 15 seconds)... some time make feel down, seeing them, make me feel worth, because the way they act sometime now and then (Section 1, Paragraph 6 and35).

Family pressures. In many patriarchal cultures, males are socialised to be strong, assertive, and independent (Real, 1997). Though this has many advantages for those who adhere to this role, its consequences may also contain higher risk-taking components in the name of competition, success, status, or power; a lack of attention to general health such as nutrition, stress management, and exercise; as well as restrained emotional expression and social intimacy (Cournoyer & Mahalik, 1995). The pressures on men may also lead to problems with depression as they ignore other aspects of their lives (Good & Mintz, 1990). If we consider the fact that some college-aged men fear being emotionally expressive because it may be perceived as a sign of weakness or as a hindrance to achieving success and therefore be viewed as "unmasculine" (Cournoyer & Mahalik,

1995), then males are very aware of others' expectations, the responsibilities and pressures imposed upon them. Therefore, as much as the family can be a resource that provides love and warmth, it also can be a stressor that causes boys to develop dysfunctional attitudes, including the need for perfectionistic achievement and constant approval by others, and may place individuals at greater risk of depression under certain conditions (Beck et al., 1979; Barnett & Gotlib, 1988). It is believed that through their interaction with stressful life events, these dysfunctional attitudes may trigger the onset of the somatic, affective, and motivational symptoms of depression (Beck et al., 1979).

In the current study, the interpretation of the respondents' answers reveals that family pressures were positioned by the men as making them vulnerable to depression on two frontiers:

First, in accordance with various studies (e.g. Beck et al., 1979; Barnett & Gotlib, 1988), the respondents reported that they love their parents and they are doing everything to satisfy their parents and have their love, but they are not happy because they are not living the life they want, they are living the life that their parents want them to live. According to those men, in order to live the life they want, they only have one option; to cut themselves off from their parents, because their parents will not approve such a change.

Second, even if they were able to separate themselves from their parents the issue will be always on their unconscious and that will affect their lives and might lead to depression. For instance, one of the men suggested, using psychoanalytic language, that his separation from his family would lead to unresolved issues with his mother and this would hinder his relations with other women and make him unhappy. The following response is indicative of the issue of parental pressures:

Fredric

I love my parents; they have done so much for me. I love them more than I love myself, so I gave that up and I attempted to do what they wanted me to do. And that just led to a whole lot of problems because that was not me, I was doing that for them because I loved them. Now I have to make the choices do I want to basically kill myself and live a life for my parents or die just to shut myself off from my parents and live my life? And that's castrating because if I do that, then there will be always Freudian, Oedipus problems in the background, unresolved issues with your mother that will hinder my relations with other women, that's something I've noticed. You want to make them happy but it's impossible to do that if I'm not myself. So now I have to make the choice am I gonna be myself or am I gonna bastardised myself and be something that please my ignorant mother? That's the source of my depression right there and that's what I have tried everything into at this point (Section 14, Paragraph 136).

So, as much as the family can be a resource that provides love and warmth, the family can also be a source of stress and depression for men through the pressures that it can exercise.

In general, the findings on the issue of family cohesion with its ramifications and problems provide support for the assertion that deficits in social support increase the risk of depression but suggest that erosion in parental support in general, may be more damaging than deficits in any other form of social support (e.g. Stice et al., 2004). Moreover, the results suggest that parental lack of support in the form of rejection, indifference and/or pressure, which leads to depression in the case of traditional men, could be related to socialisation of males based on the cultural expectations of masculinity (Good et al., 1990, O'Neil, 1990; Real, 1997). The pressures on men may lead to depression as they ignore other aspects of their lives (Good & Mintz, 1990).

b. Living Arrangements

According to DiMatteo (2004), living arrangements, such as someone living alone or with at least one other person, have various effects on various behaviours. For adults, living with someone has more positive effects in general, when compared to living alone

(DiMatteo, 2004). The analysis of the participants' responses revealed that depression was considered to be related to their living arrangements. Depression was particularly related to living away from home, and to living alone.

Living away from home. As much as being close to one's family can be a source of trouble for some, living away from home can be a source of depression as well. The respondents reported that in addition to other reasons and stressors, living away from home and family was a cause of their depression. For example, one interviewee who through the interview reported that he had a bad relation with his family said:

George

And , and also living like from home as well , I didn't have much contact with my family... cause me to feel that way, to cause me to feel pretty depressed (Section 1, Paragraph 5)

Being away from home made men depressed for various reasons: they felt homesick and missed the family sense of happiness and love. Furthermore, living away made them contemplate, understand and appreciate everything the family had done for them and that made them feel that they were losing the quality time that they could spend with their parents who are getting old. Some men reported that they could not block such thoughts and feelings, and that was what made them get depressed. The following extracts exemplify this pattern:

Edward

The depression of missing my parents never left me. I'm getting more depressed now over the fact that I have a beautiful niece in Adelaide...

My parents, my mom, my brother, my sister, everybody is married, everybody is living happily, they've got kids around them, and this is as beautiful for me as anything. The fact that I'm not there and married and everything and living with them happily and sharing the love, this is getting into me. The fact that my mom and my dad are getting older, that's getting to me. You know? And these things are always there in me. I can't block this. I can't block it. From time to time I get waved away into things, but when I think about it I think about what they went through. I

understand now what are the things they said to me before. I understand now the things they did for me, they are doing for me: the fact that my dad got up every morning and went to work. You know what I mean? When you are a kid you don't understand these things. And this brings the encouragement into you that you have such a loving father. And the fact that you are away from him that's what depresses you. You know what I mean? And the fact that something could happen to him tomorrow, you know, and I am over here, when I could really make a difference with things if I was over there. You know what I mean? These are things I can't avoid, I can't hide from. You know? If there's anything in my life that's depressing me, this is what it is. You know what I mean? I want to be able to be with them (Section 2, Paragraph 38- 40).

According to Edward, living away from home is certainly a reason for his state of depression, but living alone was also positioned as having the same impact by many other respondents.

Living alone. The interviews revealed that many participants said that they did get depressed when they had to live by themselves and without any form of social support, neither family nor peer, which are both essential in helping to prevent depression (Barrera & Garrison-Jones, 1992; Holahan & Moos, 1987; Lictra-Kleckler & Waas, 1993). The experience was reported to be so horrific that some could not describe it or name it and kept on talking about the conditions that led to being alone. The best example is the following extract:

George

(Deep sigh) I do get sometimes depressed, ahhhhhhhhhh, (silence for 12 seconds), (sighing). I guess, ahhhh, the last time I felt depressed when Jody my emmmm [girlfriend], when I just left Uni. It was after the uni break and I wasn't caring to study at first this year... I was generally at home by myself most of the time, which was (silence for 6 seconds)... I didn't have my friends after that. Previously like, as I use to be with Jenny most of the time so my relation with my friends had come to a hold. (Silence for 9 sec). If, if you now see what I'm saying, I haven't been seeing them as much. Annd, so I was all my time with her. And so when Jenny (name of his girlfriend) she's gone I was stuck by myself. (Section 1, Paragraph 5).

Other respondents reported that when they were depressed and living alone, they felt that they were stuck by themselves without anything or anybody to encourage them, or make them feel better. The following quotation exemplifies the experience of these men:

Edward

It went on for months and months and months, especially when I was staying in Ashfield. There was nobody there...I don't want to go through that stage again where I was stuck by myself, I had nothing around me. I did not have any thing Zak, I didn't have any encouragement with me. You know? I didn't have nobody right next to me saying to me: "don't worry you'll be all right." (Section 2, Paragraph 21 and 24)

Moreover the respondents reported that the mere presence of other people in the same house did not matter as much as the quality of relationships with them, supporting previous research findings (DiMatteo, 2004; Lewis & Rook, 1999; Umberson, 1987)

Edward

And when I went home, the guys were always out, they were studying or they were with their girl friends and everything. And I had nobody to talk to. I didn't have anyone to say hallo to. The only thing I'd say hallo to was my passports. I used to sit there and think over it, over it, over it, and curse and curse and curse. You know what I mean? (Section 2, Paragraph 21)

In general, the reports from the interviews on the issue of social support suggests that in a traditional man's life, it is important to assess the type and quality of relationships in order to understand the causes of depression and to assist in relieving the depressed man of his stressor. However, whilst living alone or away from home might put the traditional man at a slightly increased risk of depression, living in a family that is in conflict may increase the risk of depression considerably, suggesting that the relationship between social support and depression is a complex one.

7. Negative Thinking

The results from the respondents in this study appeared to be consistent with the theoretical claim resulting from research on cognitive models of depression that negative thinking is not only a concomitant or symptom of depression—it is also a causal antecedent of depressive symptoms (Alloy, Abramson, & Francis, 1999; Beck, 1983; Lewinsohn, Allen, Seeley, & Gotlib 1999; Metalsky, Abramson, Seligman, Semmel, & Peterson, 1982; Nolen-Hoeksema, Girgus, & Seligman, 1992; Segal, Gemar, & Williams, 1999). The interviewees reported different causes for depression, but not all of them were significant; what appeared to matter most was the way the person perceives and interprets the events or “sees the picture”. As one of the interviewees put it:

Edward

I've realised that, em, it doesn't matter how much you get depressed, or somebody or something depresses you, you know? It doesn't matter how much something or somebody depresses you, it's just how you see the picture (Section 2, Paragraphs 21-22)

In support of the findings from previous research about gender role conflict and depression (Cournoyer & Mahalik, 1995; Good et al., 1990; O'Neil, 1981a & 1990; O'Neil et al., 1986 & 1995; Real, 1997; Shepard, 2002) the traditional men reported that the source of negative thinking and depression was socialisation. For the respondents, as O'Neil and his colleagues (Cournoyer & Mahalik, 1995; Good et al., 1990; O'Neil, 1981 & 1990; O'Neil et al., 1986 & 1995; Real, 1997; Shepard, 2002) have argued in the case of traditional men, the way that men are socialised since childhood to adhere to traditional norms, to keep doing something because they have to even if they don't believe in what they are doing, and to fear being unsuccessful, was seen to be a major factor in the negative thinking and depression. One interviewee commented that if people cannot get outside the roles they are socialised in, they may waste their lives for 40 or 50 years doing

something they don't like everyday, and which they cannot negotiate, and as a result have angry thoughts that simply keep them tense, feelings inflamed, and their mood disturbed. For one respondent, happiness and positiveness rely on realising that he can do something different from what he was taught to do, the way he honestly wants it to be done. The following extract exemplifies this:

Fredric

[I]'m just like that guy (patient on the videotape played before the session) indecisive, I've no idea. I'm here at uni but I'll be honest I'm not putting 100% focus into my studies, I'm behind, I got a lot of readings and a lot of work. I started a new job, I haven't got my head 100% in that. I go to the gym like 6 times a week and I haven't 100% focus either. I do all these things and yet I feel as if I'm doing nothing. And I think that is honestly one of the major problems why depression is so high these days because people believe they need to be doing these things; they are not actually getting out of those things. People working 9 to 5 , Monday to Friday, doing something that the human organism wasn't really intended for. So, they are wasting 38 hours a week. They go home angry, snappy, they don't know why, they watch TV for a bit , they make dinner, they wake up the next day " AH, I've got to do it again." They do it for 40- 50 years. Then negative energy when they interact with people passes across to them, it's perpetuated all over the place...If you settle for something that you know is not good enough for you, then you are unhappy. If you are thinking " Oh, I could have done so much better, could have " you are not happy, because you have never realised what you honestly believe you could have realised. That negative energy, that unhappiness, goes through the child. The child grows up believing that "[he] lives the same life that you have". Has children and perpetuated and where does it end. People only really do what they know (Section 14, Paragraph 125-127)

Summary

In general, the present research supports previous findings that life stresses can trigger bouts of depression. Although stresses have negative impact on most people it seems that certain psychosocial stressors have a stronger impact on men in general and traditional men in particular. Stressors such as unemployment, financial hardship, failure, social loss, lack of family support, are positioned as being the major factors responsible for depression in men. For traditional men the impact of those stressors is possibly stronger

because through socialisation they have developed a strong belief about the importance of work, money, success, power and family in the culturally defined standards of masculinity (Pleck, Sonenstein, & Ku, 1994). Failing to adhere to the culture standards means that they are not “man” enough and that is what may precipitate depression.

As a result, one can speculate only, but cannot definitely conclude, that the original source of most of the stressors which are associated with depression might not rest in the stressors themselves, but in the negative perception of the stressors oriented by the traditional male gender role socialisation. Thus, a major source of depression in the traditional man is male socialisation.

II. Coping with Depression

This section analyses the accounts of coping strategies for depression, and uses the model of Endler and Parker (1990) as an interpretive framework. They distinguished between three coping strategies: problem-focused coping, emotional coping and avoidance. In addition, the current findings give a detailed description of men’s accounts of coping behaviours, with respect to all three of Endler and Parker’s categories.

The use of Endler and Parker’s model as an interpretive framework in stage three is due to its relevance to examine the research aims, as well as its ability to provide harmony and continuity in presentation of the results of the current stage and those of stage two. Stage two, employed the same model, Endler and Parker’s multidimensional coping inventory (MCI).

A. Avoidance Coping

The present study revealed that depressed traditional men are more inclined to resort to distractive behaviour than any other depression-coping strategy. This result is not

surprising, since it was found that the self-preoccupation characteristic of depressives, in general, increases the likelihood of avoidance coping strategies (Endler & Parker, 1990), and more as in males than females (Billings & Moose, 1981 & 1984; Endler & Parker, 1990; Felsten, 1998; Pearlin & Schooler, 1978).

What is surprising is that traditional men are aware that they are seeking to avoid their problems and that their words even define avoidance coping. In concordance with previous research (Carver et al., 1989; Endler & Parker, 1994), the men admitted that they do not reflect on their problems or do anything to solve them; instead, they try to forget about their problems by concentrating on something else, hoping that time will take care of them. For instance, one man said:

Albert

All right I tend to concentrate on other things. I find better than concentrating on those problems, but ummmmm, usually that work for me for most of the part. (Section 2, Paragraph 4).

Edward

I leave it, and as time goes by I see it being filled up more and more and more things coming in place (Section 13, Paragraph 151).

Similarly, another interviewee, Fredric, remarked:

And it's time heals always that's the way I saw it. Didn't matter what happen I knew within a week or two, a month or two, I'll be out from it. So I've put up with it, and yeah, what do you know I was back to normal in a month. (Section 2, Paragraph 5).

Not only were the traditional men interviewed aware that they are avoiding their problems, they also reported that they felt then that problems will persist. The following quotations exemplify the attitude of these men:

Albert

Well, it's a solution. It's not really a solution, it sometimes doesn't work for you cause you have to come back to it, regardless.

So, emmmm, this is what I try to do from time to time any way, it's not as the best thing to do, it's something you have to do (Section 2, Paragraphs 29-30).

Bill

I think it's a way of avoiding the problem, and if you do that the problem it just gonna come back later. So yeah, I guess it's a way of ummmm, how do you say? Ummmm, getting calm down to think about it later. But you are just gonna come back to the problem any way (Section 2.3, Paragraph 5).

According to those men, avoidance is not positioned as the best way of dealing with depression. But it is positioned as a safe means of tension releasing and self expression so that they would be able to overcome their depressive experiences, a process illustrated in the following excerpt.

Fredric

I think depression is magnified when you don't have a release, an expression of yourself some way... So what I would do instead of doing all the negative things and getting angry (because, you know, of the way I feel) I would try to think of things to do that would counter the way I feel' (Section 13, Paragraph 121 and Section 14, Paragraph 122).

The results indicate that there are more than ten avoidance-coping techniques being employed by men in this study: playing music, writing, singing, reading, playing games, going out, work and sports, imposing a structure on the day, watching TV or video or movies, intoxication. Furthermore, these avoidance techniques can be classified as either active or passive.

1. Active Avoidance Coping

Men who are high on gender-role conflict reported that they relieved their depression by engaging in active distractive behaviours. Similar results for men in general have been found in other studies (Carver et al., 1989; Chino & Funabiki, 1984; Endler & Parker,

1994; Felsten, 1998; Funabiki et al., 1980; Kleinke, Staneski & Mason, 1982). Moreover, many studies suggest that behaviour centred in active avoidance does more to lift depressive moods than any other type of behaviour (Endler & Macrodimitris, 2001; Morrow & Nolen-Hoeksema, 1989; Nolen-Hoeksema, Morrow & Fredrickson, 1989). The interviews revealed that there are three active avoidance techniques employed by men high on the gender-role scale: (a) incorporating pleasure and fun into each day; (b) keeping active; and (c) imposing a structure on the day. Each of these techniques is discussed in turn as follows.

a. Incorporating Pleasure and Fun into Each Day

From the interviews, it would seem that the first avoidance technique consists of distracting oneself by undertaking an activity that is both enjoyable and physically taxing.

As one interviewee put it:

Carl

Just taking your mind off what's depressing you and thinking about other things that makes you happy, go and do things or just have a bit of a laugh, share a joke or two... Do things that would take your minds off what's troubling you, what's making you sad (Section 2, Paragraph 12 and Section 4, Paragraph 29).

The interpretation of the interviewees various answers incorporating pleasure and fun into each day can assume different forms, namely... playing music, writing, singing, reading, playing games and going out.

The effect of music on depression is well known throughout history. The first documented case of the influence of music on the depressed is mentioned in the Bible. The Old Testament mentions that "an evil spirit from the Lord tormented King Saul" (1st Samuel 16:14). Saul's servants noticed the change in Saul's heart, so they said to Saul "Behold! An evil spirit from God is afflicting you. Let our King Saul now command your

servants, who are before you, to seek out a man who is skilful in playing the lyre! When the evil spirit from God afflicts you, he will play the lyre, and you will be well.” (1st Samuel 16:23). So Saul said to his servants, "Provide for me a man who can play well, and bring him to me." God gave Saul a problem and sent David as the solution. Whenever the spirit from God came upon Saul, David would take his harp and play. Then relief would come to Saul; he would feel better, and the evil spirit would leave him. (1st Samuel 16:23).

Though the case of Saul’s depression and David’s music as therapy is well documented, the lack of direct evidence in most periods and contexts might have led to the suggestion that music therapy was perhaps often a nice idea rather than a nice practice (Ansdell, 2004). Music therapy, with a very few exceptions, has never been central to medical treatment; it has always been a “fringe medicine” (Ansdell, 2004; Horden, 2000).

Recent research (e.g. Pelletier, 2004; Hsu & Lai, 2004) supports the use of music as a healing art or science and provides evidence of the benefits of music. Pelletier (2004) conducted a meta-analytic review on 22 quantitative studies about the effect of music on decreasing arousal due to stress. Results found that music alone and music assisted relaxation techniques considerably reduced arousal. Hsu & Lai (2004) assessed the effectiveness of soft music on major depression in psychiatric inpatients. A pre-test-post-test with a two-group repeated measures design was used. Inpatients with major depression listened to their choice of music for 2 weeks. Depression was measured using the Zung's Depression Scale before the study and at two weekly post-tests. Using repeated measures, music resulted in significantly decreasing the levels of depression, as well as significantly better sub-scores of depression compared with the control group. Depression levels decreased weekly, indicating a cumulative dose effect. The findings

provide evidence to use soft music as an empirically based intervention for depressed inpatients.

Thus, it is no surprise to find that playing music is one of the strategies that the depressed men in the present study use to alleviate their depression. However, it does not seem that music is the most favourable strategy. That assumption is based on the fact that just one interviewee referred to playing music when he is depressed, but none of the others mentioned it.

Fredric

[W]hat I would do instead of doing all the negative things and getting angry because you know of the way I feel I would try to think of things to do that would counter the way I feel. In other words, to write something, or play some music (Section 14, Paragraph 122).

Writing is yet another distraction that traditional men in this study reported using. The history of using client writing in a therapeutic setting, mostly associated with cognitive and behavioural approaches, is long (Wright & Cheung-Chung, 2001).

In recent years writing therapy, in its own right, received considerable attention especially as applied to certain clinical problems, such as asthma (Smyth et al., 1999), depression (Lepore, 1997), and traumatic memories (Pennebaker, 1989 & 1993). A recent survey conducted by Graham et al. (2000) about people preferences for the delivery of self-help psychotherapies found that 62% of respondents prefer self-help therapy via paper-based formats, and 91% of these same respondents favour some form of computer system.

In the present study, the participants reported using writing as a self help tool. Following the participants' description, writing appears to have two different forms: direct and indirect. The direct form consists of writing explicitly about the experience of depression; it is an alternative to talking to someone about depression.

Daniel

To write, like in a diary or something, just a sort of another way to get it of my chest. If I can't sit down and talk to someone I pick a pen and write... (Section 2, Paragraph 8).

This activity is private, being intended as a secret method of 'discussing' one's depression.

Fredric

Writing in a book and no one ever sees it you are still expressing it. (Section 13, Paragraph 121).

In contrast, the indirect form consists of writing about "something" other than depression to avoid dealing with depression and to alleviate their mood.

Albert

Do free lance, volunteer work that thing. I usually do writing; I usually try to write something (Section 2, Paragraph 18).

Fredric

I feel I would try to think of things to do that would counter the way I feel. In other words, to write something... (Section 14, Paragraph 122).

Unlike direct writing, this activity is mostly public, like writing "reviews and issues" as it was positioned by one of the interviewees.

Albert

I usually do writing; I usually try to write something... I tend to write reviews, I used to any way, I used to write reviews and issue like comments about stuff. (Section 2, Paragraphs 18 and 26).

Singing was cited by some interviewee subjects as a pleasurable and funny way to deal with depression while at the same time not having to think about it. The following quotation is the best representation of this view:

Fredric

If you are singing in the shower, you are singing loudly and anyway, you are still expressing [yourself] (Section 13, Paragraph 121).

Reading is yet another distraction that men who are high on the gender-role conflict scale employ. And apparently it does not matter what material is read. As one participant, Daniel, put it:

Yeah. Emm, sit down and read sometimes... just read, distract myself. (Section 2, Paragraph 8).

Traditional men also reported using games as an enjoyable distracting technique against problems and depression. The following extract illustrates this:

Albert

Well I tend to play games from time to time... games are fun that's the thing, as in like something you can use it so that you take you off your mind off the word: 'Ohhh nothing is going right.' (Section 2, Paragraph 26).

Most of the men also reported that going out was a pleasurable active avoidance-coping technique, because they regard it as an effective strategy. Thus, one man remarked:

Albert

Sometime it does work. I mean I can't say it doesn't, emmmmm, you know as in like, you go out, ok, you know go shopping or something. Unless the fact is you were bankrupted ...all his head is stopped (Section 5, Paragraph 63).

For these men, going out is important, because when they are out they forget about their depression and everything, they "switch off" as the men reported:

Daniel

I go out a lot; I make sure that I'm out of the house, just away having fun with friends. To like switch off, so I don't have to think about it... So that is another distraction I think, yeah. Yeah, pubs, just sometimes I just go to a friend house and watch a movie, just to keep mind off it. If I'm somewhere else I sort don't think about it, I don't have to deal with it (Section 2, Paragraph 16, 20).

Carl

We go out, do things... just go and party and forget everything... being able to get out and just not think about, to take your mind off it. (Section 3, Paragraph 26 and paragraph 25 and Section 6.1, Paragraph 75).

Going out for the men makes them feel distant from their problems and their depression, thus they feel that they do not have to deal with it. Going out does not have to be big or "major", going anywhere to a "pub", a friend's house, to a movie or even going for a walk is satisfactory. What is important is to be outside one's room or house with friends or people with whom they know they can have a good time. The following excerpts illustrate this:

Carl

Get out, get some fresh air, just do something, it doesn't have to be major, just something, get out of the house basically; get out of the room... just go out, if you know people that you can have good time with go out (Section 2, Paragraph 9 and Section 4, Paragraph 29).

Daniel

I make sure that I'm out of the house, just away having fun with friends... Yeah, pubs, just sometimes I just go to a friend house and watch a movie, just to keep mind of it. If I'm somewhere else I sort don't think about it, I don't have to deal with it. (Section 2, Paragraph 16 and 20).

Edward

Go with friends, have a good time, run around (Section 2, Paragraph 15)

b. Keeping Active

Keeping active is another level of active avoidance. What differentiates it from 'building pleasure and fun' is that 'keeping active' is a bit more serious and it consumes more energy. There are two major forms of "keeping active": Work and sports.

Consistent with clinical observations (e.g., Real 1997) men in this study who are high on the gender-role conflict scale appear to be using work to avoid dealing with the sufferings of depression. As one of the interviewees represented the topic:

Edward

I want to keep myself busy because I just did not accept it any more. I just did not accept it any more (Section 2, Paragraph 39).

For some participants work helped them not to think about depression, or their past, and “what went wrong.’ Furthermore, work helps them “to stay focused” and “mentally strong”. If one job were not enough to distract them from their depression then they would “take a second job”. And if that tactic did not succeed then they would involve themselves in “new things”

Edward

That’s why I have taken my second job, you know, so I don’t have time, I don’t have time to think about my past, I don’t have time to think about what things went wrong. I just want to learn from it, and move on with it, you know? And I’ve come to realise that it’s helping me mentally very, very well, and keeping me strong and focused, you know? And looking forward into things that em it has happened, if it can be fixed of course I’ll fix it, you know? (Section 2, Paragraph 15).

Moreover, the traditional men in this study tried to rationalize the relationship between their depression and their work (or perceived their tactic of avoiding depression through intensive labour as ultimately beneficial). The following extract makes this manifest:

Edward

[What] I’m trying to do is use this depression, which I know will depress me if I’m not busy, use it to work. Use it to work, to keep myself busy and in [at] the same time benefit myself from the work. (Section 2, Paragraph 41).

Throughout history various civilizations, ancient and contemporary, have used sports or exercise as a means of preventing disease, and promoting health and well-being. There is empirical evidence that sports or exercise improves mental health and well-being, reduces depression and anxiety and enhances cognitive functioning (Callaghan, 2004; Lavalley et al., 2004; Lawlor & Hopker, 2001; Ramirez et al., 1978). Findings of research show that

exercise may have an antidepressant effect in both healthy individuals (North et al. 1990; DiLorenzo et al., 1999), and among those with profound multiple disabilities (Green & Reid 1999).

North et al. (1990) reviewed the results of narrative and meta-analytic studies investigating the effect of exercise on depression. The review suggests that sports alleviate depression by changing people's daily routine, increasing their interactions with others, helping them lose weight, participate in outdoor recreation and master difficult physical and psychological challenges. DiLorenzo et al. (1999) examined the effects of sports on self-reports of depression, anxiety and self-concept and aerobic fitness, heart rate and maximum oxygen uptake. Participants were randomly allocated to either a 12-week programme of bicycle ergometry or a control condition. At the end of the programme participants allocated to the exercise programme had more positive changes in all outcomes than the control group.

In the present study the participants reported employing sports or exercise as another "keeping active" tactic to ease and release their depression.

Edward

I've got a punching bag now so I can punch that. Emm, you need releases. I think depression is magnified when you don't have a release... [So] play some sport (Interview number 6, Section 13, Paragraph 121 and Section 14, Paragraph 122)

Bill

I guess it's a way of ummmm, how do you say? Ummmm, calm down to think about it later. But you are just gonna come back to the problem any way. So, yeah. Although they help to make me feel better, going to movies or playing sports, help (Section 2.3, Paragraph 5).

Though the sports being played by traditional men in this study seem to include a wide range of sports, from tranquil sports such as “fishing” and “diving” as positioned by Carl (Section 3, Paragraph 26.) to more active sports such as “body building” and “gym exercises” as reported by George (Section 1, Paragraph 26, and Paragraph 34), or even aggressive sports like “bag punching” as Edward stated (Section 13, Paragraph 121), the element of competitiveness that usually characterizes the “masculine identity” (Real, 1997) seems to be absent from most of the mentioned sports. Men are known to engage in a wide variety of sports such as soccer, basketball, rugby and so on, but none of the subjects mentioned any competitive sports like these. Since depressives tend to be self preoccupied (Endler & Macrodimitris, 2001; Endler & Parker, 1990) it is possible that they would be reluctant to participate in sports that require more psychological stressors (fear and stress from competition) or carry the risk (via failure) of other forms of stress like shame, low self-esteem and emotional emptiness (Real, 1997).

c. Imposing a Structure on the Day

This strategy is simply to set daily goals and stick to them. It is the creation and maintenance of routine and ritual. The strategy of structuring the day is best illustrated by the following quotation:

George

Gaining someone on a routine and (silence for 14 sec) tap their focus in a life, like a ritualisation where they can look forward to’ (Section 1, Paragraph 30).

Although this strategy is presented in this study as a self-contained one, it actually needs to be part of other strategies in order to operate. For example, resorting to work or sport, as a means of avoiding depression needs to be done on a daily basis or according to a definite, repetitive schedule. The following quotations are most instructive:

George

Going to the gym in the afternoon, some activity, that keeps me active rather sitting there by my own... I go to the gym, nearly I use to go Monday to Friday to the gym. And that's one of the main things that...the only stable thing that was in my life at that time, that was the same (Section 1, Paragraph 26 and 34).

In general, building structure or routine into the day needs the other active avoidance techniques of “incorporating fun and pleasure” and “keeping active” as much as they need it.

2. Passive Avoidance Coping

As much as men who are high on gender role conflict appear to be dampening their depression through engaging in physical activity or active avoidance, they are nonetheless also reported engaging in passive forms of avoidance coping.

According to many studies (Endler & Macrodimitris, 2001; Morrow & Nolen-Hoeksema, 1989; and Nolen-Hoeksema, Morrow & Fredrickson, 1989), passive avoidance or distraction is effective in decreasing depression but active avoidance aids in distraction more than passive avoidance.

There appear to be two forms of passive avoidance employed by men who are high on the gender role conflict scale a) watching TV, movies and videos and b) intoxication.

a. Watching TV or Video or Movies

The findings reveal that the majority of men who are high on the gender role-conflict scale use audio-visual media as a means of distraction from depression. In accordance with various researches (Carver, Scheier & Weintraub, 1989; Rosario et al., 1988; Felsten, 1998) the interviewees in the present study reported that watching TV or a movie helps them to forget their depression or their particular problems. As one man put it:

Carl

Watching TV, kind of concentrate on what's on television and takes your mind off reality sort of speak, takes your mind off that, em it makes you feel better but it's kind of like avoiding reality in a way. But it does help to take your mind off it at times.... Watching TV yeah (Section 2, Paragraph 9).

Furthermore, it seems that by watching TV or a video in the comfort of their own home, these men are able to ease two particular symptoms of depression: sleeplessness and anxiety. Thus, one man said:

George

Watch TV or put a movie on and then slowly, slowly I fall asleep after that. Like cause it takes my mind off, and that is on my mind are things causing stress. Rather than sleeping there, and my mind still going thinking of all those problems, sit there and watch a movie and . . . (Section 1, Paragraphs 24-25).

b. Intoxication

The analysis of men's responses in this study revealed that without exception traditional men attempt to distract themselves from negative moods by resorting to sedative substances such as alcohol and drugs. For example, one participant remarked the following:

Fredric

You always try to run away and try to escape reality: watch TV, go to movies, very attractive as well smoking, drinking and that kind of stuff. (Section 2, Paragraph 9).

Similarly, George reported that he was 'Taking pills' (Section 1, Paragraph 24), while Carl stated that when he is depressed, he used to "go night clubbing, go drinking or what have you" (Section 3, Paragraph 25).

This result is not surprising; for in many questionnaire studies, men tend more than women to say that they respond to depressed moods by intoxication (Brennan & Moos,

1996; Brennan, Moos, & Mertens, 1994; Cooper et al., 1992; Evans & Dunn, 1995; Johnson & Pandina, 1993; Nolen-Hoeksema 1987; Ugal, 2003). Men are almost five times more likely than women to turn to alcohol and drugs as means to reduce the feeling of depression (Blazer et al., 1994; Kessler et al., 1994; Real 1997; Robins & Reiger, 1991; Schutte, Brennan, & Moos, 1998). Instead of talking about how they feel, men may try to make themselves feel better by using alcohol or drugs (Bonin, McCreary & Sadava, 2000; Real 1997; Royal College of Psychiatrists, 1998). Research indicates that if a depressed person relies on alcohol as a method of coping, then there is increased risk that they will become alcohol abusers (Bonin, McCreary & Sadava, 2000; Cooper, Russel and George 1988).

Furthermore, even though the men cited above are turning to drink to gain relief from depression and they drink till they get “smashed” as Daniel put it (Section 2, Paragraphs 22-28), they all report that it does not help. For after the wave of intoxication passes, they find themselves either in the same distressed state where they began, or else they feel even worse. Research findings (Blume, Schmalin & Marlat, 2001; Francis-Cheung & Grey, 2002; Marlat, 1987; Okoro, Brewer & Naimi, 2004) explain that this feeling is typical in cases “of drinking and being upset.” While normal drinkers begin with relatively good feelings from the start, depressed people begin with an experience of internal pain. “Like wheels within wheels” and “it’s a bad feeling, relief, then worse feelings” (Marlat, 1987). One of the men described drinking as follows:

Albert

You know drink out, have fun or nearly binge drink. You know drink out, have fun, go to a pub you know talk. But the thing is, you know, sometimes doing that is getting too close to the problem. So I don’t know sometime it just doesn’t seem to help (Section 5, Paragraph 61).

Another interviewee, Edward, said

When I go out with my mates and they used to drink and all the inside started to come out. And I saw that and I said . . . and believe it or not I drank, drank, drank, have a good time. This is when I used to drink... when I was at “Collector” (name of a Pub). My soberness took my mentality back, you know? (Section 2, Paragraph 34.)

In the case of traditional men, there seems to be an additional reason to feel bad or worse after drinking, which is related to them talking about their emotions while they are drunk. Men, and especially traditional men, are not used to voicing emotional issues because through socialization they are taught it is unmanly to do so (Blazina & Watkins, 1996; Good & Mintz, 1990; Good et al., 1995; Leafgren, 1990; O'Neil, 1981a, 1981b, 1982, 1990; O'Neil & Good, 1997; O'Neil et al., 1986; Pleck, 1981 & 1995; Real 1997; Sharpe & Heppner, 1991). So if a traditional man talks about what is causing him anxiety he'll appear weak and unmanly and will feel bad or worse when he is sober. Keeping that in mind the men seem to drink but feel restricted because they cannot be themselves and would not enjoy drinking and they would not find it helpful. Hence the following remark by Edward:

It started to put it to my lips, you know? But I bit my tongue, in “Collector” (name of Pub) I bit my tongue, you know? I bit my tongue and swallow it back inside of me, you know? Because I just don't want to let it out, you know? (Section 2, Paragraph 34.)

B. Problem-Focused Coping

Reports of gender differences in the use of coping strategies have continuously shown that females employ coping-strategies that focus on emotions, whereas males employ strategies that distract them from their emotions (Rosario et al., 1988; Felsten, 1998). In this manner, females use more passive coping strategies that focus on their distress and seek more social support (Ptacek et al., 1992; Rosario et al., 1988), thereby inhibiting the

use of problem-focused coping, and as a result, diminishing their sense of control over the environment (Compas et al., 1993), which can lead to prolonged and severe periods of depressed mood (Nolen-Hoeksema, 1991). In contrast, males have been reported to be more likely to use active coping strategies that distract them from their depressed mood and therefore decrease their symptoms (Nolen-Hoeksema, 1991). The distraction can also facilitate the use of problem-focused coping strategies which can increase their sense of control (Compas et al., 1993).

Across a wide range of normal and clinical samples, problem focused coping has generally been associated with more positive results, such as lower depression, in comparison to avoidance and emotion-focused coping (Aldwin & Revenson, 1987; Billings & Moos, 1981; 1984; Bowman & Stern, 1995; Endler et al., 1994; Endler & Parker, 1990a; 1990b; 1994; Folkman & Lazarus, 1985; Jung, 1993; Ptacek et al., 1992; Sigmon et al., 1995; Vollrath et al., 1994; Zeidner, 1994).

In the current study, the interviewees described employing problem-focused strategies to remove or reduce the stressors causing their depression, but these were positioned as secondary after avoidance coping. The interpretation of the respondents' various answers in regards to problem-focused strategies can assume four different forms:

- Reflecting
- Taking concrete actions
- Developing positive perceptions about life situations.
- Instrumental support seeking.

1. Reflecting

Traditional gender stereotypes encourage women into expressing themselves emotionally and cultivating relationships, whilst men are encouraged to cultivate their public, assertive selves, at the expense of revealing their emotions (Ptacek et al., 1992; Rosario et al., 1988). Men are not supposed to show or talk about their pain. It is “unmanly to talk” (O’Neil, Good, & Holmes, 1995). Many men, feeling the shame of depression’s “unmanliness”, have been found to mask their mental health problems from their friends, families and from themselves (Real, 1997). In this research study, the respondents reported that whilst they don’t talk about their depression, they are aware of their condition of depression. They are able to “detach from their emotions” and see themselves objectively as if “another” person is viewing them, as is illustrated in extracts from Fredric and George below.

George

I know my ah, I know myself. I can see myself from another point of view. I tell myself when it builds up. I always ask myself why I’m acting this way? Why I’m feeling like that? Or what the situation causing me to feel like that? (Section 1, Paragraph 118)

Fredric

The way I mostly dealt with it was introspection, so I was trying to figure out what’s actually happening, yeah, yeah. Trying to detach myself from my emotions actually, have a look and see what’s taking place and what’s actually happening. Rather than, maybe in this emotional situation, I step out of it, I tried to see how the situation is from another person sense of view, and then tried to deal that way, objectively (Section 2, Paragraph 14)

The interviewees reported that they prefer to reflect on their condition in order to find a solution, as well to learn how to avoid it in the future. The following extracts illustrate this:

Bill

When I get depressed I usually try to figure out why I get depressed, and try to solve the problem (Section 2.1, Paragraph 3)

Edward

I used my depression and I looked at why I was depressed, to learn and to avoid, you know, from any future depression...I look back into things, you know? As in what happened, where things went wrong and how it came about that something has happened which has got me so upset, you know? (Section 2, Paragraph 4 and 14)

Many respondents reported that they prefer to reflect on their condition and solve their problems by themselves because everything is seen as relative, and people have different perceptions, personalities and philosophies. Since there is no one way to see and solve problems, the respondents position the best option as finding a solution for their condition by themselves. And since the solution stems from them they say that they then feel more satisfied or “comfortable” with their decision. The extract from Bill illustrates this pattern.

Bill

I guess the major reason: you are the best person to consult. (Silence for 8 sec). I mean the problem I'm having could be nothing to the other person. But because of my personality, because of my philosophy, it could be a major major issue for me. So you gotta do what you feel is the right way for you. There's no THE right way. It's not black and white all the times (silence for 10sec). Gotta do what most comfortable to you. Yeah (Section 9.7, Paragraph 89)

As a whole, the respondents revealed that when they are depressed they do not talk about their depression but they do not mask it from themselves. They prefer to think about their problems to solve them –and not to focus their attention on the negatives, as would be the case of emotion-focused coping (e.g. Hollon, Kendall, & Lumry, 1986; Krantz & Rude, 1984; Rude, Krantz, & Rosenhan, 1988).

2. Taking Concrete Actions

According to Seiffge-Krenke (1993), taking concrete actions to solve problems is a positive form of active functional coping. Though taking concrete actions is positive and

functional in resolving any problem, taking concrete actions is not always an option. Sometimes the solution to the problem is beyond the person's reach or control (e.g. if the solution is money and the person does not have money, or enough money to solve the problem in hand). Another difficulty, as previous research suggests, is that there are qualitative differences between coping strategies used by people facing normative difficulties and those facing more severe problems (Seiffge-Krenke, 1993). In a study on coping and depression in adults, Ring and Vazquez (1992) analysed the strategies that psychiatric patients and normal controls use when they are sad or depressed. They found that psychiatric patients used fewer coping strategies than the normal sample. Moreover, the coping-strategies, employed by the psychiatric patients, were generally less effective in counteracting the patients' depressed moods (Ring & Vazquez, 1992). This seems to imply that there is an important relationship between the types of coping strategies that are used and depressive symptomatology in general; however, addressing the problem of agitation through taking concrete actions may not always be an option, especially in the case of psychiatric patients.

In this study some of the respondents, none of whom was severely depressed or a psychiatric patient, reported that they employed active steps to try to remove or circumvent the stressor or to ameliorate its effects. In other words they were taking concrete actions, similar to the core of what Lazarus and Folkman (1984) and others term problem-focused coping. Moreover, as different circumstances involve different solutions, the respondents resolved matters according to their problem or cause of depression. For example, Edward reported that one of the major reasons for his state of depression was feeling lonely since he left his family and friends in Adelaide and moved to Sydney to work. The first time he had the chance to go out for a drink in one of the

pubs with his colleagues from work was the beginning of his feeling better and being able to address the source of his depression. Going out helped him to feel that he is not a stranger, but an accepted and valued person in his new family of colleagues, which boosted his self-esteem and morale.

Edward

Going out with everybody at work... the first time I went with everybody, I was blown away, you know what I mean? That day I released a lot of frustrated energy from me, you know? I felt that I was being accepted, once again. I felt like that I was being valued, you know. (Section 3, Paragraph 51)

Similarly George reported that the source of his depression was feeling lonely since his girlfriend left for overseas to visit her family, and because he had lost contact with most of his friends, because he was investing all his time in his girlfriend. Added to all of that it was university summer break, he was unemployed, which meant he had no colleagues or money. When he found a job that was the beginning of the change and recovery. The job helped George to have a “schedule”, to be in contact with people, and to have money to help him support himself. George started to feel better, and this boosted his self-esteem and his confidence in him-self which in turn appeared to have reinforced George to take another concrete action in that he started to re-animate his contacts with his old friends. Weeks after this he reported being back to normal.

George

So I had to find, an, an, a job while I was off Uni, cause I was off Uni and I was not working so I'd to go back and get a job.

Annd, oh yes that also helped me cause I was then back sort of, ehhhh, a bit more than regular day to day, emmm, schedule rather than sitting at home and doing nothing much. And getting bit more to schedule and bit more contact with people. And also it takes your mind off worrying about things as much. Annnnnnd also there's on mind rest of it things I have got, ahhhhh, some money coming in to be able sort of helping myself out of the situation... started to get in contact with all my old friends again. And started to see them and going out with them. So generally after like a couple of weeks or a month after that things started to get back to a normal

level again. If not, still had flash problems I still working at it. And I knew down the track everything will be taken care of. So, emmmmmmm,(silence for 20 sec). That's when like, aahhh, I felt like I was myself again, felt normal and....(Section 1, Paragraph7-8 and 9).

In general, taking concrete actions was positioned as a very positive and effective strategy in resolving the sources of depression. However, it is not always an easy solution, as it is not a strategy always available for the depressed, especially in the case of the depressed psychiatric patients in which the person's mental faculties and insight are hindered (Ring & Vazquez, 1992).

3. Developing Positive Perceptions about Life Situations

According to cognitive researchers, the critical factor in stress and depression is the person's interpretation of the stressors' potential impact. Thus, an event interpreted as a threat or danger elicits a non-specific stress response, and an event interpreted as a loss (of either an attachment bond or a sense of competence) elicits more grief-like depressive responses, while an event interpreted or perceived positively elicits more positive responses (Compas et al., 1993; Nolen-Hoeksema, 1991; Ingram et al., 1998).

Results of several studies of gender differences in the use of coping strategies have continuously shown that males employ more positive or optimistic attitudes in dealing with depression than females (Compas et al., 1993; Hamilton & Fagot, 1988; Rosario et al., 1988; Felsten, 1998). Women use coping strategies that focus on their depressed mood, thus remaining preoccupied with negative thoughts and consequently reducing their sense of control over the environment (Compas et al., 1993; Nolen-Hoeksema, 1991). Studies designed to investigate whether gender role conflict in men was associated with specific patterns of depressive symptoms, have suggested that the restriction of emotions is the strongest gender role conflict predictor not only of psychological distress

for men in both clinical and non-clinical samples (Cournoyer & Mahalik, 1995; Good et al., 1995,1996; Sharpe & Heppner, 1991), but also of certain patterns of depressive symptoms characterised by a negative state of mind and, specifically, such symptoms as self-dislike, feelings of failure, guilt, and pessimism in college men (Shepard, 2002.). According to the cognitive theories of depression (Beck et al., 1985; Ellis, 1962; Power & Brewin, 1997), how individuals view and interpret stressful events contributes to whether or not they become depressed.

The interviewees reported that they developed a positive attitude toward life events through their previous experience with depression. The positive attitude they have developed seems to emphasise not positioning any event as threatening or bad because they have learned through experience that there is something good in everything bad that happens. And if something bad or stressful happens, they prefer to keep looking “forward” and to carry on with life as normal because there is no use in looking backward. This positive attitude, as some men have reported, is taking them “further away” than just carrying on with life. The following extracts illustrate this:

Edward

I’ve always learned that there’s something always good in everything bad that happens... Maybe I used to go out with my friends, have a good time, Saturday nights, blah blah blah. But now I suddenly realised I work at (Company name), I work at the restaurant, I’m lonely at home, and I don’t enjoy myself that much, it gets me stressed out. I now, I often realise that I do get depressed about it too. But I’ve also realised that I have more money in my pocket (laughs), you know? And it works better for me and that’s what I accept, you know? I accept that because that’s taking me a lot more further away (Section 2, Paragraph 4 and 14)

Harry

But I’m moving on and getting on with, with life and just I don’t look back at it any more, like I use to....I pick me self up that’s the attitude I got now that’s why I hardly have any dramas. Cause what happened today is today and what happens tomorrow is another day (Section 2, Paragraph 150 and 155)

Carl

“Yeah face, face the facts, it’s happened, look forward” (Section 2, Paragraph 5,)

Furthermore, as one of the respondents, Edward, reported, the experience of depression and dealing with its consequences taught him to develop a positive attitude toward others and himself as well.

Edward

I started to realise a lot of things, valuing people, and being able to deal with problems. Em, and being able to accept that nothing is hundred percent because I’m not hundred percent...[I] realised that I am still young, and I’m still learning, and I’m not perfect, and I am allowed to make mistakes, and accepting those things in life (Section 2, Paragraph 31)

The positive perception of others and the self is quite significant, especially the self, although the point was reservedly suggested by the one of the respondents. Cognitive therapy has always been centrally concerned with meaning and the self, as opposed to being interested in others. Both Beck and Ellis trace dysfunctional thinking patterns in the moment back to beliefs about the self. The idea that the threat lies not in the objective situation or self but in the meaning attributed to the situation or self is also fundamental (Power & Brewin, 1997). In research that has been done on self-concept, there has repetitively been indicative evidence of a positive relation between self-esteem (a factor of self-concept) and well being. People who have high self-esteem have been found to be less anxious and depressed than those who have low self-esteem (Good & Mintz, 1990; Sharpe & Herpner, 1991; Cournoyer & Mahalik, 1995; Smith, 1999).

Nonetheless, a number of the participants also reported that they learned through previous experience to perceive depression as a “challenge” and “a positive opportunity to learn from” , to become stronger, to have a different and better view about life, and opportunity

to become a new and better person “reborn”. The following extract from the interview with Edward illustrates this.

Edward

I look at it from different point or angle all together. Most people that they get depressed they are like “Oh, why did this happen? Why did this happen? Why did this has to happen this way? But I look at the opportunities, there are reasons that I lost, that I suffered, or that, you know, things went wrong...[Depression] really has given me...made me much, much more stronger, and it gave me a better perspective of my life, depression did, believe it or not. It has changed me around. Unbelievably, it has actually improved a lot of parts of my life, I had no stability, and I had no consistency, all right? And these things that do now exist in my life have been generated, have been born through depression, you know? (Section 2, Paragraph 14 and 25)

Edward

It gave me the chance, whatever these problems was, it gave me the chance to come out where you can prove yourself. You know what I mean? (Section 13, Paragraph 140)

Overall, the analysis of men’s responses in this study revealed that traditional men attempt to neutralise their negative moods through developing positive perceptions about life. Those cognitive behaviours emphasise a positive attitude toward life events, self and others, and the perception of depression as an opportunity. What is ironic is that all those positive strategies were born from the womb of depression it-self.

4. Instrumental Support Seeking

a. Seeking Advice with a Hidden Agenda

The traditional men in this study revealed the usage of another coping response that can be considered as relevant to problem-focused coping, that is the seeking out of social support and, specifically, using instrumental support. People can seek social support for either of two reasons, which differ in the degree to which they involve problem focusing. Seeking social support for instrumental reasons is seeking advice, assistance, or

information. This is problem-focused coping (Carver, Scheier & Weintraub, 1989). Seeking social support for emotional reasons is getting moral support, sympathy, or understanding. This is an aspect of emotion-focused coping (Carver, Scheier & Weintraub, 1989). Moreover, the majority of the respondents disclosed that though they sought advice, assistance, or information when they were depressed they have never talked about their depression nor did they seek help directly. All of them reported asking for help indirectly or as George put it “with a hidden agenda.”

George

I did sort of seek help, like I've spoken to my mum, but not directly saying as if I was depressed or anything like that. Just, in a more round about way, like going around the issue and just, ehhhhhhhh (silence for 10 seconds). Sort of speaking non-directly to her, like trying to get advice, or what I should do, like how to get out of my situation of, the money that I owed... I pursue like advice from my friend I was living with, and also my friends and my parents. But I didn't seek, I didn't speak directly saying I was feeling depressed or anything like that. I'd sort went around about way of getting advice. If you know what I mean, like asking questions, eehhhhh, you know (silence for 15 seconds). How do you say it? Like with ahhhh, a hidden agenda (Section 1, Paragraph 7- 9)

Similarly, the other interviewees remarked:

Albert

I mean sometimes you keep want to say things but you just can't say it. So, you have either to leave them out or to leave [it] till later and talk about to people that, aaa or how quite around the bush, you are trying to go around in circles sort of speak. It works sometimes, sometimes it doesn't (Laugh) (Section 6.1, Paragraph 96)

Carl

Even if you do talk about it, eh even if I do talk about it, it wouldn't be in depth, It would be like “oh this happened.” kind of you wouldn't really express yourself totally. You can talk about the situation, talk about what has happened, just to give the person an idea of something has happened. But generally you stay away from it, kind of take your mind off it (Section 2, Paragraph 12)

Edward

You can say I prefer to keep it to myself, but from time to time I do let it out. I do let it out with people, but I don't let it out to them as in it happened to me. You know? I'd put it in a different way (Section 4, Paragraph 66)

Harry

I probably won't come directly. I'll say some hints and stuff like that in sort of get my friends to guess it. And I'd rather have them guess it than no (Section 2, Paragraph 17)

Furthermore, the interviewees explained how the advice appeared to work even if it were not directly obtained. They described taking whatever advice they were given, even if it were not related to their depression, then identifying what fitted or related to their experience of depression, and making it work for them as if it were advice given to them directly for depression. The following extract makes this manifest:

George

[I] use both [parents and friends] of their advice, like the, up fitted to myself and make it work for me. Like, I cause aaah, I would be talking to them, and in a bit they could be giving me advice on something, emmmmm, when not actually mean to be depression but I can relate it, in like, to my life and my experiences. And make that work for me. And help me. If you understand what I'm saying? Yeah? They are probably the two. Yeah (Section 1, Paragraphs 45-46).

Overall, the majority of the traditional men revealed that they were using instrumental support in the form of seeking advice to deal with their depression, but all of them were "masking" (Real, 1997) and seeking advice through a hidden agenda. According to many researchers (Good et al., 1990, O'Neil, 1990; Real, 1997) this attitude of masking and not seeking assistance directly could be related to the cultural expectations of masculinity. The continuous message they keep receiving from society including their parents and friends is "The man who is struggling should not expect help" (Real, 1997) and he should solve his problems on his own. Hammen and Peters (1978) studied college dorms across

the United States on this issue. They found that when depressed women reached out to their roommates and said they were depressed, they were universally met with help, guidance, empathy and nurture. In contrast, when male college students reached out to their room mates and said they were depressed, they were withdrawn from, met with hostility and treated as if they were losers. So the idea that the interviewees have that coming “out of the cavern” with depression is a risky business, is not necessarily incorrect.

The interviewees reported three specific sources of social support that they used for advice when they were depressed: support from family, support from friends, and support from respected and elderly people. As well, they reported which source of support they prefer and why. The specific interplay of sources and types of support (e. g., support from parents, and support from friends) and their differential effects on the depressed are spelled out in only a few studies (Hagedoorn et al., 2000; La Greca et al., 1995; La Greca, Bearman, & Moore, 2002; Revenson & Majerovitz, 1991). In the following we present each source of social support and the discourse around it:

b- Support from Family

A dominant perspective is that deficits in social support, especially family support, increase the risk of depression (Monroe, 1983; Windle, 1992). Perceived deficits in support from parents have predicted future increases in depressive symptoms during adolescence (Lewinsohn et al., 1994; Sheeber, Hops, Alpert, Davis, & Andrews, 1997; Slavin & Rainer, 1990; Stice & Bearman, 2001; Windle, 1992). In this study the participants disclosed that they have previously sought their family’s advice and support to cope with depression. They indicated that they were mostly seeking nuclear family support (Father, mother and siblings).

Bill

I talk to my parents about it, because I think they understand me the most (Section 2.1, Paragraph 3).

Carl

I had my older brother, older sister and another older brother to rely on and to get back to, and they just helped me through it. Just like a kind ehh talk and face it (Section 2, Paragraph 4)

George

Ahhhhh (silence for 9 sec). In some of this, I used to talk to my mum and she goes emmmmmmm, I always regard her in high terms in regard she's very wise and knowledgeable, and I was (silent for 3 seconds) any, any myself advice I always take it as, as a gospel. Because she's been through like a lot of experiences herself, and she understands a lot what young people go through. So, a lot of her advice helps. As well as, (silence for 7 seconds). As well as my dad (Section 1, Paragraph 44).

c. Friends' Support with Conditions

The analysis of the interviews suggested that the traditional men prefer and trust their friends more than their parents. These findings concur with those from past studies (Helsen, Vollebergh, & Meeus, 2000; Weigel & Devereux, 1998). Helsen, Vollebergh, and Meeus (2000), in their study about the relationship between social support (from parents and friends) and emotional problems in adolescence, pointed out that for boys, the influence of parental support declines with increasing age, whereas the influence of support from friends increases. Although girls perceived higher support from peers, family support continued to play a role in preventing depression. For boys, on the other hand, peer support was the only resource protecting them against depression (Liu, 2002).

Albert

Friends, well, yeah I tend to trust friends more than family (Section 17, Paragraph 210)

According to the respondents the preference to seek friends' advice rather than family's advice is related to many reasons:

It is easier to talk to friends than the family especially when the person is depressed, even if the person were more comfortable with his family than his friends.

Daniel

I guess with issues that sort of depress me I think I find it a lot easier to talk to friends about it rather than family. I don't know why this, but it just happens that way. Although I am a lot more comfortable around my family than my friends and I've been living with them for all my life I still find it hard to be able to talk to them rather than my friends. I don't know, I find that weird but it's just the way it is. (Section 25, Paragraph 203)

The traditional men want somebody to listen to them and advise them without prejudice, as illustrated in the extract from Daniel below. But in many cases, the parents do not seem to listen, merely to talk and preach, as is illustrated in the extracts from Albert and George below:

Daniel

I'd have to say my friends, my friends, yeah. Like just know one is there to talk to, and they wouldn't judge or anything, they just being ear to listen to. And, yeah, I guess somebody neutral that isn't actually in it. That helps a lot. (Section 3, Paragraph 37)

Albert

Last you wanna hear is like yapping. You have parents or I have parents it's a like, to shut the hell up and wash the dishes and I'm going away (Section 5, Paragraph 66).

George

So, Yeah. Oh, mainly me listening to them [Parents]. Yeah. For my friend I used to talk to him, he sorts listen. (Section 1, Paragraphs 51-53).

Another reason why many of the traditional men prefer and trust their peers more than their family is that they report that they perceive their friends' advice to be more practical, straightforward, and helpful. The advice could be something general and common sense,

but still helpful. This intersects with the findings of many researchers treating the issue of gender role conflict and depression (Cournoyer, & Mahalik, 1995; O'Neil, Good & Holmes, 1995; Real, 1997). The following extract from Bill illustrates it:

Bill

Yeah, I guess friends they would tell me some thing practical. Like well let's go out for a while and think about it later, let's go and see a movie or so. And I guess when they do give me advice it's very general, very straightforward but for some reason I find that helpful. (Section 3.5, Paragraph 13).

Furthermore the participants explained that parents as well as female friends tend to think more in an emotional way and not in a practical way, the way that "guys" deal with things. Men's means of, and advice about, dealing with depression could be seen as "shallow" but it is effective, illustrated in the extract from Albert below. Men in this study reported restricting their emotionality and preferring to deal with problems more practically, a finding that is consistent with a vast literature on this subject (Good & Mintz, 1990; Good et al., 1996; O'Neil, 1981; O'Neil et al., 1986; Sharpe & Heppner, 1991).

Albert

Most genuinely speaking girls tend to not think of logic. No, that's a bad term. They tend to see things in a more emotional way than, you know. They tend more to think about the ...they think mother think. Guys are more like let's talk about this, let's talk about that, let's go for a drink, you know. I'd say most the people I know are deep shallow (laugh) I mean not shallow but depending emmm, or yeah I have to consider shallow that's the best part to go for it. (Section 6, Paragraph 84)

Although the traditional men reported that they preferred to talk to their friends more than their family when they were depressed, the analysis revealed that traditional men do not think that their friends can unconditionally help them. Friends cannot always help because sometimes friends are self-centred, do not want to listen, and sometimes they

listen but they try to persuade their friend to take certain options that they think are the best solutions as illustrated in the extract from Albert below, while the depressed friend might not think that way as illustrated in the extract from Bill below. That is why some of the interviewees suggested that the best option for advice might not always be from a friend but from a mature person. Thus, though peer support is favoured over parental support it is perceived to show more variability over time than mature and parental support (Stice et al., 2004).

Albert

I tend to trust friends more than family but some of them tend to fall more than the other. You know what I'm saying? They don't want to know about it, or they try to push you in directions they think they are your best solutions. They give you options if anything. (Section 17, Paragraph 210)

Albert

For some reason younger people just don't want to know. You know what I mean? As in like (silence for 6 sec). Or maybe, maybe just younger people they have a general vow kind of self-centred law (laugh). (Section 5, Paragraph 59)

Bill

Although I like being around friends and stuff but I don't think they have enough life experience to help me solve my problems. And yeah, I need someone who's mature to give me the advice and I don't think my friends are adequate to do that. Yeah.(Section 3.3, Paragraph 11)

d. Support from Respected and Elderly People

Some of the respondents reported that they sought support and advice from mature and respected people in their life. They reported that the support they got in the form of advice and reassurance was beyond expectation and changed their lives, as is illustrated below.

Edward

It was very unexpected for me that a manager, and not any manager he's a manager in (company's name) and that he is giving me that extra hand, that pat on the back, you know what I mean? Like, good on you, well done, blah, blah, blah. ...Leon played a very great part of encouraging me,

and lifted me up. He played a very great part. That's why, em even like now we're friends, I just can't look at the person in the eye. you know what I mean? I can't. I have definite respect for him. I've already talked to him. This guy changed my life. you know? (Section 2, Paragraph 31 and Section 3, Paragraph 50)

Furthermore, some of the interviewees reported that they sought help not just from mature people but from elderly people as well. They have found that the old people are easy to talk to because usually they don't talk, they prefer to listen. And when they talk they have a stable and serious "look on life", and they know what they are talking about and what should be done, as if they were "playing chess"; their advice is very deep and precise. Being with old people was positioned as therapy by itself by some interviewees. The following quotes portray this phenomenon:

Albert

But you know what I mean the older [sic] people tend to have more stable look on life. So I tend to find it easy to talk to them because the fact is that they listen to what you are talking about and nothing else. Cause the that fact I know to some degree they are actually, you know, not under, hippped up sort of speak as best I can describe it. So, that's... (Section 4, Paragraph 53)

Edward

This is why I'd have been with elderly people. Because they don't talk, elderly people don't like to talk about things to make them laugh. You know what I mean? They like to talk about things that make sense, make understanding because they don't have time for these things (Section 4, Paragraph 66)

Edward

me being still 25 years old and rarely came across all those problems, most of the doors are still closed. I still don't know ... I mean to my understanding things the way they were over the last three years or something, I still have the same understanding. But the way I used to think things has grown in, like deeper, the meaning of it is changing. You know what I mean? I see deeper into it, I see how it feels how it reacts and things like that. And the reason I'm gaining this is from these older people. Because being young, you only see: you did this and this is what happened. You know what I mean? The older people, they'll take you through the whole different ill of it, you know what I mean? "This was gonna happen, and this was gonna happen and this was gonna happen" as

if they've seen it right through, you know, they've seen it right through. That's why admire like... to me honestly, being with older people, mature people, I see at as therapy for myself. You know what I mean? They know exactly what they are talking about, they know exactly what ...it's like as if they were playing a chess game, they know exactly which move to make, you know what I mean? (Section 8, Paragraph 104)

In general, traditional men reported that they seek social support, but they are very secretive and they use instrumental social support and not emotional social support. Furthermore, the traditional men revealed that they use specific sources of support (e. g., support from parents, and support from friends) and that each source has different effects on men's willingness to talk.

To summarise, the responses of the interviewees revealed that traditional men report employing problem-focused strategies to remove or reduce the stressors causing their depression. The respondents' various answers in regards to problem-focused strategies appeared to present in four different forms: Reflecting, taking concrete actions, developing positive perceptions about life situations, and instrumental support seeking. The respondents revealed that when they are depressed they do not talk about their depression but they do not mask it from themselves (Real, 1997). They prefer to think about their problems to solve them –and not to focus their attention on the negatives as in the case of emotion-focused coping. And when they cannot find a solution they seek advice from the people they trust, in an indirect way.

C. Emotion-Focused Coping

The results of the present study suggest that traditional men do use emotional strategies to a certain extent, but it is not very significant. In accordance with previous research about gender and coping with depression (Boyd-Wilson et al., 2000; Chino & Funabiki 1984;

Funabiki et al., 1980; Kleinke, Staneski & Mason 1982; Nolen-Hoeksema, 1987 & 1990; Pearlin & Schooler, 1978) the interviewees in the present reported that they are more likely to seek distraction, and are less likely to cope with depression through emotional strategies. And even when they choose to do so they tend to use a distractive form of emotional coping rather than absolute emotional coping. As well they seem to be very conservative in employing such strategies, using only two forms thereof: talking and being surrounded by people.

1. Talking

a. Talking to Feel Better

A small number of traditional men in this study reported that they sometimes talk about their emotions when they are depressed and that they find relief in doing so.

The following response is indicative:

Carl

I think for me, from my experience, the worst thing to do is spending time alone. Spending time alone you start to think and think badly. When you are in that state, everything is negative. But there are people you can speak to that can help you think positively and that would change a lot (Section 4, Paragraph 29).

And although traditional men seem to find relief in talking about how they feel, they do not ruminate or talk excessively about it as reported in previous research (Nolen-Hoeksema, 1987). Rather, they talk about their emotions briefly “just to share it” and “get it off their chest”. The following excerpts illustrate this.

Carl

And I express myself to him in the same things: stress, depression and things that make me sad and things that make me happy, just sharing it with him.

Daniel

Ahhh, efffff, probably sit down with a friend or a family member and talk about it. Hmm (silence for 4 sec.). Yeah, I find if I can get it off my chest I feel a lot better. If I sit down and talk to someone about it, like I get over it (silence for 5 sec.). That's about it (Section 2, Paragraph 4).

Afterwards, traditional men quickly move on to other topics, be they general issues or matters relating to the person with whom they are conversing.

Traditional men report talking about their emotions in order to feel better, but it seems that talking by itself is also helpful for traditional men to feel better. In other words traditional men use the emotional technique of "talking" but they do not have to talk about their emotions to feel better. They reported that talking by it-self is helpful. An impression that is supported through the statements of two men who were depressed and were not sharing their feelings with anybody, they both were using the "phone" extensively just to talk (about anything) and to feel better. The way interviewee Harry put it was:

"[I am] Always busy just ringing people," (Section 2, Paragraph 5).

Similarly, George said:

"I've built a big 'phone bill calling my girlfriend everyday, which was for a couple thousands of dollars." (Section 1, Paragraph 7).

Based on all of the above results it seems the best that can describe traditional men's emotional expressiveness, as one of the interviewee described it, is as a "distraction value" (Albert, Paragraph 51).

2. Keeping Company with Friends or Acquaintances

Traditional men reported that when they are depressed they always crave “company” (George, Section 1, Paragraph 47). There is no need to talk about anything; what’s important is that there’s somebody else in the room. For example, Harry said:

[A] s always there someone there even you didn’t have to say boo-hoo to each others ... as there was someone else in the room that did help with the depression.” (Section 2, Paragraph 5).

The need for the “presence” of somebody is persistent, for some men, even at night.

Albert

Company, in the loose, I mean, not include in this the Internet, so I can’t exactly say. Company in the loosest sense, you know, to talking, presence I should say the best I can describe it. (Section 4, Paragraph 51)

Harry

because I was upset and I felt it’s hard to be on my own, like I had friends that would come and stay over or stay till late hour as the night then they’d go home. Where as normal they’d be no one, as the day over have your dinner, go to sleep, do whatever. But because I couldn’t sleep properly and stuff like that, I suppose they are there for me. So that you know, few close friends that were there for me (Section 2, Paragraph 21).

What is important for these depressed men is not to be left alone, because being with someone was positioned as helpful to forget about depression.

Carl

if you’ve got friends you can talk to, hang out with, em that helps. Being alone doesn’t help, being alone and lock yourself up in the room doesn’t help (Section 2, Paragraph 9).

When these men are alone, they report that they dwell on their depression and this can exacerbate it.

Harry

Going through and through and through but when you’re here with someone you’re not, but as soon as you’re not with them you sort of still depressed (Section 2, Paragraph 5).

In other words, the emotional strategy of having company can be seen as another emotional-distractive strategy intended to avoid both depression and “the passive” coping style of “rumination” that is likely to exacerbate their depressive experiences as Nolen-Hoeksema ascertain (1990).

Indeed, the men in this study reported that they are aware of the fact that this is ‘more of an escape rather than a solution’ (Fredric, Section 4, Paragraph 16), or a temporary replacement for what the depressive is grieving over. As one of the interviewee, Harry, declared:

I suppose until I met other people I’d feel better than I knew that they sort were replacing the person I was grieving [over] and once again I [had to] start all over again until you meet your mate and your mate (Section 2, Paragraph 5).

The results pertaining to emotional coping suggest that traditional men do exhibit emotional coping to depression, but even when they choose to do that they have a greater tendency to use emotional-distractive strategies instead of being just emotional.

Summary

Traditional men seem to rely more on avoidance and task coping, than on emotional coping to alleviate their depression. These results clearly support Eisler’s (1995) view that male gender role socialization restricts traditional men’s coping repertoires to those that are gender sanctioned. More precisely, these results support the view that men who are traditional are restricted from being emotional, because it is positioned as unmanly (Blazina & Watkins, 1996; Good & Mintz, 1990; Good et al., 1995; Leafgren, 1990; O’Neil, 1981a, 1981b, 1982, 1990; O’Neil & Good, 1997; O’Neil et al., 1986; Pleck, 1981 & 1995; Real 1997; Sharpe & Heppner, 1991), and therefore men might be feel compelled to chose coping strategies that are more distractive and less emotional,

ruminative or “feminine” (Boyd-Wilson et al., 2000; Chino & Funabiki 1984; Compas et al., 1993; Funabiki et al., 1980; Kleinke, Staneski & Mason 1982; Nolen-Hoeksema, 1987, 1990 & 1991; Pearlin & Schooler, 1978).

III. Seeking Professional Help

The issue of the likelihood of seeking help when one is experiencing an upsetting personal problem has been studied by a number of researchers over the past four decades (Blazina & Watkins, 1996; Fischer & Farina, 1995; Fischer & Turner, 1970; Fischer, Winer, & Abramowitz, 1983; Good, Dell, & Mintz, 1989; Robertson, 1989 & 2001; Robertson & Fitzgerald, 1992; Simonsen et al., 2000). Research has reported that about two thirds of all clients seeking psychological services are women (Stoppard, 2000; Tijhuis et al. 1990; Wills, 1983). Furthermore, it has been estimated that 1 in 3 women seek help from a mental health professional at some point in their lives, whereas only 1 in 7 men do the same (Collier, 1982; Courtenay, 2001). Robertson (1989) reported that predictions of positive attitudes toward counselling included higher feminine scores on gender role measures, while negative attitudes were related to high scores on various masculinity measures. In 2001, Robertson found that women sought counselling at higher rates than men did, although men had similar if not higher rates of distress than women.

Although many studies have found higher rates of depression for women compared with men (American Psychiatric Association, 1994), recent research (Cochran, 2001; Good & Sherrod, 2001; Real 1997; Royal College of Psychiatrists, 1998) has argued to the contrary. Cochran (2001) referenced studies in which rates of depression for men were found to be at least equal to rates for women, and some studies in which the rates of depression for men actually exceeded those for women. Depression in men could be

under diagnosed because “the male experience of depression” (Cochran, 2001; Good & Sherrod, 2001) may not be in line with the criteria of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (American Psychiatric Association, 1994). Equally men mask depression (Real, 1997) in forms that can include "alcohol- and drug-related comorbidity, behaviours characterised as compulsive and antisocial, and increases in interpersonal conflict such as anger, withdrawal, and defensive assertions of autonomy" (Cochran, 2001, p.233) in order to avoid seeking help (Cochran, 2001; Good & Sherrod, 2001; Mahalik et al., 1995; Real, 1997).

This section of the chapter describes the conditions under which the traditional men in this study report that they would seek professional help, and outlines the types of therapeutic approaches they would seek to alleviate their depression.

A. Depression and the Conditions of Seeking Professional Help

In accordance with previous studies (Cochran, 2001; Good & Sherrod, 2001; Good et al., 1989; Mahalik et al., 1995; Real, 1997) most of the traditional men in the present study reported that they have a negative attitude toward seeking professional help in general. To seek professional help, and particularly to seek a psychologist's or therapist's help, is a fraught issue and they would need a lot of convincing.

Bill

I'd try not to see a therapist (Silence for 12 sec). Umm, yeah. I think I might need a major convincing to go and see a therapist... I can't think of any reason why should I go and seek help from a psychologist (Section 11, paragraph 107).

Consistent with previous studies (e.g. Robertson, 2001), the respondents of the present study reported that to be convinced that they need psychological help they would need first to perceive that they are in a totally dangerous and critical situation, a situation that

does not happen in everyday life, a highly distressing situation. Moreover, they reported that they would need to feel that they do not have any control over the circumstances, that they cannot get out of it on their own, and they are stuck. For men in this study, seeking psychological help is thus positioned as the last option or resort to turn to. The following extracts illustrate this pattern:

Albert

Cause the fact that psychologist is one in many people I tend turn to, you know, but as last resort. Is more the last resort thing cause the fact is that you tend to try to find, yeah it's a step, constant to you than most...if I can get a psychologist for twenty minutes I would run to them for mission critical...stuff that's imperium absolute dangerous.... Sort of thing you have to get to the conclusion where, you know you are not gonna do with it. And the thing is... from there you know where to get to (Section 7, Paragraph 111-116).

Bill

I can understand when the 911 happenings some people go to a psychologist to seek help, that's something beyond anyone control. So in cases like this you should probably see a psychologist. Cause that's something that doesn't happen in everyday life and probably it's hard to feel or what to feel about it, yeah. Yeah, I would consider it myself. I mean I would consider it as a last source any way. But if something like that occurs to me, yeah (Silence for 6 sec) I wouldn't hesitate (Section 6.1, Paragraph 60 and section 11, paragraph 113)

Carl

It's kind of something extreme, last resort (Section 6.1, Paragraph 71).

Fredric

Yeah drastic circumstances (Section 7, Paragraph 60).

Negative attitudes toward seeking help in general became clearer after discussing the conditions of seeking help in the case of depression. The interpretation of the traditional men's various answers suggested that there are three different sorts of conditions which would force them to seek professional help in the case of depression; namely: severity of depression itself, social conditions surrounding the experience of depression, and to appease a court system or satisfy a vocation.

1. Severity of Depression Itself

According to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (American Psychiatric Association, 2000) the diagnostic guidebook used by most clinicians and psychiatrists throughout the world, depression can be categorised into subtypes by difference in severity: mild, moderate, and severe. In the present study, the respondents reported that what would have made them, or would make them, seek professional help in the future, is the severity of their depression. According to the respondents, the severity of depression is relative to one or more of the following three circumstances: depression is continuously bad or recurring, presence of suicidal thoughts, and depression that impairs daily life (American Psychiatric Association, 1998).

a. Bad Depression: Getting Worse or Recurring

In accordance with various research studies about depression in men, both in general (eg Robertson, 2001), and in traditional men (Good et al., 1989; Good & Sherrod, 2001; Good & Wood, 1995), the respondents in the present study reported that they did not seek help in the past because they did not have high level of distress. For the participants, as long as depression is “mini or general depression”, which clinicians would describe as mild (American Psychiatric Association, 1998) or covert depression (Real, 1997), they do not feel the need to seek professional help, because they believe they still have control over the situation and they have their friends’ support. If they had felt that depression was continuous or getting worse and the situation was beyond their control or the power of their social network, they said that they would have sought help outside their ordinary circles, not necessarily professional help, but help in general. The following extracts from the interviewees illustrate this:

Bill

Long time bases? Umm, I guess at some stage I would consult a psychologist but unless I feel really, really, really dark. As a last source probably. Like I've said if I can't solve it I don't know if anybody else can do it for me (Section 6.5, Paragraph 64)

Carl

emm, if you can see it's getting worse and worse I would (Section 6.1, Paragraph 71)

George

what is the major reason that would have made you seek help?...That would be continuously feel depressed Definitely if there was a quite bad depression I think this time I would go and get professional help(Section 1, Paragraph 5-223).

Some of the participants reported that if their previous experience with depression would repeat itself in the same way, or was worse, they would seek professional help. One reason was to prevent the previous bad experience with depression happening again in the future. Another reason was because it is a concern that the experience is not temporary but recurrent and can happen again. The extract from George put it this way:

George

Because of, that I have had experiences before I know that this time that I would go and get professional help to prevent it from being that feeling that way again, in the future... similar to before, yeah, I would go...Cause I'd know then it will be it's a concern, because it's recurring...if it was a more a general feeling, like you get to know the feeling to judge your own feeling, like same sort of feeling coming across again and the same thoughts, then I would, I think I would go and get help. If it's the same sort of, ehhhhhh, (silence for 6 sec). If that feeling start to come across again like it was, something to be concerned about, I would (silence for 5 sec). Get help, yeah (Section 1, Paragraph 223, 232-236 and 250)

b. Suicidal Thoughts

Another factor that the participants positioned as crucial and alarming and which would lead to their decision to seek professional help is the presence of suicidal thoughts. The following responses are indicative:

Albert

I mean unless I thought how to jump off a cliff in that case I'll probably be strained first (Laugh) (Section 7, Paragraph 112)

Harry

If I had to, like if I thought about say taking my own life or something like that. Then that way I'd totally go and get help (Section 2, Paragraph 92)

Researchers and clinicians advise that any male who is depressed, or who is being treated for depression, should be considered at increased risk for suicide (Cochran & Rabinowitz, 2003). And it is even more critical that he be seen by a professional immediately if he shows any signs of suicidality or suicidal thoughts (Francis-Cheung & Grey, 2002). For a man who feels suicidal, and particularly a traditional man, there is nothing more demoralising than to ask for help and to feel that others do not take him seriously, as he would invariably have taken some time to pluck up the courage to tell anybody about it (Morgan et al., 1998). Asking for help requires the "traditional men to set aside much of their masculine socialization simply to get through the door and ask for help" (Robertson, 2001, p.148). Thus, a man who feels suicidal and who asks for help should be always taken seriously and immediately.

c. Impairment of Daily Life

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 2000) and most researchers (e.g. Stoppard, 2000), consider depression to be severe when it starts to interfere with the person. They all agree that depression can vary between mild, moderate, and severe. In mild depression there is some impairment of daily life, in moderate there is significant impairment in daily life. In severe depression, or overt depression (Real, 1997) most activities of daily life are virtually impossible (American Psychiatric Association, 1994).

In the present study, respondents reported that if their depression had been acute and dramatic to the extent that it was impairing their daily life and affecting the life of others too (American Psychiatric Association, 1994), they would have sought help. For some participants, the issue of impairment is really important to the extent that they have reported that even if they did not realise that their depression was affecting their relationships with other people, it would have been enough for somebody to bring the issue to their attention to make them seek help. The following extracts illustrate this:

Carl

If it's affecting you know, yeah, everyday living (Section 6.1, Paragraph 71)

George

and it was affecting my life and the people around me then I would have gone and sought help...If it was affecting my quality of life and I not be able to enjoy, enjoy things I'd definitely seek help. And even if I didn't know it like hmmm, like someone third party would have said it's affecting my life in regards my relationship with other people then I would. I'd take theirs, that sort of point of view and I'll take that into mine, and probably see, seek help. (Section 1, Paragraph 110)

In summary, the severity of the depression in the form of impaired daily lives of the depressed themselves and the lives of others, the continuity and recurrence of the experience of depression, and the presence of suicidal thoughts all are positioned as important and crucial factors in facilitating the process of traditional men setting "aside much of their masculine socialisation and to get through the door and ask for help." (Robertson, 2001)

2. Social Conditions Surrounding the Experience of Depression

Apart from the severity of the depression itself, the respondents suggested that they would have sought professional help if there were social circumstances related to, or

surrounding, their experience of depression, and they named three conditions: social loss, absence of social support, or a close person's positive experience with professional help.

a. Social Loss

In a previous section of this chapter, titled "the causes of depression", the participants reported that social loss was one of the things that was most likely to push them into a serious depression, confirming previous research (American Psychiatric Association 1998; Royal College of Psychiatrists, 1998; Overholser, 1990). It seems that social loss was also one of the reasons most likely to make the participants think about seeking professional help. Consistent with previous research (e.g. Rule et al., 1994) the results of the participants in the present study, reveal the importance of interpersonal (particularly family and friends) issues, and the likelihood of seeking professional help. According to the respondents, death or something happening to a friend or any family member is a huge event. They have predicted that they would not be able to cope with that and they would need to seek professional help. For instance, some interviewees said:

Bill

I guess if it's a huge event in your life. Like a loss of your friend through an accident (Section 6.1, Paragraph 60)

Edward

The major reason em that would be maybe trouble in the family. I don't really care about myself...I mean if something happened to my family...I value and became to realise how much my family worth to me. You know? My sister, my brothers how much they helped out and everything. And if anything happened to them... I'm just hoping like I haven't come across the situation...My mom's brothers and sisters and dad's brothers and sisters over time, recent time, they passed away (Section 7, Paragraph90-91)

Fredric

There would be a very dire circumstances for me to have to see someone, like maybe death in the family that I'm not able to cope with and I really need to speak to a professional (Section 7, Paragraph 60)

Similarly, the men remarked that breaking up with a good friend, a girl friend, or a spouse is also distressing and they might not be able to bear it, and probably they would seek professional help. Consistent with previous research (American Psychiatric Association 1998; Royal College of Psychiatrists, 1998) the respondents reported that breaking up, especially with a spouse (getting divorce), would be a major psychological cause of depression that would require professional assistance. The following responses are indicative:

Daniel

Probably, break up in a really good relationship. Like whether being a really with one of my best friends, something happens, or a girl friend I've been with for a very long time. Emm, I think something that would hit me, as in like emotionally. Or probably death in the family another issue. Emm, I don't know (silence for 6 sec). That's about it, probably (Section 6, Paragraph 123).

Edward

been noticing how people all over, you know, all around me most of the time getting married, getting divorced, getting married, getting divorced; you know what I mean? And I just thought to myself again that would be something that I'm not be able to bear; something like that would force me to freaking buy a gun and start running after to get divorce (Laughs) you know what I mean? And now I see it that maybe there's something severe did happen to me, you know? I might be able to calm myself down by seeing a psychologist, and speaking to him and letting him... (Section 13, Paragraph 139)

b. Absence of Social Support

It was reported earlier, in discussing the causes of depression in traditional men, that absence of social support could lead to depression. Again absence of social support was positioned as a reason that would activate traditional men to seek professional help. According to the respondents, if they were depressed and there was nobody to talk to, seeking professional help would not be an option except in a relatively bad depression and in extreme circumstances of isolation (Good et al, 1989; Good & Sherrod, 2001; Good & Wood, 1995). The findings support Kemp's (1989) and Cook's (1984)

conclusion that people have a strong preference for close friends or relatives over counselling psychologists and clergy. One of the interviewees described the situation as follows:

Carl

It's probably if I was that depressed and there's nobody to speak to, no one absolutely no one, it's probably I would seek help. It's probably to the extreme if there's nobody out there; If it's the last resort sort to speak I would definitely, yeah...If it was and I didn't have people there but I need more than that I would seek help (Section 6.1, Paragraph 70- 71).

Another interviewee said

Fredric

If I really get depressed. If I really get depressed and I had no one around that is a stable good friend of mine that I could talk to, then I can think ok who would be best. My guess is a professional. Let's say if I went overseas and had no friends and something really happened, you know, and I really needed to talk to someone I may do that (Section 7, Paragraph 59)

The above findings in a way sustain the proposed view of this thesis, that adherence to the traditional male gender role may be a source of hesitation towards using mental health services and, consequently, there is a significant relationship between the male gender role and men's help-seeking attitudes and behaviours (Good et al., 1989). Furthermore, the results seem to substantiate the importance of assistance and support from friends and family in encouraging optimism and self-esteem, buffering the stresses of being ill, reducing patient depression, improving sick-role behaviour, and giving practical assistance (Connell et al., 1994; Monroe, 1983; Shumaker & Hill, 1991; Wallston et al., 1983; Windle, 1992) and at the same time decreasing the demand for professional help.

c. Close Person's Positive Experience

The interpretation of the participants' various responses in regards to the reasons for which depressed traditional men seek professional help can assume also that previous experience with depression and seeking professional help from people with whom the

traditional men have a close or qualitative relationship (DiMatteo, 2004; Lewis & Rook, 1999; Umberson, 1987), may result, directly or indirectly, in either facilitating or inhibiting the seeking help attitude in traditional men. The following extracts make this manifest:

Carl

I know someone who's going to a psychologist now, or who has seen a psychologist and he's on medication. And I, for me from a different perspective there's no problem in that. I think if you are ill and you need help you seek help. And it's good if they can provide you help. Personally, this person is on medication after has been to a psychologist and she was embarrassed that I saw the tablets, the medicine she was taking, she actually hidden it from me. As soon I saw it I knew what it was because I've seen or heard about it before. And yeah she was hiding it from me but then I said to her it's ok. And she said: "this is a medicine to help her do this, do that." And I said: "I've got no problem just, you know, take it you are not feeling well and that's what the doctor prescribed." Yeah and that how I see from a different perspective and I can understand where they are coming from. And by being on the other side I can see if I was to see a psychologist I don't think there should be a problem (Section 5, Paragraph 40).

Daniel

I learned that it helps the person in major way. Because they helped my brother to get through his depression stage...My friend saw a psychologist with his family and he sort of influenced me by like his experience with the therapist. Because I guess you can say that like he's very manipulative him-self and he sort of saw the psychologist manipulating him and he sort of manipulating back. So it was a bit sort of artificial in a way and it was not genuine, as I would have liked it to be. I guess that sort of influenced in a negative way, but then again through my brother's depression period that influenced in a huge positive, positive effect (Section 19, Paragraph 181 and 182)

The findings at the level of social conditions surrounding depression suggest that in a traditional man's life, it is important to assess the aspect of social loss, the presence and absence of social support, and to consider the influence of social relationships and experiences in order to understand the reasons that could facilitate the seeking help attitude in men and consequently assist in relieving the depressed from his stressor.

3. Other Reasons: To Appease a Court System or Satisfy a Vocation

An examination of traditional men's responses in the present study suggests that apart from the severity of depression and the social conditions surrounding depression, they reported that they may seek professional help if they were mandated or forced to see a therapist, for instance to appease a court system or order. As one participant said:

Harry

If I did something, and say I got a court order and they say you have to see a psychologist I'd go there would be nothing that can stop from that (Section 2, Paragraph 87).

Similarly, to satisfy the requirements of a vocation paying a lot of money, another interviewee remarked:

Fredric

if I was in some kind of vocation that demanded I see someone, and that vocation would have to be paying me a lot of money (Section 7, Paragraph 54)

According to many researchers (Shay, 1996; McCarthy et al., 2004) a man may enter therapy for alternative goals or reasons other than simply the desire for therapeutic support. A client who is legally mandated to see a counsellor may want to appease the court system, satisfy job requirements or placate a partner but not explore issues (McCarthy et al., 2004). Such therapy is not always helpful. In such cases, Shay (1996) advised professionals not to try too hard in the counselling process, because it can be counterproductive. He advised professionals to take less conventional approaches, and to apply a more concrete manner from the beginning. Shay (1996), based on his clinical experience with men, advised professionals to speak with reluctant men "in great detail about the nature of their business interactions, about the movies they've seen, about the sporting events they watch", a route by which men are encouraged to be more open and offer more about themselves (McCarthy et al., 2004).

In summary, an examination of men's responses revealed that traditional men are hesitant to seek professional help, except in certain crucial conditions, namely: severe depression (exp. presence of suicidal thoughts), social conditions surrounding the experience of depression (ie. absence of social support or close people positive experience with therapy), or other mandatory conditions (for instance judicial).

B. Professional Help Preferences

Closely related to the conditions under which traditional men are prepared to enter and undertake counselling is the choice of help (Beutler & Clarkin, 1990; Beutler & Harwood, 1995). Several ideas and suggestions regarding professional help were proposed by the traditional men in the present study. The following section summarises a number of them along three themes: biomedical vs. psychological therapies, one-on-one vs. group therapy, and the most favourite psychological therapies vs. the least favourite ones.

1. Biomedical VS Psychological Therapies

In the present study, the participants reported that, in general, it is easier for them to seek medical help than psychological help. The men's reason was that they want quick relief from their sufferings. While medical help can provide this condition in the case of physical diseases, they do not think that psychological therapy provides this condition in the case of psychological disorders (Bedi et al., 2000; Ward et al., 2000).

Bill

No it isn't like seeing a doctor. If you feel really bad physically you go and see a doctor, to get a shot or to get prescription because that help directly. I don't think seeing a psychologist just for feeling bad for one day gonna make you feel better. I mean you're gonna feel better tomorrow any way (Section 6.3, Paragraph 62).

Harry

Like if I thought therapy is an easier way out I would. Go for the easiest option, and do it. Because I'm one of those people that might be in pain and suffer but I wanna it to end now and then, now, today, stop, that's it (whistle) over (Section 2, Paragraph 167).

However, the participants in the present study, in parallel with various other research studies (Priest et al., 1996; Lam, R. 2001), reported that they would not seek medical or biomedical therapy for psychological reasons, and showed preference toward non-medication treatments, such as counselling, for treatment of depression.

An analysis of the participants' comments regarding biomedical therapy shows that it relies on two ideas:

First, that the nature or origins of the problem are positioned as defining the nature of suitable therapy. As such, psychological problems are positioned as requiring psychological therapies, though it is not always an easy option to seek psychological help.

The extract from Carl expresses this:

I think the most appropriate one would be psychological therapy because that's what you are suffering from. But it wouldn't be as easily available as say physical therapy: massage, relaxation, what have you. But yeah, if it's mental and. Basically if I need to seek therapy I would consider what would help most, and that's psychological, definitely psychological (Section 7, Paragraph 78).

Second, that medicine or drugs, given in biomedical therapy, are positioned as neither suitable nor similar to therapy to deal with depression. Medicine is just repressive of the symptoms but does not solve the actual problem. Furthermore, medicine stops the person from being himself and makes him addicted, whether the person likes it or not. Thus one man, Albert, said:

I don't tend to trust more scientific looking or medical sort of. I definitely don't trust medicine to a degree, cause the fact is that I've being trained up, is not exactly my idea of therapy, you know (Laugh). There is nothing in particularly messed. The fact you can get some drug it really worth it...the other thing is repressive, yeah as in like medication is a repressive

type. As in you know, as in like you stop to react in a certain way when this happens and this happens. I don't think you like that cause the fact that you stop thinking from time to time as in like some times you have to take the pill regards you like or not (Laugh) (Section 8, Paragraph 119-122)

Similarly, another interviewee, Harry:

I'd go to my GP first and get him to refer me to someone but I wouldn't just take medication because I could be taking them for the wrong reasons. You know what I mean? If there's a problem I got find out what it is and work on that and not take medication to feel better. Because once the medication stops there problem still be there (Section 2, Paragraph 101)

From the interpretation of men's comments regarding biomedical help and depression, it can be concluded that traditional men have a preference toward non-medical therapies to deal with depression, such as psychological therapies, even though it does not provide the quick relief they want.

2. One on One VS Group Therapy

Consistent with other research that suggests that gender-role conflicted men (or traditional men) have more negative mood reactions to group therapy (Robertson & Fitzgerald, 1992; Blazina & Marks, 2001), the majority of the traditional men in the present study reported a preference for one-on-one psychotherapy or counselling.

Fredric

I've never really considered various types of therapy. If I ever came to my mind it would have been the one on one counselling type of psychotherapy (Section 8, Paragraph 64)

George

more one on one. For one like speaking and getting feedback from them. What's the name for that? Psychotherapy? Is that what it is? Yeah, psychotherapy. Yeah (Section 1, Paragraph 143).

The participants, in accordance with the strict "code of masculinity" (Pollack & Levant, 1998) and the set of culturally embedded standards of appropriate masculine behaviour (Levant, 1998) such as "Big boys don't cry" (Good & Sherrod, 2001), or men do not talk

about their weakness (Real, 1997), explained that their preference of one-on-one is because they prefer not to share their experience with others or strangers, and they would rather cooperate with one person such as a professional helper (Levant, 1990). The extract below illustrates that.

Carl

And people tend to keep it to themselves as well so I guess that's why you have one on one therapy, and people who don't like to share with the world they just share with their psychiatrist, something more of in-house (Section 12, Paragraph 131)

One participant expressed his interest in pursuing group therapy in the case of depression, comparing it to the alcohol anonymous therapy model. The following extract from Harry illustrates this:

Harry

I'd rather do things like as a group...A bit like alcohol anonymous, they do it all together and it works a lot better than this one on one...Set up with more than one person and with the same sort of problem can work it that way (Section 2, Paragraph 104)

In accordance with what previous researchers have found (e.g. Rabinowitz, 2001; Robertson, 2001), one of the participants, Harry, positioned counselling and therapy groups as very efficient, because even if somebody does not want to talk or is too embarrassed to ask questions, there is always somebody who would dare to ask and to share. The group atmosphere encourages men to improve their communication skills by presenting opportunities for them to share with others and also assists them in establishing friends and emotional connections with others (Robertson, 2001) and that could be an supplementary incentive for men to attend the sessions more frequently. The following extract put it this way:

Harry

They should get people that have the same issues and do like workshops together and then let them all work on together workshop that way, because there could be stuff you don't understand, you don't want to ask and stuff like that. But there's always someone who would ask question you want to and you will feel more encouraged and stuff like that. And I reckon you can resolve things faster too and people would feel better with themselves. And they'd attended more because they might be making friends there as well. And they can talk to their friends about it...And even if "Joe Blow" did not want to say what's wrong with him "Tim" and "Sim" could say for "Joe blow" what's wrong with him and they can discuss it as a whole. And there'd be people of the same sort of issue and they can, umm, you know? With one stone kill many birds (Section 2, Paragraph 104-105).

Though the majority of the participants expressed more interest in one on one therapy, previous research has suggested (Blazina & Watkins, 1996; Tracey, 1985) that issues of power and expression of emotions may play into gender-role conflicted men's negative attitudes toward therapy. Men's anticipation of losing power and expressing emotions may cause gender-role conflicted men, in part, to terminate one on one therapy early.

As for group therapy, some researchers have suggested that group therapy can meet the problem of gender-role conflicted men's negative attitudes toward one on one therapy or traditional therapy, but in order not to run counter to men's socialization, they suggested that such therapy should be specially designed for men (Williams & Myer, 1992). Therapy for men includes men's groups, weekends, or retreats where the traditional socialization of non-emotional disclosure and vulnerability are reversed (Williams & Myer, 1992). In these settings, men are encouraged to be more emotionally disclosing in the presence of other men while not suffering traditional social stigma or sanctions. Utilising the group process in a workshop format, O'Neil (1996) established a Gender Role Journey Workshop where men and women mutually explore attitudes toward gender-role socialization, role definitions, and sexism. Finally, Eichenfield (1996)

discussed a support-group approach where male students and members of the community meet at university-based mental health clinics to discuss gender issues and strain.

Men's group therapy seems to be gaining a legitimate place in helping men discuss gender-related strains and issues. However, this alternative modality may not be the best preference or, at least initially the most appropriate for the majority of traditional men because of the expectation of disclosure within the group format. Group therapy in traditional men's perspectives may be the most difficult of both worlds: expectations to go against social norms to disclose emotionally while doing it in front of other gender-role conflicted men. That is why traditional therapy, or one on one therapy, is preferable for traditional men.

3. The Most and Least Favourite Psychological Therapies

Psychotherapeutic approaches, which deal with depression, vary, but they all seem to produce similar results (Depression Guideline Panel, 1993). The therapies that deal with depression either target the depressive symptoms (cognitive or behavioural therapies) or specific interpersonal or current psychosocial problems related to the depression (marital therapy, psychoanalysis and related therapies: interpersonal psychotherapy, brief dynamic psychotherapy.) (American Psychiatric Association, 1998; Fadem et al., 1997; Depression Guideline Panel, 1993). The following section describes the participants' attitude to proposed psychotherapeutic approaches, with which they would or would not seek to deal if depressed.

a. Preferred Therapies: Psychoanalysis and Related Therapies

In the present research, none of the participants expressed interest in the therapies that target depression directly (cognitive or behavioural therapies). Most of the traditional men

reported their preference for therapies that target specific interpersonal or current psychosocial problems related to the depression, particularly psychoanalysis and related therapies (Fadem et al., 1997).

Sigmund Freud, the father of the psychoanalytic school, suggested that depression was a form of internalised violence due to repressed experiences, and he developed and used what today are known as psychoanalytic techniques (free association, transference analysis, and resistance analysis) to recover the repressed material to help the patient recover from depression and other psychological disorders (Fadem, 1997; Freud, 1985). Psychoanalysis is the basis for a range of psychotherapies considered to be very efficient in dealing with depression (American Psychiatric Association, 1998; Fadem, 1997).

The participants who expressed interest in and preference for psychoanalytic therapy explained that their preference is initially based on the fact that they can talk about what they want and let it all out (free association), and at the same time the psychoanalyst would listen to them, access their out of sight experiences (repressed experiences), and integrate those experiences into their personalities. In other words the participants are interested in the underlying strategy of psychoanalysis (Fadem, 1997). The following extract makes this manifest:

Edward

I go for psychoanalysis basically because I can talk a lot (laughs), I can talk a lot but I won't be able to...I love letting it all out, you know what I mean? Because it just relieves you. em, am, to be able to sit there and just talk, talk, talk, talk, talk, talk it right through and em, let the person, the person know what you are talking about, you know? And let him see the points and things where you are missing out. Simply I enjoy, I would enjoy, not enjoy but I would relieve myself in letting it out. And the person, who is overseeing, more knowledgeable in the field, he knows about it, he will be able to listen and he'll be able to see. Because why I would...Em, I would rather him understand exactly where I'm coming from, what's happening, why I've been depressed, blah blah blah that would make me feel comfortable. You know?...And simply also because it

sounds like a more calm and relaxed way of expressing what things has happened blah blah blah (Section 8, Paragraph 108).

Interpersonal therapy is considered to be one of the therapies related to psychoanalysis (Fadem et al., 1997; APA, 1998). In a meta-analysis review study on the efficacy of interpersonal psychotherapy in comparison to various other therapies (Elkin et al., 1989), the efficacy of interpersonal psychotherapy exceeded that of cognitive therapy by 13.2 percent, that of placebo plus clinical management by 22.6 percent, and that of Imipramine by 12.3 percent. Interpersonal psychotherapy did significantly improve social functioning. Further research failed to find a lower relapse rate in interpersonal psychotherapy responders than in responders to the other three acute treatments in an 18-month follow up (Shea et al., 1992).

In the present research, an analysis of the participants' description and expectations of any other therapy that they favoured suggested that they value interpersonal therapy for treating depression. The expectations and needs of the traditional men from therapy, coincide with the aims of interpersonal therapy for depression, namely the clarification and resolution of interpersonal skills' difficulties that are causing, concomitant to, or maintaining depression (Depression Guideline Panel, 1993; Fadem et al., 1997), and that the therapist helps the patients to define the nature of the interpersonal difficulty and work to resolve it. As one man put it:

Daniel

But I guess one therapy that would probably help me into organising my life. Like sort of knowing what I really want to do in life and helping me sort of find that. And, and sort of help me manage my life well. So, yeah. Only if it can help me find where I wanna be because this is what I find hard in trying to do. Yeah (Section 7, Paragraph 132)

However none of the participants explained why they had this preference for interpersonal therapy.

Hypnosis is considered to be a psychoanalysis related therapy (Ousby, 1990), and psychoanalysis came into existence as a result of hypnotic experiments (Ousby, 1990). Hypnosis was used largely in psychoanalysis as a means of discovering the hidden forms, content and operations of the unconscious (Ousby, 1990). Psychoanalysis together with other branches of medical science is making increasing use of hypnotism as a tool (Mamtani & Cimino, 2002).

There is sufficient evidence to show hypnosis can effectively reduce anxiety and help patients with chronic pain, insomnia and panic disorders (Mamtani & Cimino, 2002). Its usefulness is also documented in patients with cancer for significant reduction in anxiety, increase in fighting spirit, with an improved sense of coping and improved sleep (Wright et al, 2002). Additionally, hypnosis can successfully complement the effects of Cognitive Behavioural Therapy (CBT) for treatment of phobia and obesity (Vickers & Zollman, 1999). Hypnosis has also been found to be valuable in asthma and irritable bowel syndrome (Vickers & Zollman, 1999).

In most of the literature (e.g. Mamtani & Cimino, 2002; Vickers & Zollman, 1999; Wright et al., 2002), hypnosis seems to have an effect on certain of depression's symptoms (e.g. sleep, food intake) or related factors that can affect depression (e.g. coping, fighting spirit), but none of the research indicates a direct relation between hypnosis and depression. In the present study, coinciding with previous studies (e.g. Graham & Harris, 1981) the participants said that they would consider using hypnosis for urgent problems such as depression. According to the participants, hypnosis in itself is very interesting, and as a tool it could be very helpful in achieving a sort of internal

catharsis “detox”, in which all that is bad, repressed and causing depression would be brought out and consequently might lead to a change in perception or insight, which might help in alleviating depression. The following extract illustrates this:

Fredric

Hypnosis is very interesting and all of that would be interesting and I think it would maybe release something like a detox, like really get it out and then you might see things differently. Yeah I could maybe be persuaded into that (Section 8, Paragraph 72).

In general, the traditional men supported the traditional and classical therapies of psychoanalysis. This does not necessarily mean that the participants think that those therapies have greater efficacy, but just that they prefer the traditional therapies. The preference for psychoanalytic related therapies and particularly hypnosis, even though research does not show that it alleviates depression directly (e.g. Mamtani & Cimino, 2002; Vickers & Zollman, 1999; Wright et al., 2002), might be based on what they know or inaccurate or false information related to the stigma associated with mental illness (Real, 1997; Lam, 2001) that traditional men try to avoid (Good et al., 2001; Mahalik et al., 1995; O’Neil, 1996; Real, 1997). It was not based on previous experience with therapy because none of the participants have had any experience of therapy, as reported and discussed in detail in the following sections.

b. Least Favourite Therapies: Virtual Help

Online help (virtual or cyber assistance), defined as the provision of mental health services through the Internet, is a growing field that has attracted an abundance of interest in recent years (Cook & Doyle, 2002). Since the mid-1990s (Powell, 1998), many have started using the Internet as a medium through which to receive mental health services.

Recent research (Rainie et al., 2001) indicates that more than 14% of American adults with Internet access go online to find mental health information.

In the present study, and consistent with previous research that has found that many men do not like using the Internet for mental health information and services (Cook & Doyle, 2002; Powell, 1998; Rainie et al., 2000; Stubbs, 2000), the traditional men disclosed that they would just use the online self-report questionnaires as a screening tool to detect if they were depressed or not, but they would not use any other form of online psychological help, whether virtual therapy or support, even if it were anonymous.

Carl

You would like to speak. Talking is more important, more important. But for me if to see a psychiatrist and I was hesitant and there's this form that was on the net to fill out I'd say ok let's have a go anyway. It's not gonna hurt, no one's here, no one would know about it (Section 12, Paragraph 142-146)

Researcher

Is what you are saying you would take it as diagnosis but not as therapy?

Carl

yes exactly, exactly, yeah. Talking would help more giving of your chest. I need to talk (Section 12, Paragraph 146-149)

The findings have also uncovered the participants' concerns regarding limitations of cyber-therapy on one hand and the nature of people on the other hand.

From the interviews, it would seem that the interviewees perceive the online services as having two limitations: very impersonal and very anonymous. The participants reported that the online service could be very impersonal because the other person online might be some sort of made up entity, such as a robot or intelligent software, and not a human being. The participants added that they would feel ridiculous if they were sharing their emotions and thoughts with the computer (software or robot). The following quotes illustrate this:

Albert

If you want to talk to someone you got to talk to someone that you can actually see and who is you actually know he's human rather some made up... who know I can be talking to some sort of really smart robot (laugh). I mean we are getting close to that point (laugh). (Section 16, Paragraph 165)

Carl

No, no. Human, human. I wouldn't talk to a computer (laughs) no (laughs) no. No I wouldn't do it. I won't be serious about it anyway. You won't reveal your emotions, you know, to a computer. You'll think this is ridiculous (laughs). Human.(Section 12, Paragraph 153)

Furthermore, the participants suggested that even if the other online was a human, the relation would still be impersonal because they would never be able to meet, know each other genuinely in person, or make friends.

Albert

As in when I meet people on the net, they'll never meet me, they'll never make friends, and they'll know what I'm really like. Because the fact is that all they know is a person, they won't know a name and won't see my face. They will see me but they won't see what on me... (Section 16, Paragraph 159)

Anonymity, or perceived anonymity, may foster intimacy by increasing the amount of personal, self-disclosure in friendships on the Internet, because the fear of rejection present in face-to-face relationships does not exist. Consequently people are often more frank when they feel anonymous, as many do over the Internet, and this leads indirectly to greater intimacy (McKenna, 1998). However, despite this the respondents commented that online psychological services would never work and they would not recommend them, even if the other online is a human and that is because of its very anonymity. For the participants, anonymity is a problem, and especially in the case of virtual therapy because of the inability to verify the provider and the provider's credentials and competence level (Smith & Reynolds, 2002); Bill Gates, the postmaster of the service, or

just any person online can pretend to be a therapist. This is portrayed in the following excerpts:

Albert

No it would not work (laugh). I will not recommend it. It's to a degree as in like, I talk to my friends about it cause the fact I know them but the thing is I couldn't do therapy on-line with nobody cause the fact that you don't know who is on the other side...I don't want to be anonymous, just the fact that how would I know the other, I mean if I went to a psychologist I want somebody who actually I can, you know, I mean maybe check credentials. I don't want to check credentials, but you know, I want to know that the person I'm talking to really does have the experience. So, yeah, it could be anyone from what, he could be anyone from Bill Gates, the postmaster and up, you don't know... I wouldn't recommend a totally anonymous (Section 16, Paragraph 162 and 165)

Harry

I can go on the chat line now and someone goes on I'm upset and I can pretend to be a psychiatrist, so what's wrong? (Section 2, Paragraph 175)

Because of all of the above reasons, the participants suggested that no matter what the conditions, they prefer to meet people face to face to know them and to understand with whom they are dealing.

Daniel

It's better to be in person. I think it's a bit more personal that way...I'd like actually to meet the person that I'm talking to and sort of get to know them in a way; so I know who I'm dealing with and whose trying to help me (silence for 5 sec) em (Section 20, Paragraph 185)

Harry

Prefer face to face (Section 2, Paragraphs 178-180).

There is empirical research regarding the effectiveness of online therapy, however several published studies are finding similar outcomes between traditional, face-to-face therapy and online therapy (Cohen & Kerr 1998; Barak & Wender, 2000). For the traditional men, virtual therapy could arguably work, but for them being with the therapist in the same room is not so bad that they will avoid it. The personal interaction and knowing that the person they are dealing with is real, is more important. In the cases where face to face

was not available, the participants in the present study, as was suggested in other recent studies (Smith & Reynolds, 2002), suggested having some sort of audiovisual conference (camera and sound), but still as a last resort.

Albert

At least if you knew the person or emmm, on line I recommend if you have full telecommunication service, conference room here, conference room there, and link up. I expect the only thing that could be close to as in, you know, you got TV screen, full voice full sight from both sides. That's the only thing I'd recommend that's close. That probably as the last resort. Cause, emmm the message that you need it: know that person there is real. You need some sort of contact. I mean that's the thing, arguably speaking you could work, I mean therapy arguably could work but I wouldn't recommend it as in you know, do it straight away sort of thing. I wouldn't recommend it as the best thing to do...I prefer some sort of visual, probably visual at least, visual and voice contact. I don't see being in the same room as a bad thing (Laugh) (Section 16, Paragraph 162 and 165).

Because of the nature of people in general, not the nature or the limitations of online services, the findings of this study indicated that the participants doubt the efficiency of virtual support or group support online (Davison et al., 2000) where no credentials are needed. Some participants distrust the intentions of people online because of their previous personal experience online, they believe that the majority of people are self-centred and do not care for anybody but themselves.

Albert

That generally speaking 99% of the people on the net tend to be absolute outlet selfish bastards (laugh). That's just me because I've just dealt with that sort of people (Section 5, Paragraph 59)

Other respondents reported that they think that people care, but cannot be fully trusted. According to those participants, people who care or support a depressed person would not say the whole truth to the depressed, they would just tell the person what he/she wants to hear to distract the person from thinking negatively and falling into depression.

Harry

Do this, do that, don't worry about it you will be all right. blablabla. Like I said it feels like just they telling you everything you wanna hear, don't think of the negatives (Section 2, Paragraph 175)

In contradiction to a panel of experts using Delphi methodology who forecasted that in the next eight years classical psychoanalysis is expected to decline and "virtual" therapy services are expected to flourish (Norcross et al, 2002), and in contradiction to the researcher's personal expectations that traditional men would seek such professional help because it is anonymous, the respondents positioned anonymity as a limitation that does not make them feel comfortable to use online psychological services.

In summary, the findings of this section, "Seeking Professional Help", in accordance with various other research studies (e.g. Good et al., 1989) propose that adherence to the traditional male gender role could be a source of hesitation in seeking professional help. When it comes to help traditional men have specific preferences. They prefer non-medical therapies to deal with depression, such as psychological therapies, even though that does not provide the quick relief they want. Furthermore the majority of traditional men prefer one-on-one therapy to group therapy, and particularly they prefer the classical therapies of psychoanalysis. They dislike the non-classical therapies and especially virtual mental health services, whether for support or therapy, because they perceive them as exceptionally impersonal and anonymous.

IV. Barriers to Help Seeking

The mental health professions have a long history of researching the components and factors that influence professional help seeking. One reason for continued interest in this topic is that counsellors and psychotherapists recognise that people's attitudes and

behaviours affect both the utilisation and success of mental health services (Stiles et al., 1986; Grencavage & Norcross, 1990).

In 1970, Fischer and Turner began a program of research to identify characteristics and behaviours related to the attitudes people have about seeking help from mental health professionals, and they discovered strong gender differences in help-seeking, with females being more open to seeking professional help. Gender differences in help-seeking have been replicated across demographic groups and national boundaries. (Garland & Zigler, 1994; Rickwood & Braithwaite, 1994; Husaini et al., 1994). Research has shown that sexual orientation does not alter the typical pattern at all, with gay men being much less likely to seek counselling than lesbians (Modcrin & Wyers, 1990).

Research studies (Good & Wood, 1995; Wisch et al., 1995) that have focused on working out what it is about the psychology of gender that is important in predicting different attitudes toward seeking help, indicate that those who adopt stereotypically masculine attitudes, especially restricted emotionality, limited expression of affection for other males, and dedication to work at the expense of family, have less willingness to seek help.

In addition to gender, researchers have studied the impact of various other factors on help seeking attitudes. Deane and Chamberlain (1994) studied people's fears about what others might think of them as a barrier to seeking professional help. The study suggested that people's own stereotypes about, and fears related to, mental illness itself, could be a barrier for being in therapy. This could be called self-stigmatisation (Deane & Chamberlain, 1994). Kushner and Sher (1989) found that the people who fear and avoid therapy most are those who admit that they needed it in the past but did not seek it. Such negative attitudes have been labelled avoidance factors (Kushner & Sher, 1989; Deane & Chamberlain, 1994).

Bayer and Peay (1997) reported that confidence in mental health professionals, and a belief that others would approve, encourage a help-seeking attitude. Shame and embarrassment, fears of painful self-discovery and of hospitalisation, beliefs that no-one could help, and lack of information about services have also been reported as barriers (Belle, 1982; Wells et al., 1994; Small, Brown, Lumley, & Astbury, 1994; Meltzer et al., 2000). Research has consistently found cost to be the only structural barrier from a list of structural barriers such as transport and opening times, to be mentioned by interviewees as a reason for not accessing help (e.g. Wells et al., 1994; Outram et al., 2004).

This section of the chapter describes the attitudinal and the structural factors that were reported by the traditional men in the present study as barriers to seeking professional help.

A. Structural Barriers

Structural barriers were rarely mentioned in the qualitative interviews. Consistent with previous studies done in the United States, New Zealand and Australia (Wells et al., 1994; Outram et al., 2004) the traditional men in the present study reported that financial barriers were the only structural barrier for not accessing help. Most of the participants reported that they could not afford to visit a psychologist for various reasons: high consultation fees, the necessity for repetitive visits to the therapist for which they had to pay, as well as stating that lack of money was a factor in their depression. The following quotes illustrate this:

Bill

The consultation fees, I don't know, very expensive I reckon. And it's not one of things that doctor gives a prescription and wait for a couple of days and you'll be all right. You have to keep coming back to them and there's no insurance that's gonna solve the problem, right?... Yeah, I guess that's a big issue I don't exactly know how much is the fee but I think it's very dear. I mean the amount of money that you can spend on psychology you

could probably do something else that make yourself feel better (Laugh) without it. (Section 5, Paragraph 46 & 58)

Daniel

Yeah that has something to do with it as well. Yeah. Emm (silence for 5 sec). My parents are not doing that well, and I hate to ask them for money. So, I try to be as independent as I can with financial, like banking and stuff. Yeah, it's a bit hard on my-self to try get by with all the things that I have to pay for already; and I guess a psychiatrist is just would be an extra load on to of that. (Section 5, Paragraph 114)

Edward

THEY COST TOO MUCH (Laughs). 45 dollars an hour? Where to get this mate? (Laughs).

It's not really a price em, the thing is that em... before, at that stage the fact that they do cost a bit, fair bit, which I think around 45 dollars an hour or something, and I was on an apprenticeship, I refused to carry on with it. It's a financial scrutiny that's how I saw it. And part of the deal was that finance has played a big part of the stress in my life, you know? ...But yeah, finance I do think that...still psychologists cost heaps (Laughs). You know? But if I had the money to see them and if it was a necessity to see them then I would see them. (Section 5, Paragraphs 69-70 & 83)

The reason for this result in Australia, where Medicare ensures access to health services, particularly to people who are unable to pay, might be that most respondents, with few exceptions, were not aware of public mental health services.

George

And financially no, nothing would have stopped me, because it's what you call it? Part of Medicare and things like that. Certain psychologists are under Medicare. So that wouldn't have been a problem. (Section 1, Paragraph 84)

Another reason as evidenced from a handful of interviewees, was that they preferred to access a private psychologist rather than a counsellor based at a community health centre.

Albert

If I want to see a psychologist I have to save for like six months (Laugh). I mean well that's a professional, I mean if not talking about professional or part of professional here, as in like gay community based I think it tend to be free or something like that, you know.

But the thing here , sometimes I wonder if I should go to a private one (Section 6.1, Paragraphs 100-101)

Furthermore, the interviewees also reflected the relative unwillingness to pay for psychological services previously reported amongst non-users of such services (Hopson & Cunningham, 1995; Outram et al, 2004). The majority of the participants reported that seeking psychological assistance could be a waste of money because nothing can prove that they are going to benefit from the mental health services. And if talking helps in alleviating depression, they would rather talk to a friend in a cosy environment, and use the money doing something else that can make them feel far better than just getting affirmation from a psychologist. The following excerpts illustrate this:

Fredric

But the thing that would have stopped me from actually getting benefit out of it is the single fact that I'm paying for affirmation. If you pay for something you'll get it but that's only because you pay for it and not because of anything you have done, it's just a monetary thing...even if I could afford it it's not the fact that I'm losing this money it's the fact that.... Ok. We are all humans, we all want to love, and we all want to make love. There's a difference between going up to a beautiful lady giving yourself to her, and then taking her and making love to her and you know whatever, or going to a prostitute giving her a hundred dollars for having sex with her. I see that as exactly the same as going to a psychiatrist or psychologist; giving them money and talking about your problems, or going to a good friend that you respect, sitting there talking about your problems, having tea, eating something. (Section 6, Paragraph 35 & 40)

B. Attitudinal Barriers

The participants identified substantial attitudinal barriers that limited them from taking action to seek professional help. The stated barriers to seeking services, in order of frequency of responses, were men's socialisation, stigma of mental illness, lack of trust in health-care providers, lack of knowledge and misinformation about mental health services, as well as men's feeling of invulnerability regarding health concerns.

1. Stigma of Emotionality

The primary attitudinal barrier in seeking help for the traditional men in the present study was fear of the stigma of emotionality, continuing previous research findings (Blazina & Watkins, 1996; Good & Wood, 1995; Good, Dell, & Mintz, 1989; Heppner, 1995; Levant, 1990; Nadler et al., 1984; O'Neil, 1982; O'Neil et al., 1986; O'Neil, 1990; Robertson, 2001; Robertson & Fitzgerald, 1992; Simonsen et al., 2000; Wisch et al., 1995).

In congruence with previous research on traditional men (Blazina, 1997; Blazina et al., 2001; Blazina & Watkins, 2000; Davies et al., 2001; O'Neil et al., 1986; McCarthy & Holliday, 2004; Real, 1997) the respondents reported that usually they are reserved with their emotions and reluctant to express or share their feelings, whether through talking or crying, with any other individual.

Carl

Yeah, I don't generally talk about emotions, not that much. (Section 8, Paragraph 94)

Edward

eh my emotions always been with me...I try to remain as constant as I can with anybody. (Section 9, Paragraph 114)

George

I might hold it back if I felt like was gonna probably make me. Yeah...No I [do] not think gonna cry that's it, not now, just hold in this grip of my tears and swallow, swallow yeah ...But yeah this feeling back of my mind, sort of lack of mind, holding myself back from letting these feelings out, letting these emotions out. So I end up just holding it in and just keep it to myself. Rather than dealing with it and expressing it totally. (Section 1, Paragraph 169, 185, 194)

Harry

I can be very emotional but I don't like to show it, in ways. (Section 2, Paragraph 115)

The participants commented that they might express positive emotions such as laughing or happy crying, if they were in an intimate relationship with someone. Expressing negative emotions, particularly crying in public, was positioned as forbidden under any circumstance. Negative emotions, according to the participants, are acceptably expressed in more external ways such as through anger and tension continuing previous research (e. g., Casper et al., 1996; Timlin-Scalera et al., 2003). The following extracts illustrate this:

Edward

eh my emotions always been with me, I only intend to let it when I'm seeing somebody, you know? That's the only time I let out, other than that I don't. (Section 9, Paragraph 114)

Harry

If I'm happy I'd show more emotions, when I'm happy like a happy cry or something like that. And so sad cry. Where sad cry you can look out of the window, take a deep breath, and then you can hold to, later when you are on your own ...I don't like to show anyone. Maybe sometime like to a close person I would. But that would be it. Or it depends; it could be a shock (Yawning) or anything (Yawning) and stuff like that (yawning). (Section 2, Paragraph 115, 118)

Albert

I wouldn't cry period. I just don't cry any more (laughs). I mean not cry in the emotional sense I still cry from time to time but as from pain or anything. But what I am saying, generally speaking I wouldn't do certain things in front of people (Section 17, Paragraph 202)

George

I feel I guess it is not right. Not right for me to cry. Not the right situation, not the right place....Funeral no, in public no...Of course you maybe looking upset but not break down and cry, I wouldn't (Section 1, Paragraph 186, 190, 194)

Carl

Yeah, I don't generally talk about emotions, not that much. Like my emotions are extreme, I'm pissed off. Or you know I'm having a good day, I'm happy kind of thing. Just very general, very general, that's more like thoughts. (Section 8, Paragraph 94)

In congruence with previous research (e. g., Berger & Kelly, 1986; Evans, 1976; Evans & Katona, 1995; Ichiyama et al., 1993; McCartney, 1995; Pennebaker & Susman, 1988), the

interviewees reported that self-concealment (Kelly and Achter, 1995; Larson & Chastain, 1990), or not sharing their distressing intimate information or emotions, made them feel bad (Cepeda-Benito & Short, 1998). The interviewees explained that they felt that they were placed in a “double bind” (Good et al., 1990) in that they may need or benefit from talking, or expressing their emotions to a friend or a counsellor, but they were resistant to doing so. The following excerpts illustrate this:

Carl

Things that you don't want to share and you just want to keep which is not good. It's good if they show that, you would express yourself more and get off your chest, makes you feel a lot better...For me personally, it's something that you tend to hide sometimes, those things you don't want to talk about. You should talk about but you don't want to talk about it. (Section 4, Paragraph 33)

George

It's not the manly thing to do but this is also could be an opinion that's confusing ahhhh (silence for 6 sec) because I know it's what I should do, I should be able to express my feelings and emotions. (Section 1, Paragraph 194).

Thematic analysis indicated that men's attitude and comments about emotions is underpinned by three main beliefs or issues that the traditional men have learned through socialisation, namely: emotions mean femininity, vulnerability, and dependence.

a. Emotions Mean Femininity

In congruence with previous research on traditional men (Blazina, 1997; Blazina et al., 2001; Blazina & Watkins, 2000; Davies et al., 2001; O'Neil et al., 1986; Real, 1997), the participants reported that through socialisation they have learned to fear and reject those qualities deemed feminine, including expressing emotions which is socially considered incompatible with being a man and that may lead them to avoid seeking help. The participants explained that men's and women's social rules are different, and that it is

normal for women to express feelings and talk about intimate issues, but not for men. Society expects men to be strong and to be able to cope with their problems; expressing or talking about emotions or depression (affective disorder) whether with a close or a professional person, is thus considered a sign of weakness for men, a sign of femininity and signifies that the person is not a “man” (Blazina, 1997; Blazina et al., 2001; Blazina & Watkins, 2000; Cournoyer & Mahalik, 1995; Davies et al., 2001; Good et al., 1989, 1990, 1995 & 1996; O’Neil et al., 1981, 1986 & 1995; O’Neil, 1990; Real, 1997; Wisch et al., 1995). The men stated that protecting their image from the stigma of femininity is what prevented them from seeking help and that’s why no man would talk about his emotions or depression “unless a gun is pointed to his head.” The following excerpts depict this:

Carl

Females are or can be, weak and guys or men got to be strong. So it is along that line. I know women who see psychologists, yeah, you don’t see them differently, women. But for guys, I don’t know anyone who sees a psychologist, not one person, not one guy. And yeah, it’s definitely, it’s an image thing (laugh). Guys got to be this, guys got to be that. It’s social, yeah....And you know too feminine, to be weak like that (laugh) go and see a psychologist. (Section 5, Paragraphs 48-49 & 64)

George

I guess this is similar to (silence for 6 sec), like also like toward my dad, my dad is similar in that way. Rather than like my sisters there, especially if someone sitting there, they’d break and cry. Yeah, so, so my brother. But me compared to the others, no I wouldn’t, the rest of my family, I just hold it in myself (silence for 26 sec).... It’s not the manly thing to do... Ahhhh, Because it’s not right, Ehhhhh, Like it’s Socially it’s not right for men. Is that what you are saying, for male to break down and crying? It’s more a female thing. Even though I think myself that there shouldn’t be that, eeehh, male-female thing about expressing emotions. You should be able to, but there still that, ahhhhh, label, saying that you got be a man and deal with emotions yourself and not looking weak.(Section 1, Paragraph 194 & 200).

Albert

Most guys I know won’t talk about feelings unless, you know, you point the gun to them and say “you tell how you feel or else” sort of thing....

Because the fact that girls and boys the rules are different, it's different obviously. I mean there are still certain things you can do but you know. I mean you know what I mean in real life I wouldn't do certain things just the fact that they are gonna go crazy on me for, could be thinking that I'm not too reasonable, you know. That's probably, you know. It's an image thing I imagine, that's the best way I can put it. (Section 11, Paragraph 142, Section 15, Paragraph 148 & Section 17, Paragraph 199)

The participants reported that restricted emotionality can befall both genders and in all societies, but it usually applies more to men than women and the expectations placed on men can be more detrimental in some cultures than others (Cooke & Rousseau, 1984; Crosby, 1987). For example some participants (Australians) of certain ethnicities- Arabic, Indian, Korean and Irish- perceived that their acculturation according to their parents' ethnicities could have had an impact on their attitude toward help-seeking more than other cultures. However, this has not been reported by participants in the study from other ethnicities (Chinese, English, Polish, and Vietnamese). The following illustrate that:

Bill

I guess some of the cultural values that you inherited from your parents (Korean). I don't think there is that many psychologists who understand that (Section 10.5, Paragraph 101)

Daniel

No, not really. I don't know just (silence for 7 sec- then sighing) I think it's a sort of cultural barrier as well because they are sort of more Arabic cultured and you can't really talk to them. (Section 3, Paragraph 54)

Edward

But the fact, still I would stress to you, is the fact that most of the community looks at you when you are visiting a psychologist, especially in our community (Indian community), you know? I mean the outside community they've accept it, they don't have a problem with it, you know you are emotionally disturbed blah blah blah... Because that is the community, this is the way it is. (Section 12, Paragraph 133)

George

I am Catholic of Irish background and it's not the manly thing to do (Section 1, Paragraph 194)

But in general and as previous studies indicated (Atkinson & Gim, 1989; Atkinson et al., 1990; Gim et al., 1990; Kim et al., 1996) there appears to be more commonality than difference in acculturation and the traditional men's restriction of emotions and their attitude toward help-seeking.

b. Weakness and Vulnerability

The participants reported another belief, related to socialisation and fear of the stigma of feminine emotionality, the fear of vulnerability (Blazina, 1997; Blazina et al., 2001; Blazina & Watkins, 2000; Cournoyer & Mahalik, 1995; Davies et al., 2001; Good et al., 1989, 1990, 1995 & 1996; Nadler et al., 1984; O'Neil et al., 1981, 1986 & 1995; O'Neil, 1990; Real, 1997; Wisch et al., 1995). According to the participants, emotions, feelings, and any form of communication that emphasis emotions and feeling such as seeking help and support in men are positioned as signs of weakness and vulnerability and that is why they should be avoided (Nadler et al., 1984; O'Neil, 1982; O'Neil et al, 1986; O'Neil, 1990). This includes seeking help from anybody even parents and close family members. The following extracts depict it:

Bill

Yeah, even though they are my parents the thing is about feeling weak. I don't want to show it to them, I don't want to show to anybody. It's bad enough I feel weak. So I care about it. Yap.(Section 9.11, Paragraph 93)

Carl

How people see you. For myself, I don't think that if I need to see a psychologist it makes me weak, I don't think that. But I think if I see a psychologist and people know about it and they think I'm weak, I can't handle it or I've got problems that why I am seeing a psychologist...Yeah, in a way yeah, it does seem to make you kind of weak. Does make... kind of weak and you know if people see you weak, especially a guy, then it's like (silence for 3 sec), it's a bit of a sissy thing. (Section 5, Paragraph 44 & Section 8, Paragraph 98)

Edward

I bit my tongue and swallow it back inside of me, you know? Because I just don't want to let it out, you know? It's weak to me, it feels like a weakness that I'm not just gonna accept. You know what I mean? (Section 2, Paragraph 34)

Similarly, other men who did not think expressing emotions is wrong, but who were afraid of the stigma of emotionality remarked that if they had breached the social code for men regarding expressing emotions, and sought help for depression, the negative feelings and thoughts of weakness, vulnerability, and being looked down at by others would have made their depression worse, re-affirming previous research findings (Cochran, 2001; Evans & Katona, 1995; Good & Sherrod, 2001; Good & Wood, 1990; Levant, 1990; Nadler et al., 1984; O'Neil, 1982; O'Neil et al, 1986; O'Neil, 1990). Thus, instead of seeking help they would have been facing more trouble and depression.

Fredric

I express my emotions but the thing is I still react; if I let it go, if you express emotions it's like putting a hair on chopping board, is not it? You are giving, you are giving a lot of energy and it depends on what's around you they can take it and cut you off and leave you depleted. And you feel very small, you feel very negative, your thoughts become negative and unhappy and depressed...if you are on stage, let's say you are singing. You see on stage and the crowd silent and you think to yourself "Oh my God what's happening." And then depending on whether they start clapping and cheering, or whether they start booing, you are either God or you might kill yourself. So it's a very dangerous thing to express your emotions.(Section 9, Paragraph 92)

c. Dependence

Another belief that the men reported is that expressing emotions and help-seeking are associated with dependence and loss of control or power, supporting previous research (Addis & Mahalik, 2003; Blazina & Watkins, 1996; Davies et al., 2000; Erikson, 1962; Freud, 1937 & 1963; Timlin-sclera, 2003; Tracey, 1985). The traditional men reported that their anticipation of losing control and power in the session and over their life in

general kept them from approaching professional help. They were afraid that they will be forced to reveal what they were concealing and that the therapist, helping them solve their problems, will take away power and control from their lives, which is something they did not want, as they wanted to be strong and independent. The following extracts reveal this:

Daniel

if it's, you are going to a psychiatrist, so that they can solve your problems; and then it sort of takes away control from your life, in a way. They are my problems, so I feel like if they are my problems and I should be able to solve them, and then sort of do that through my own way. So if I go and see a psychiatrist, then (silence for 4 sec) they sort of taking control on my life, in a way. You know what I mean? (Section 5, Paragraph 102)

Edward

getting back to the topic of seeing a psychologist and what would prevent me would be (silence for 7 sec), mainly because I want to be strong about myself, and I want to handle my problems. (Section 5, Paragraph 76)

The participants reported that being able to demonstrate to the world and society that they can take care of themselves was not the issue or the only issue, the issue was that they did not want anybody to control their lives because of two reasons: trust and pride.

The men reported that if they are concealing their emotions and not seeking help and wanting to be independent, it is because they do not trust others.

The men added that have been betrayed and hurt too many times previously for trusting people, and because they have seen others being hurt, humiliated and left alone once they lost power and talked about their troubles and concerns to close people and friends corroborating previous research (Davies et al., 2000; Leong, 1999; Timlin-Sclera, 2003).

The following excerpts depict this:

Edward

I don't want to run to other people because I do not have the belief in other people; I've always seen people walk away from their problems, I've always seen people being around when things are good, and I've always seen people take different tracks as soon as things change. So, I keep my

problems to myself to keep these people whoever, from these instance of ruining their own relationship with me, you know?...may be somebody is sitting in front of me and saying “ I’ve got this, I’ve got this, I’ve got this” I’d mostly turn around and walk away myself, I don’t like that. You know what I mean?...I’ve had instances where people have turned around and said “ mate, this guy has a lot of crap and he’s always in problems and always in crap.” In a way it hurts when you see friends and especially the people you trust are laughing behind your back, you know what I mean? Over and over and over time I’ve seen that being done, not only to me but to other people as well.(Section 5, Paragraph 76 & 88)

Fredric

If people were shy about expressing their emotions, probably because they have been hurt too many times for doing it. (Section 10, Paragraph 101)

The participants reported that their pride and dignity restricted them from relying or depending on anybody and made them avoid help-seeking and expressing their emotions, continuing previous research (e. g., Hayes & Mahalik, 2000; Jennings & Murphy, 2000; Lewis,1992; Nathanson,1993; O’Neil, et al., 1995; Pollack, 1998; Real, 1997; Thompkins & Rando, 2003; Wright, O’Leary, & Balkin, 1989; Wurmser, 1981).

Albert:

some guys you couldn’t get a feeling out of them even if you...their pride made of rock. (Section 6.1, Paragraph 94)

Carl

it’s a self-pride thing. (Section 5, Paragraph 36)

George

So pride in yourself ...it’s dignity I think (Section 1, Paragraph 194).

Fredric

I’m very arrogant and proud and I believe what I know is what I know. And people can tell me like a professional, he studied this long and that long, done whatever... Everyone knows the truth, they all have it inside but they all misled. (Section 7, Paragraph 61)

Seeking help and expressing emotions seems to counter men’s goal of independence.

Their experiences and relationships with society and the community increased their sense

of pride and distrust and that has increased their need for independence and self-reliance and made them perceive seeking help as unnecessary.

In general and as previous research suggested (e. g., Berger & Kelly, 1986; Evans, 1976; Evans & Katona, 1995; Ichiyama et al., 1993; McCartney, 1995; Pennebaker & Susman, 1988), men are self-concealing (Kelly & Achter, 1995; Larson & Chastain, 1990), and restrict their distressing intimate information or emotions (Cepeda-Benito & Short, 1998; O'Neil et al., 1986) and do not seek help. Men's socialization is to fear the stigma of emotionality because it is deemed feminine, and it brings with it vulnerability and dependence. This appeared to be the greatest barrier in expressing emotions and seeking help in the men interviewed in this study.

2. Stigma of Mental Illness

The second attitudinal barrier reported by the participants was the social stigma involved in seeking counselling for depression and mental illness in general; an issue that is highlighted in previous research (Davies et al., 2000; Ester et al., 1998; Farina, 1998; Goldstein & Rosselli, 2003; Hayward & Bright, 1997; Loewenthal et al., 2002; Outram, 2004; Real, 1997; Timlin-Scalera et al., 2003; Watari & Gatz, 2004; Wodarski, 1983).

The interviewees reported that the perceived stigma of mental illness was an important element in their decision not to seek help from a mental health professional, confirming the findings of previous research (Davies et al., 2000; Outram, 2004; Sartorius, 2001 & 2002). The participants reported that they could not talk about their depression even with close friends because of their fear of being ridiculed. Thus seeking help from a professional who is a stranger was never an option because the very act of seeking help, whether a diagnosis of mental illness is substantiated or not, would have initiated a social

bias against them (Wodarski, 1983) and that would have carried with it inevitable ridicule and the stigma of being abnormal, crazy, homicidal and psychotic:

Fredric

[I]t's seen as "OH you are going to see a psychologist, you are crazy, you are a psycho, there's something wrong with you" (using a shaky voice to imply horror) so that was never an option. (Section 6, Paragraph 35)

Albert

It's when I talk to someone else if I am gonna tell him: "oh psychiatric clinic", for example they will give you red, red looks. I guarantee it (laugh). So you know. Cause that just like you are not supposed to be there, you suppose to be normal, you look perfectly normal, relax, you are happy, you know. Why the hell you want to go there for? It's only for the nutcase to be locked up...Because I mean you know psychologists are out there and make money out of the crazy people not us. (Section 16, Paragraph 154-155, Section 17, Paragraph 184 & 210)

The interviewees reported that society's perception of mental health professionals, its unfavourable beliefs about psychological services, the negative attitude about mental illness, and society's stereotype of help seekers as crazy, have prevented them from seeking help. For the traditional men, society, maintained and strengthened through family and peers' pressure, is a potent inhibitor of help-seeking behaviour in people (Davies et al., 2000; Ester et al., 1998; Outram, 2004). The following illustrates this:

Edward

And if it in terms to getting that sort of help, I wouldn't have been able to that sort of help. But the fact, still I would stress to you, is the fact that most of the community looks at you when you are visiting a psychologist...you know you are emotionally disturbed blah blah blah. But in my sort of community people turn around and say he's a psycho (Laughs), he's going to the psychologist. And I know this for a fact; you know? Because that is the community, this is the way it is. (Section 12, Paragraph 133)

The participants noted that if they had to seek professional help, the perceived stigma of mental illness and the usage of psychological services, and the associated embarrassment

and fears of judgement, and the subsequent desire to keep troubles private (Davies et al., 2000; Outram, 2004) would have discouraged them from admitting it.

Bill

I probably wouldn't tell anybody that I'm seeing a psychologist, yeah. (Section 5.7, Paragraph 50)

Carl

If it was myself, if I think I'm gonna see a psychologist I think I'll keep it to myself. I wouldn't say to people I've gone to see a psychologist; If I'm depressed and I want to see a psychologist they'll probably turn and say, you know, "what's your problem"(laugh). People are judgmental...And just how people see you; how people would judge...I don't think I let another person knows that I'm seeking it unless it is a person that really close. (Section 5, Paragraph 63 & Section 12, Paragraph 122)

3. Lack of Trust in Healthcare Providers

The third most frequently mentioned barrier to seeking health services was the participants' doubts about mental health service providers' technical and personal competence to meet men's health and counselling needs (Bayer & Peay, 1997; Davies et al., 2000; Fennema et al., 1990; Meltzer et al., 2000; Small et al., 1994; Wells et al., 1994). The participants' mistrust about health providers appeared to fall into two basic categories: cannot help and feeling uncomfortable

a. Cannot Help

In accordance with recent studies on help seeking for depression in both women and men (Bayer & Peay, 1997; Outram, 2004), several traditional men in the present study reported that their lack of confidence in mental health professionals' ability to help was a barrier in help-seeking (Bayer & Peay, 1997). This attitude was underscored by the belief that one's difficulties and issues are unique, and nobody can solve them but the person himself. Professionals, according to the participants, have degrees and experience, but

they are not able to understand (Davies et al., 2000; Outram, 2004), unless they had been there themselves, thus they are not able to provide a solution or answers to the depressed men.

Bill

I mean you are the best source to consult, to solve the problem. You know exactly who you are and what the problem is and how serious it is. Yeah...[Psychologist] are trained to help people to feel well or solve their psychological problems but I don't know if they understand the extent of the problem to me personally... I guess if I'm giving this guy money, and he has training, years of study, I would expect him to give me THE solution to the problem. But I know he cannot do that. (Section 4.9, Paragraph 30, Section 8.1, Paragraph 72)

Fredric

I don't believe a professional is any more qualified than someone that I bestowed that qualification upon...I've got enough understanding of the way things work, the way people work, to know what options available for me to get over it. So, no I wouldn't, I wouldn't go seek help. (Section 7, Paragraph 55 & Section 14, Paragraph 125)

Albert

You know what I mean? So sometimes it doesn't, you know, sometimes you just, you don't think about, understand it...is not they won't understand the problem, just the fact it doesn't seem to be able to get a full scope of it because (stop sentence). I mean, yeah, you know they got training you know, they've seen a lot of cases before I understand that (Section 6, Paragraph 72)

In concordance with previous research (Davies et al., 2000; Outram, 2004), a number of the participants also stated that the psychologists cannot understand or help them, because all psychologists are materialistic and very scientific. Materialistic because counselling is a financial business and the psychologist every now and then asks about the bill. Scientific, because psychologists are perceived to be non-humanistic and merely try to classify, define and affirm the problem. In contrast, the participants expected the psychologist to be caring, to understand the problem from the personal perspective of the depressed person and to try to stop it, and not just to give "excuses" and make people feel all right for what they are doing. The following illustrates this:

Albert

If you talk to a psychologist about it, it's just the fact that they'll be able to classify sort of speak... I mean to them is more a scientific business rather than more a human field...But from time to time you feel that they still have that, you know (silence for 5 sec) the bill sort of speak (Laugh)...It's just about that when you are depressed you tend to want to talk to people. As in like, in a more, I mean if you have just wanna to be with your girlfriend you don't wanna hear a scientific person going out and say, you know: " Yey , yenny how do you know you had a chance of be? get? who?" ...you can't go scientific on a problem like that (Depression problem), or at least that's what I find anyway...If depression was that easy everybody would be given just to think like this, to think like this, take this, take this pill three times a day and that the end of it. They wouldn't have this problem, would they? (Laugh). So yeah, I don't think a scientific approach really, really work. Well, this is maybe me being pretty reserved about it because yeah (Laugh). (Section 6, Paragraph 72,74 & 76)

Fredric

In recent year, going to a psychologist or counsellors or psychiatrist, I have not ruled it out. But I honestly believe the only thing they will tell me is what I know already, but the only benefit I will have is affirmation from someone... I have met some girls here have what's that disorder? Self-mutilation disorder where they cut themselves and they get some sort of adrenalins reaction out of it. I was talking to one of them...she goes " Oh I go to see a counsellors, and he says I've got this and he says this, and he says this, and he says this" and I'm thinking he's giving her definitions of what she does....So he's basically not stopping what she is doing, he's making her feeling all right for what she's doing. And that's giving people excuses... (Section 6, Paragraph33 & 44)

b. Feeling Uncomfortable

Another point that the participants reported, related to the issue of men's doubts about mental health service providers, was significantly associated with the ability to feel comfortable when talking about their own problems. The analysis of the various responses highlighted men's feelings of embarrassment (Belle, 1982; Meltzer et al., 2000; Outram, 2004; Pepinsky & Patton, 1972; Small et al., 1994; Wells et al., 1994), and concerns about being judged (Bayer & Peay, 1997; Outram, 2004) when they talked about their problems, particularly with strangers, even if this stranger was a professional health provider. Parallel to previous research (Kelly & Achter, 1995; Cepeda-Benito et

al., 1998) the interviewees noted that their feelings of being uncomfortable, whether it was because of talking to a stranger, the environment, or a feeling of being judged, would have made them “self-conceal” and keep distressing intimate information secret from the health provider, whether a dentist or a counsellor. The following excerpts illustrate it:

Albert

You can talk about certain things to strangers, you can't talk about other things (Section 8, Paragraph 119)

Edward

Getting onto counselling I would say it has something that whoever the person who's been counselled with, he has to feel a hundred percent himself, you know what I mean? So for someone like me, I would have to feel a hundred percent comfortable with the environment around me, not tensed, you know?...For me if I'm being counselled or something like that, I'd be tensed about it, you know? And for the person he has to agree with what I'm saying, you know? Because if he doesn't, if goes “you are doing wrong blah blah blah”, he will automatically take me to another level, you know what I mean? (Section 6, Paragraph 86 & Section 9, Paragraph 111)

Harry

Even if he is there to help because I don't know I won't feel comfortable, I wouldn't tell him everything. (silence).It's like going to the dentist. Do you floss? Yes everyday. And you only floss once every week. Do you know what I mean? You tell them what they want to hear. In a way. (Section 2, Paragraph 67)

In contrast to previous studies (e.g. Timlin-Scalera, 2003), the participants commented that their feelings of discomfort and reluctance to self-disclose is not related in any way to issues of confidentiality because they are sure that psychologists are professional, and they abide by the law not to discuss clients' personal matters. Confidentiality would not have limited them from seeking help. For instance, some interviewees said:

Edward

Although I understand that psychologists are professional, and they are abided by the law not to discuss a personal matter, right? ... You can't just go home and talk to your family or... you know those sorts of things. (Section 6, Paragraph 86)

George

Anything he says is confidential within (Section 1, Paragraph 156)

The belief that no-one can help, also evidenced in previous studies (Wells et al., 1994; Small et al., 1994; Meltzer et al., 2000), and feelings of being uncomfortable with health providers, associated with embarrassment (Belle, 1982; Meltzer et al., 2000; Outram, 2004; Pepinsky & Patton, 1972; Small et al., 1994; Wells et al., 1994) and concerns about being judged (Bayer & Peay, 1997; Outram, 2004), appeared to intensify the men's reluctance to self-disclose, thereby inhibiting help-seeking, all of which suggested a lack of confidence in health providers.

4. Lack of knowledge about Where to Go for Help

Consistent with previous findings (e. g., Belle, 1982; Davies et al., 2000; Meltzer et al., 2000; Rew, Resnick, & Blum, 1997; Robertson & Fitzgerald, 1992; Small et al., 1994; Timlin-Scalera et al., 2003; Wells et al., 1994), lack of knowledge about where to go for help was commonly reported by males in the present study as a barrier to seeking help. The participants noted that they have a lack of awareness of psychological services (e. g. Rew, Resnick, & Blum, 1997; Robertson & Fitzgerald, 1992; Timlin-Scalera et al., 2003; Davies et al., 2000), not because they do not know about counselling and psychologists, but because they do not know where to go. Some interviewees noted that they could have looked for a psychologist in the yellow pages, but they did not because it is not the way to seek psychological services. The participants explained that psychologists are not available as readily as general practitioners who practically are on every corner of the street, and there is no public guidance as to which psychologist to go to or where to obtain information, or people who would point you in the right direction. Availability, according

to the participants, would have assisted them to take the step of seeking professional help, as it would help a lot of other people. The following statements illustrate that:

Bill

Umm, I'm not really familiar with the concept of seeing a psychologist. I mean if you get sick you go to a doctor, practically they are on every corner of the street. But to seek psychological help you have to, first you don't know whom to go to (Section 5.3, Paragraph 46)

Carl

I don't see a psychologist. I haven't seen a psychologist. I don't know where to start to look for a psychologist, maybe in the yellow pages, I don't know. It's just availability.... If I didn't I would have never considered a psychologist due to the availability: I don't hear about it but I know about it... one is like you know: "hey you should see a psychologist." or "hey you should see this doctor, he's good, he can help you." There's no guidance to go and see a psychologist....Don't know where to obtain information, or people who would point in the right direction, it's availability...Ok, just on a generalisation of the whole thing, I think this is for a lot of people, taking that step to go and see a therapist, a psychiatrist I think the availability needs to be there so people know that this is available to them. You know, seek help, this is available to them, I think that need to be out there more. ((Section 5, Paragraph 36-62 & Section 12, Paragraph 122-131)

5. Misinformation about Psychological Services

Consistent with recent research conducted at the University of Oregon by a group of counsellors (Davies et al., 2000) some men in the present research reported that the incorrect information they had about the psychological services had an impact on their attitude toward seeking help. According to the interviewees the way the media, and particularly television, portrays psychological services as a service for people who are weak or very troubled (Rew, Resnick, & Blum, 1997; Robertson & Fitzgerald, 1992), and the counsellors or psychologists, as unhuman, who do not listen, and who are just running a business (Timlin-Scalera et al., 2003), was a barrier in their help seeking attitude. The participants reported that they need a positive and real contact with the mental health field to promote better perceptions of help seeking, which sometimes translate to increased

help-seeking behaviour (Fischer & Farina, 1995; Timlin-Scalera et al., 2003). The following responses are indicative:

Bill

I guess from what I see may be on TV or here (at Uni) seeing a psychologist is for people who got major major problems in their lives. And I feel my little problem is not significant enough to talk to a psychologist. Yeah....[T]his perception I have of psychologists is something that I saw on TV or just read in newspaper, magazine or just yeah. Need realistic experience. (Section 5.5, Paragraph 48 & Section 11.7, Paragraph 116)

Harry

And I feel that, though I've never been to one, I feel psychologist, only just watching the movies, just come back, come back, come back...I feel they only taking you for everything you have got. But then again I suppose I've been watching to many movies where the bloke laying on the bench talking to him and the psychiatrist goes out, eats lunch and comes back (laughing) with toothpick (laugh). An hour later. (Laugh).(Section 2, Paragraph 107)

6. Feeling Invulnerable to Health Concerns: Think Their Condition not Serious Enough

Consistent with previous research (Courtney, 1998; Davies et al., 2000; Mermalstein et al., 1992; Weissfeld et al., 1990; Zuckerman, 1994) the men indicated that it was hard to be motivated to consult a psychologist regarding depression issues because they felt invulnerable about health concerns, thinking that their condition was not serious enough.

Furthermore, men's perception and belief in their own invulnerability seems to influence men's perception that long-term health risks are associated with current habits (Davies et al., 2000), an attitude that was found in previous research to be associated with a variety of health issues, including sun exposure, driving risks, physically dangerous activities, and sexually transmitted infections (Mermalstein et al., 1992; Weissfeld et al., 1990; Zuckerman, 1994) together with men's failure to adopt positive health behaviours, for example conducting self-exams for testicular cancer (Katz et al., 1995). The following quote illustrates that:

Bill:

Cause who goes to see a therapist when you are a teenager or in the early twenties. I guess some people do, but I think at that age you'd have such major problems in your life to see a therapist, generally. I guess there are more significant problems, when you have your own family, or stress from your job or change of careers. But eff. This is something I heard from my friend who is studying psychology, and it's like: "I have sometimes psychological thing in the middle of the session when I say oh shut up, what is your problem? Get over it." So (Laughs). (Silence for 8 sec). Yeah. (Silence for 12 sec)...I don't think I myself had such a major problem or issue to consult a psychologist.(Section 10, Paragraph 97& 101)

Men's belief in their own invulnerability seems to be a motivational barrier associated with their underestimation of the risks of depression and a variety of health issues and thus the failure of men to adopt a positive health attitude toward seeking help.

In summary, the traditional men identified structural and attitudinal barriers that limited them from taking action and seeking help when they were depressed. Despite the fact that the men's concerns about service costs were the only structural barrier to seeking health services, they identified substantial attitudinal barriers.

Men's socialization to fear feminine emotionality, to conceal vulnerability and be independent was positioned as the greatest attitudinal barrier. Many of the men spoke about their strong reluctance to seek help from family, friends or professionals for emotional problems because they cannot trust anybody and they want to protect themselves and their dignity.

The perceived stigma of mental illness was another important attitudinal element in their decision to seek help from a mental health professional (Davies et al., 2000; Outram, 2004). Seeking counselling carried a greater social stigma than seeking help from friends or medical services.

Furthermore, men's lack of trust in healthcare providers and men's lack of knowledge and misinformation about psychologists and psychological services and feeling invulnerable to health concerns were also frequently cited barriers.

All in all, it seems that the traditional men not only struggle to find counselling and/or psychotherapy effective, but they also have difficulty in initiating the help-seeking process.

The challenges for mental health professionals often seem to start with the issue of the negative social messages that many men, both traditional and non-traditional, receive about seeking help rather than the issue of therapy efficiency and preference. The greater problem is that the men are self-concealing and are avoiding seeking help, not only from the professionals but also from the closest to them, their families and friends.

V. What Depressed Men Need to Open Up

The traditional men in the present study had several suggestions for making it easier for them to open up and talk about their depression and emotions. Their suggestions provide relationship guidelines that might be able to be used with family, friends and professionals rather than technique guidelines that could be used in treatments or in professional settings only. The following section summarises the men's suggestions along two major themes: first, to encourage the man to talk and gain his trust, and second, to help the man acknowledge his feelings.

A. Encouragement to Talk and Build Trust

Regarding encouragement to talk, the participants reported the need for general assistance and support before they become ready to express emotions and show vulnerability and for that they have suggested nine encouraging factors: to be invited to talk, a secure and

comfortable atmosphere, kindness, to be given a lot of options, not to force advice, to be encouraged to problem solve, to know about other people's similar experiences, trust and time.

1. Invited to Talk without Barriers

Previous research (Berscheid, 1985; Hook et al., 2003) pointed out that when people are aware that they are not welcome, loved and liked, the risks associated with self-expression increase, and they become less willing to open up and share their ideas and feelings. They know that people who show them love and affection will be much more receptive to their feelings and ideas than people who do not care for them. Therefore, they rarely, if ever, confide in people who appear unconcerned or indifferent to them (Hook et al., 2003). Similarly, in the present study, the participants reported that the first thing they need is to feel welcome to talk without any restrictions or barriers and not to feel that they are a burden on others. The participants reported that when they were depressed they wanted to talk and they like to talk, but they could not talk because nobody wanted to listen to them. The participants explained that some people did not like to hear about depression at all, others did not have the time to, or they did not have any concern or genuine interest to listen and to help them when they were depressed. That is why the men emphasised that to help the depressed man to open up, encouragement is needed to invite him to talk and to make him feel welcome. The following extracts illustrate this:

Carl:

People, close ones, you can do or you can talk to them.... Just talking about it....show that they are genuinely interested in what you are saying If they are trying to be pushy they are just helping you getting it off your chest. Sometimes when you are trying to express yourself you are reluctant to reveal it all. I do that myself. You do want talk about it but you can't just let everything go, you feel no you shouldn't talk about it. If people are pushy in a way, genuinely interested, want to hear, if they do that, it gets a lot of things off your chest.... If they are pushy and they are

genuinely about it then it's an opportunity for you to get it out.(Section 4, Paragraph 29, 30, 33)

Daniel:

Make sure you always have the time, so don't, don't not have the time for them. So, if like they want to talk you are always there. Cause I guess if you are depressed you don't feel depressed for a long time; So that partly you feel depressed you want to talk, and if no one is there to talk to then I think is the worst to do with it.(Section 4, Paragraph 63)

George:

You feel a burden if you're not welcome to talk. Yeah, or they don't want to listen, or not interested listening. (Section 1, Paragraph 76)

2. Secure and Comfortable Atmosphere

Because men are socialised to fear the stigma of mental illness (Davies et al., 2000; Ester et al., 1998; Goldstein & Rosselli, 2003; Loewenthal et al., 2002; Outram, 2004; Real, 1997; Timlin-Scalera et al., 2003; Watari & Gatz, 2004; Wodarski, 1983) and emotional femininity (Blazina & Watkins, 1996; Good & Wood, 1995; Good, Dell, & Mintz, 1989; Heppner, 1995; Levant, 1990; Nadler et al., 1984; O'Neil, 1982; O'Neil et al., 1986; O'Neil, 1990; Robertson, 2001; Robertson & Fitzgerald, 1992; Simonsen et al., 2000; Wisch et al., 1995) the participants in the present study reported that they need a secure and comfortable environment where they can open up without any form of social bias toward them (Davies et al., 2000; Outram, 2004; Wodarski, 1983). They want to talk without being judged as crazy and dragged to a mental hospital or being ridiculed and laughed at by family, friends or professionals. As long as they fail to have this sense of security and comfortability they will keep self-concealing (Kelly & Achter, 1995; Larson & Chastain, 1990), and restricting distressing intimate information or emotions (Cepeda-Benito & Short, 1998; O'Neil et al., 1986).

Edward:

Make me feel comfortable, as in he knows what's going on, as in he can, whatever I'm going through, maybe he can see something in there and then tell me. It would be more easy for me to be able to communicate... (Section 8, Paragraph 108 Section 9, Paragraph 111 & 122 & Section 12, Paragraph 133)

George:

You have to feel totally at peace and comfortable with the person.(Section 1, Paragraphs 75)

3. Kindness

Studies continually suggest that kindness is always valued by both sexes (Baskerville et al., 2000; Buss, 1994; Buss & Barnes, 1986; Li et al., 2002), but more valued by women than men (Baskerville et al., 2000; Li et al., 2002). Studies also suggest that people may desire as kind a mate as possible, so much so that they continue to invest in increasing kindness to ensure their "mate budget" increases (Li et al., 2002). Norman Li and colleagues (2002) proposed that people who are average in kindness are perceived as those who are willing to be of service to others but who expect a fair and equal amount of benefits in return. People who are very kind are perceived as altruistic and as being kind even if he or she is under-benefited. Those who have been treated kindly are significantly more likely to behave kindly than those who have not received the same kind treatment (Strenta and Dejong, 1981; Franks, 1992).

Acts of kindness, including mentoring programs, provide individuals with the kind of encouragement and help often essential to make a positive change in their life (Freedman, 1993; LeTourette, 1987). In line with previous reasoning and research the results of the current study indicate that kindness is essential. The participants reported that to help them to open up and talk they need to be treated and communicated with kindly and treating them harshly was to be avoided. The following extracts illustrate this:

Edward

But where as if you talk to me nicely, kindly, and be understanding about how you're communicating and...You know? (Section 9, Paragraph 122)

George

Yes like dealing with a scared animal you can't just go and grab it, force will just snap out of it. You have to be kind, you have to be gentle. (Section 1, Paragraph 74)

4. To be Given a Lot of Options

The men reported that to help them open up they need to be given lots of opportunities or options. They need to be offered lots of practical ideas and suggestions to help in opening their horizons and their ways of thinking (Salovey & Mayer, 1989-1990) to help them to bounce back from negative emotional experiences and to become flexible in adapting to the changing demands of the stressful experience of depression (Block & Block, 1980; Block & Kremen, 1996; Lazarus, 1993). They want to be given lots of opportunity and options to widen their scope and help them to cope more effectively with their depression (Salovey, Bedell, Detweiler, & Mayer, 1999). The following quotes illustrate this:

Edward

Take you through the whole different alley of it, you know what I mean? "This was gonna happen, and this was gonna happen and this was gonna happen" as if they've seen it right through, you know, they've seen it right through. (Section 8, Paragraph 104)

George

showing them like opportunities. Opportunities and also like pass they can take, rather than just limiting their emmmmmm, their horizon. Like giving them so many points of views they can look at. (Silence for 15 seconds). (Section 1, Paragraph 62)

5. Not to Force the Issue or Advice

Because men are socialised to be strong and independent, and because for them, talking about emotions and help-seeking is associated with dependence and loss of control or power (Addis & Mahalik, 2003; Blazina & Watkins, 1996; Davies et al., 2000; Erikson,

1962; Freud, 1937 & 1963; Timlin-sclera, 2003; Tracey, 1985) most of the traditional men reported that they hate to be forced to reveal what they are concealing or to be obliged to comply with the advice they are given. The men reported that they prefer to be encouraged gently to talk without any constraints and to be made feel better through doing things that they like to do such as talking about other things other than depression or how they feel, playing sports, or going out. This gives them the power to decide whether they need assistance, and encourages them to come forward and to open up. The following depict this:

George

You have to give encouragement to people to talk. You don't want force them. Cause forcing them will only make them like draw back even more (silence for 9 sec). But like the way when you (silence for 4 seconds) may try to tame an animal or something you have to, show them ahhhhhhh like reward, reward them before like. Give them something to come towards. Rather than attacking them and forcing them a bit open up or do something or speak. (Silence for 11 secs)... Not forcing them. Or not asking them to cause I think that will close them off. It'll stop them, like, if you keep asking to express their emotions. I think it would. (Section 1, Paragraphs 70-73 & Section 1, Paragraph 210)

6. To Be Encouraged to Problem-Solve

Tannen (1990) proposed that men's first reaction when confronted with problematic emotions, such as depression, is to problem-solve, whereas women simply want understanding. In contrast to women, men favour doing or behaving instrumentally and assertively (Gilligan, 1982; Mansfield et al., 1992) and assuming positions of control or power (Addis & Mahalik, 2003; Blazina & Watkins, 1996; Davies et al., 2000; Erikson, 1962; Freud, 1937 & 1963; Tannen, 1990; Timlin-sclera, 2003; Tracey, 1985). Timlin-sclera (2002) proposed that men would be more willing to seek help and presumably gain more from that help if they were engaged at a problem solving level rather than in a traditional talking and listening counselling style. In other words, men are expected to

preserve their independence in both actions and words. Along the same lines, the participants in the current study reported that they prefer to be in charge and solve their problems by themselves and they do not like others to do it for them. Some participants reported that problem-solving makes them feel good because they are doing it themselves, they are not cheating, and if something goes wrong they hold responsibility and there is nobody to blame or condemn but themselves.

Bill

I just like to solve my problems by myself. It's extreme case, but if I get someone else help to solve my problems I feel I'm cheating in the exam. It's a very extreme example but that's how I feel about it (Section 4, Paragraph 28)

Harry

I want to solve it all myself. Then if I did it the wrong way I can't blame anybody but myself (Section 2, Paragraph 55,)

It seems what the men are suggesting is that who ever wants to help depressed men should not take charge of their lives and solve their problems, but encourage them to solve their problems by themselves, which according to researchers helps in regulating the negative mood and increasing the depressed person's confidence in their ability to solve problems and have a positive attitude toward life (D'Zurilla et al., 2002; Spence et al., 2003).

7. Know About Other People Experiences

Because men find it hard to talk and express emotions (Blazina & Watkins, 1996; DiMatteo, 2004; Lewis & Rook, 1999; Good & Wood, 1995; Good, Dell, & Mintz, 1989; Gray, 1992; Heppner, 1995; Levant, 1990; Nadler et al., 1984; O'Neil, 1982; O'Neil et al., 1986; O'Neil, 1990; Robertson, 2001; Robertson & Fitzgerald, 1992; Simonsen et al., 2000; Tannen, 1990; Umberson, 1987; Wisch et al., 1995) the traditional men in the

current study reported that learning about peoples' positive personal experiences with depression and seeking help could be encouraging for them to open up more. This gives them feelings of relief, trust and comfort such that they can open up without any negative consequences (Davies et al., 2000; Outram, 2004; Wodarski, 1983). The participants noticed that the positive experiences with mental health professionals of people that they love and respect has more effect on them than if they don't know the person or just seeing some people on TV talking to a psychologist. The following represent this:

Bill

it would [like to hear about] very personal experience. Rather than seeing some people on TV and talking to a psychologist make me so much better or help me to choose the right or something like that. (Section 11.3, Paragraph 110)

Daniel

Through my brother depression I learned that it's probably better to be able to talk to someone rather than hold everything in. And I think that's something that I probably have known long time before because, I guess I've just said, I use to hold a lot of stuff in...My friend saw a psychologist with his family and he sort of influenced me by like his experience with the therapist. Because I guess you can say that like he's very manipulative himself and he sort of saw the psychologist manipulating him and he sort of manipulating back. So it was a bit sort of artificial in a way and it was not genuine, as I would have liked it to be. I guess that sort of influenced in a negative way, but then again through my brother's depression period that influenced in a huge positive, positive effect. (Section 19, Paragraph 181-182)

Edward

There's only a couple of occasions when I let it out on you, you know? It was only because I saw a lot of people talking to you. Because (Tom) gained my trust, and I saw him turning to you. There had to be something about you, there had to be something about you that (Tom) had to turn to you and seek your advice. And it showed me, it showed me just like (Tom) is a master in his field and what he's doing so are you, you know, in what you are doing, and so is everybody whatever they are doing. And this why I thought I'll speak to you. (Section 13, Paragraph 139)

In other words what the men are suggesting is to encourage them to open up through giving them anecdotes from real life which according to John Gray (1992) could be

valuable for a man because it “helps the man to centre himself and become more objective.” And that prepares the man in the next stage to be ready to talk and to be asked questions. However, Gray (1992) advised not to ask question after question if the man is slow to open up and to be patient.

8. Trust

Parallel to previous studies (Hatfield & Rapson, 1993; Hook et al., 2003; Schul et al., 2004) the participants reported that their willingness to open up and disclose intimate details of their lives to people definitely depends on trust. The participants reported that when they were depressed they could not trust anybody to share their problems with and open up to. Their previous experiences and suspicion increased the complexity of trusting and disclosure (Fein, Hilton, & Miller, 1990; Fein, McCloskey, & Tomlinson, 1997; Hilton, Fein, & Miller, 1993; Schul, 1993; Schul et al., 1996).

Edward

being honest with you I still don't have at this stage anybody around me that 100% I can commit to, you know what I mean?... it hurts when you see friends and especially the people you trust are laughing behind your back, you know what I mean? Over and over and over time I've seen that being done, not only to me but to other people as well. And I just don't want it to happen again... (Section 4, Paragraph 62; Section 9, Paragraph 122)

George

there's not really someone that I can really trust, cause in trust, trust in that sense, being able to cry in front of someone or express telling all your emotions to someone, has to be built. (Section 1, Paragraphs 65-67 & Section 1, Paragraph 194)

Harry

And I only speak to people you can trust about it, because if you'd speak to someone that you can't they get things to the wrong hands or whatever then it can be a nightmare for you (Section 2, Paragraphs 35)

Interestingly enough, and as David Lieberman (2000) noted, the participants reported that the easy entrance to their trust is “through the unprotected back door”

(Lieberman, 2000), that is, to make them laugh and talk about general issues at first. Talking about general issues, as the participants reported, is a form of revealing and opening up that makes them feel closer to the person listening to them (Strentz & Auerbach, 1988; Lieberman, 2000). They will then feel secure and comfortable and feel that there is nothing wrong about talking and that their disclosure will remain confidential and their inner selves will not be exposed in front of everybody (Hatfield & Rapson, 1993). If the person they are confiding in is genuine, honest and means what he says this will significantly increase the psychological bonding and will make them open their floodgates and express anything and everything, corroborating previous research findings (Fein, Hilton, & Miller, 1990; Fein, McCloskey, & Tomlinson, 1997; Hilton, Fein, & Miller, 1993; Kruglanski, 1989; Kruglanski & Freund, 1983) . The following extracts illustrate this:

Carl

Just talking to close friends, people you feel you can trust you can talk to them, talk to them, there's no point keeping it to yourself...But if you look at it in the first instance, it would be my thoughts that I would be revealing. And then if the situation is right I'd be revealing my emotions too but if I have to, yeah, if I need to. (Section 4, Paragraph 29 & Section 8, Paragraph 109)

Daniel

it's usually just the closest friends are the only ones I can talk to; Someone that I really know and knows me well, as well, who I can trust basically...If I have a friend I can trust and he knows me so well then I think I can trust his judgment and (silence for 4 sec) and yeah. (Section 3, Paragraph 46 & Section 4, Paragraph 72)

Edward

The trust can be gained very easily by the conversation I'm having with the person....It seems like, you know, they make you laugh in the beginning, and you feel comfortable and everything, but they are very easy and they are very easily gain your trust, you know? (Section 9, Paragraph 118 & 122)

In general, the participants emphasised the importance of trust as a corner stone in the process of opening up and revealing emotions. And trust is easy to be gained through letting them reveal about themselves indirectly through talking about general issues, and making them feel appreciated (Strentz & Auerbach, 1988;Lieberman,2000), secure and comfortable without being judged or exposed in front of everybody (Hatfield & Rapson, 1993). All of that will significantly increase the psychological bonding and will make them open up and self disclose.

9. Time

It could be hard for men, particularly traditional men, to talk and express or share their emotions, but the men interviewed suggested that with time they will open up. Most of the participants reported that those who want to help depressed men should never stop trying. The men explained that they could be stubborn, or cowards, but they are still humans and like everybody they need help, and over time, and especially if they trusted the person who wants to give them a hand, they will open up, they will let their shields down. The men reported that sometimes they do not like to talk because they could be stressed or angry and they prefer to be left alone and not to be distracted. That's why the one who wants to help not only should be patient but also should be wise enough to choose the right time to ask the depressed about his feelings and talk about it. The following illustrate this:

George

You have to, have to take time. (Section 1, Paragraph 74)

Fredric

Now everybody is stubborn, coward or whatever, but if you go up to someone and try to do that, tried to push him and push him, if you care, don't get de-turned and you keep showing him what you have to offer they'll lean, and then eventually they will let their shield down. I don't mean you should make them confident and make the other person believe

that you are really can help but what you want to do is raise them up and not let them down. (Section 5, Paragraph 27)

Harry

It depends if it just happens and I am angry, no, I would rather be left alone about it. But after I've realise what's happening and what's real from wrong then I'd rather I 'd like to talk about it, and push because it'd help me get over it faster. (Section 2, Paragraph 45).

Overall, it seems what men are suggesting to help them open up is that they need to trust the person before they are ready to talk. Building trust is a long journey that needs a lot of time and patience. The gateway to building trust is the invitation to talk without any barrier. On the way toward building trust and opening up, the person who is trying to help them should treat them kindly, provide them with a secure and comfortable environment where they can talk without any barrier. Moreover, the help provider should be able to give the men a lot of options supported by examples from real life about how to solve the problem and get out of the state of depression without controlling or forcing the men to choose what the help provider thinks is the best for them.

B. Help Men to Acknowledge Feelings and Vulnerability

Once trust is built it will “create unexpected vulnerability and attachment” (Lieberman, 2000) toward the help provider and the depressed man will be ready to seek support (Lieberman, 2000; Strentz & Auerbach, 1988), open up and show vulnerability. However, the help provider needs to let the depressed man know that talking about emotions is not bad, feminine or negative, and to do so the participants reported the need for two elements: listening, as well as empathic understanding and acceptance.

1. Listening

Previous research (Lieberman, 2000; Strentz & Auerbach, 1988) recommended that making a person focus on his emotional state, significantly increases his need to talk and to be listened to. In a study done by Strentz and Auerbach (1988) FBI trainees were asked to play the role of abducted hostages. Some were asked to focus on their emotional state, others on the situation, and the rest were not given any instructions. The results of the study concluded that “self-focusing on emotions leads to increased emotional awareness and a strong desire to seek social support.” (Strentz & Auerbach, 1988). Other researchers (e.g., Francis-Cheung & Grey, 2002) advised that when a man talks about his feelings it is better to focus on his feelings and keep silent. Because talking, commenting or advising the man at this stage of vulnerability might send him the wrong message that feeling hurt is wrong and bad, that will make him retreat and hold his feelings (Francis-Cheung & Grey, 2002).

In the present study, all the participants without exception reported that what is important in helping them to talk about their emotions is listening to what they say without interrupting them, advising, arguing or debating their belief (Lieberman, 2000). They prefer that the person in front of them stays silent (Francis-Cheung & Grey, 2002; Lieberman, 2000). Though “keeping silent is painful” for the listener (Francis-Cheung & Grey, 2002) for the participants it is more productive and helpful than talking because it shows that the person really cares for them and is interested in what they are saying. The following depict that:

Albert

They listen to what you are talking about and nothing else...Last you wanna hear is like yapping. (Section 4, Paragraph 53 & Section 5, Paragraph 66)

Carl

[I]t's preferable if they listen and show that they do listen and care about you. If you speak to people who don't care and just kind of "yeah whatever" you feel no one cares, no one is interested, and that's the worst thing. So just getting someone to listen, I think that's good... (Section 4, Paragraph 30)

Daniel

Just being ear to listen to...just be able to be there, talk to them, like be an ear so that you can listen. (Section 3, Paragraph 37 & Section 4, Paragraph 63)

Edward

be able to listen and he'll be able to see...I can tell you the whole thing is that you were there and you listened, you know what I mean? (Section 8, Paragraph 108 & Section 13, Paragraph 139)

Fredric

Listen to their problems.(Section 5, Paragraph 20)

George

Yeah. I would talk a bit to my dad. He'd listen more...And yeah listen, listen to them (Section 1, Paragraph 57 & 63)

Harry

Even though he wouldn't have to say much about him, him just listening and good thoughts and bad thoughts and other thoughts, would make me feel more comfortable. (Section 2, Paragraph 145)

2. Empathic Understanding and Acceptance

Several researchers and clinicians (deCarvalho, 1999; Real, 1997; Rogers, 1951, 1957 & 1986; Wickman & Campbell, 2003; Francis-Cheung & Grey, 2002) have reported the importance of reaching out and communicating empathy to people and patients throughout the process of any intervention or treatment (Moss, 1999). Carl Rogers (1951 & 1957) was among the first to emphasise the importance of empathy, he considered empathy to be (1) a central construct in therapy more than just a precondition to other forms of treatment, (2) a therapist's attitude toward the client rather than any particular therapist behaviour, (3) an interpersonal process ground in a non-directive attitude, and

(4) a part of a whole attitude wherein the experience of empathic understanding is intertwined with the therapist's unconditional positive regard toward the client (deCarvalho, 1999; Wickman & Campbell, 2003). Real (1997) considered empathy to be the exact thing that men truly need, but the men are seeking the exact opposite of what they really want. Because through traditional socialisation the men learned that to be unconditionally accepted they have to demonstrate themselves worthy of human connection, they must be competitive and winners, which intrinsically demands disconnection from vulnerability, and what they want, such as love, emotions and empathy (Blazina, 1997; Blazina et al., 2001; Blazina & Watkins, 2000; Davies et al., 2001; O'Neil et al., 1986; McCarthy & Holliday, 2004; Real, 1997). The disconnection of the person from human attachment and even from himself leads to depression (Real, 1997) the pain of which is paradoxically soothed through reconnection and empathy (Francis-Cheung & Grey, 2002; Real, 1997). Francis-Cheung and Grey (2002) emphasised that men when depressed need and accept empathy, but not sympathy. For men empathy means understanding and acceptance without prejudice while sympathy conveys weakness and pity, and that is the last thing a depressed man needs, as he is already feeling bad about himself. Furthermore they have stressed that empathy and acceptance do not mean agreeing with everything the man says or does when he is depressed, it just means to accept and acknowledge how a man is feeling so that he can move on. Not empathising with a depressed man makes him feel wrong, criticised, rejected and defensive and that is not helpful to making him feel or cope better.

Similarly to previous research, most participants in the present study reported that they need empathic understanding, not sympathy, to help them feel comfortable and to encourage them to open up more. The participants added that when they open up and talk about the negative feelings surrounding depression, they need understanding and

acceptance, and not to be sidelined, judged, advised with authority (e.g. you should or must do this or that), or to be told to “snap out of it and forget it, get a grip of it, or to get a life.” Any of that would make the depressed feel bad and stop expressing his feelings. They do not want to hear anything because it does not work and after all they do not want to be depressed and it is not their fault to feel that way. The following excerpts illustrate this:

Edward

The person know what you are talking about...I would rather him understand exactly where I'm coming from, what's happening, why I've been depressed, blah blah blah that would make me feel comfortable. (Section 4, Paragraph 66 & Section 8, Paragraph 108)

George

I would probably talk to my dad more so, he'd be more understanding on that sort of, on that sort of available. My mum not really, cause she, she's got more attitude like, forget about it, get on with your life, snap out of it sort of thing. While my dad is a bit more, emmmmmmmmm, not sympathetic but a bit more understanding. Cause he's been through like similar, when my parents divorced, similar circumstances. And he sought help, as well, when he was going through that time... I don't want to feel vulnerable, if this person is judgemental, or weak in front of him. (Section 1, Paragraph 68 & 194)

Instead, the men reported that they prefer to be asked why they are feeling that way (Francis-Cheung & Grey, 2002) and to be asked meaningful questions that can help in understanding them and what they are suffering from, which might lead to finding an outlet or giving them some sort of help. As well, they reported that they like to be assured that it is not their fault that they feel depressed or bad and it is all right for a man to feel this way.

George

And bit have a deal with what they are feeling and why they are feeling that way... And make it appear it's not them, it's ahhhhhh, sort of circumstances surrounding. It's not them as the problem it's things causing them to feel this way. And try to get this message across as not having this native false in their head. (Section 1, Paragraph 63)

Harry

Unless he asks all those information how is he supposed to put something together to help you out. If he only knows the bad he could be setting something out for you that gonna make you worse. If he doesn't know it, he can't help, can he? Or he can give you some help and you think that's right but he doesn't know everything, how can he just know that? He can't. (Section 2, Paragraph 145).

Furthermore, and similarly to what many researchers have suggested (deCarvalho, 1999; Real, 1997; Rogers, 1951, 1957 & 1986; Wickman & Campbell, 2003; Francis-Cheung, 2002) the men reported their preference for unconditional positive acceptance. The positive acceptance makes the man feel loved supported and cared for, and that gives him encouragement, energy and boosts his self-esteem. The men reported that positive regard or acceptance is important for the depressed man because it is refreshing; it makes the man aware of his gifts, talents or what he is good at and that can weigh out the negatives, which helps in alleviating depression. And that is why some of the participants emphasised not to take everything the depressed man says personally and react to it negatively because that will not help the depressed and it will take away his energy at a time he needs energy and support to change his negative view about life, his self worth and almost everything. His rejection behaviour is not actually directed at the person who is giving him help, it is just because he is depressed and has problems in regards to asking for help. The following illustrates that:

Harry

Use the positives to follow the negatives. Yeah. I don't know, you might feel like you're low and you're useless and you got nothing going and stuff like that. But if you didn't know actually what positive things you own in your life, like you might be a really good touch football player or you might be a, you know, really good at your work. And he can use those positives to weight out the negatives and helping your depression. (Section 2, Paragraph 145)

In general, to open up, talk about depression and show vulnerability, the men need to trust the help provider, whether the help provider is the family, friends or mental health experts. To gain their trust and preserve it, the men want the help provider to continuously show them kindness, respect for their independence, security, empathy, unconditional positive regard and genuineness in talking and listening. Most of what the men want, particularly empathy, unconditional positive acceptance and genuineness, is nothing but what Carl Rogers and the humanistic therapies (deCarvalho, 1999; Moss, 1999; Rogers, 1951, 1957 & 1986; Wickman & Campbell, 2003;) consider as the "necessary and sufficient conditions" that enable the individual to spontaneously grow and seek fulfilment and personal change. They constitute the clinical framework for the humanistic therapies. Thus what the men need to open up, show emotions and talk about depression (emotional disorder by definition) is simply to be treated in a humanistic way.

CONCLUSION

The present stage of the research provided insight into what men, in particular traditional men, perceive as important causes in their depression, their coping strategies, the barriers that discourage them from seeking help, and many useful suggestions to help them open up and seek help.

The traditional men in this study positioned stressors such as unemployment, financial hardship, failure, social loss, lack of family support, as major factors responsible for depression in men. However, they reported substantial barriers to seeking help and therefore had taken little effective action to address those concerns in their own lives. Men's socialization to fear feminine emotionality, to conceal vulnerability, and to be independent, was positioned as the greatest attitudinal barrier. The perceived stigma of

mental illness was another important attitudinal element in their decision about whether to seek help from a mental health professional. In addition, men's lack of trust in healthcare providers and men's lack of knowledge and misinformation about psychologists and psychological services and feeling invulnerable to health concerns were also frequently cited barriers. The participants' strategies for coping with stress and depression are similar to those found in previous research that reported that men are more likely than women to rely on themselves, relying on coping strategies that are more distractive and less emotional to alleviate their depression (Amirkhan, 1990; Billings & Moos, 1981 & 1984; Bonin, McCreary & Sadava, 2000; Boyd-Wilson et al., 2000; Carver et al., 1989; Chino & Funabiki, 1984; Compas et al., 1993; Endler & Macrodimitris, 2001; Folkman & Lazarus, 1988; Funabiki et al., 1980; Khantzian, 1987; Kleinke, Staneski & Mason, 1982; Lazarus & Folkman, 1984; Morrow & Nolen-Hoeksema, 1989; Nolen-Hoeksema, 1987, 1990, 1995 & 1991; Nolen-Hoeksema, Morrow & Fredrickson, 1989; Pearlin & Schooler, 1978; Real, 1997; Ugal, 2003). When it comes to help, the traditional men in this study have specific preferences. They prefer non-medical therapies to deal with depression, they prefer the one-on-one classical therapies, in particular psychoanalysis. They dislike the non-classical therapies and especially virtual mental health services, whether for support or therapy, because they perceive them as exceptionally impersonal and anonymous. The men reported that the factors that would help them to open up, talk about depression, show vulnerability and seek help, is trust in the help provider and being treated in a humanistic way: to be continuously shown kindness, respect for their independence, security, empathy, unconditional positive regard and genuineness in talking and listening.

CHAPTER 5

CONCLUSIONS

The current chapter briefly summarises the results of the three stages in turn, recapitulates the findings of the three studies as a whole, discusses their implications for policies and practice, and presents suggestions for future studies.

SUMMARY OF THE THREE STAGES

A central aim of stage one was to investigate the relation between gender role conflict and therapy preferences for depression, both techniques and conditions, so as to determine whether gender role conflict influences preference for type of therapy that men choose. The results suggest that the participants who are high on gender role conflict prefer biomedical therapies more than men who score low on the gender role conflict scale. Men who were high on gender role conflict rated behavioural therapies higher than low gender role conflicted men after controlling for attitudes toward seeking psychological help.

The analysis of men's preferences for therapeutic characteristics revealed that both high and low gender role conflicted men ranked modality of therapy first in importance, accessibility second and length of therapy third. As for the therapist's characteristics the current study findings suggest that both groups of men (high and low GRC), seemed to focus on issues of professional traits, such as experience, more than on the demographic traits of the therapists.

The results of stage two revealed that the exposure of men in general, and both high or low gender role conflict scoring men to therapy, using counselling videos, influenced the

men's subsequent preferences and ranking for therapies. Following exposure psychoanalytic therapy ranking increased and became first, while cognitive therapy ranking decreased and became second, while both behavioural therapy and biomedical therapy became equal third. Furthermore, the exposure to therapy, using the counselling videos, influenced high and low gender role conflict men preferences for therapies. Men reporting high gender role conflict who were exposed to either an emotion-focused or a thought-focused counselling video preferred biomedical therapies more than men reporting low gender role conflict who are exposed to the same counselling video. However, men in the high GRC/thought-focused condition preferred behavioural and psychoanalytic therapies significantly more than men reporting low GRC whether in the emotion-focused or thought-focused condition. Finally, coping was found to mediate the relations between gender role conflict and therapy preferences, with task coping was significantly related to the three favoured therapies, biomedical, behavioural and psychoanalytical.

The last stage of the current research revealed insights into what traditional men perceive as important causes of their depression, their coping strategies, the barriers that discourage them from seeking help, and many useful suggestions to help them open up and seek help. The men positioned stressors such as unemployment, financial hardship, failure, social loss, lack of family support, as major factors responsible for their depression. They positioned their socialisation to fear feminine emotionality, to conceal vulnerability and be independent, and the perceived stigma of mental illness as the greatest attitudinal elements in making a decision whether to seek help. The traditional men reported that in times of stress they rely on coping strategies that are more distractive and less emotional to alleviate their depression. They said that they prefer non-medical

therapies to deal with depression, they prefer the one-on-one therapies, in particular psychoanalysis. They gave accounts of disliking the non-classical therapies and especially virtual mental health services, whether for support or therapy, because they perceive them as exceptionally impersonal and anonymous. The men reported that they want to talk about their depression, they want to open up and show vulnerability, and seek help, but first they need to feel they can trust the help provider and that the help provider is treating them in a humanistic way: to continuously show them kindness, respect for their independence, security, empathy, unconditional positive regard and genuineness in talking and listening.

RECAPITULATION AND DISCUSSION

The men in this study reported that depression was a common phenomenon for them. They identified that stress had a negative impact on them and made them depressed. Although stresses have negative impact on most people it seems that certain psychosocial stressors have a stronger impact on men in general and traditional men in particular. The main psychological stressors reported to be responsible for depression in the interviewed men included unemployment, financial hardship, failure, social loss and lack of family support; factors which are often the main things that give a man his sense of worth and self-esteem. For traditional men the impact of those stressors is possibly stronger because through socialisation they have developed a strong belief about the importance of work, money, success, power and family in the culturally defined standards of masculinity (Fleck, Sonenstein & Ku, 1994). Failing to adhere to the culture standards means that they are not “man” enough and that is a factor that contributes to depression.

Consistent with previous studies (Berger et al., 2005; Good et al., 1989; Good & Wood, 1995; Robertson & Fitzgerald, 1992; Wisch & Mahalik, 1995), the men were found to have a negative attitude toward seeking professional help and difficulties in initiating the help-seeking process, particularly the traditional men, who identified various barriers that limited them from taking action and seeking help when they were depressed. Many of the traditional men spoke about self-concealing and avoidance of seeking help, not only from the professionals but also from those closest to them, their families and friends because they cannot trust anybody and they want to protect themselves and their dignity. The stigma of mental illness was another important attitudinal element in their decision whether to seek help in general. Lack of trust in healthcare providers and men's lack of knowledge and misinformation about psychologists and psychological services and feeling invulnerable to health concerns were also frequently cited barriers. Men's concern about service costs was the only structural barrier to seeking health services. Different barriers seem to be related to the different patterns of conflict the traditional men struggle with. For example, while traditional men who have issues of "success power and competition", "restriction of affectionate behaviour between men", and "conflict between work and family relation", avoid seeking professional help because of fear of interpersonal openness, traditional men who have issues of conflict between work and family relation report that they also avoid seeking professional help due to distrust of mental health practitioners.

For the traditional men to set aside much of their masculine socialisation and seek counselling or therapy for depression requires critical conditions such as the depression condition being very severe (e.g. impaired daily living, the continuity or recurrence of depression, and suicidal thoughts), dramatic social conditions surrounding depression

(e.g. social loss, presence and absence of social support, quality of social relations), and in some cases mandatory circumstances (for instance a judicial decision).

When depression is not very severe, the men's strategies for coping with it are similar to those reported in previous research, avoidance of emotional coping, self-reliance, and trying to talk themselves out of feeling depressed through avoidance or problem solving attitudes (Boyd-Wilson et al., 2000; Chino & Funabiki 1984; Funabiki et al., 1980; Kleinke, Staneski & Mason 1982; Nolen-Hoeksema, 1987 & 1990; Pearlin & Schooler, 1978). Traditional men identified using various active coping strategies, (e.g. playing music, writing, singing, reading, playing games, going out, working doing exercises, routine, watching TV or video or movies, intoxication) that distract them from their depressed mood and therefore decrease their symptoms (Nolen-Hoeksema, 1991). Distraction and avoidance appeared to facilitate the use of problem-focused coping strategies (e.g. reflecting, taking concrete actions, developing positive perceptions about life situations, and instrumental support seeking) which can increase their sense of control (Compas et al., 1993). The traditional men revealed that when they are depressed they do not talk about their depression but they do not mask it from themselves. They prefer to think about their problems to solve them, and not to focus their attention on the negatives as in the case of emotion-focused coping. When traditional men do exhibit emotional coping with depression, they have a greater tendency to use emotional-distractive strategies instead of being just emotional, such as talking about anything or being surrounded by people.

Men's coping strategies seem to respond to environmental and psychological demands. For example, a focus on emotions in counselling seemed to provoke the men stimulate their avoidance defences. Moreover, coping seems to mediate the relations between

gender role conflict and therapy preferences, and consistent with Lazarus and Folkman (1984), coping choices were important predictors of changes. Task coping was significantly related to the three favoured therapies, biomedical, behavioural and psychoanalytical, more so than through avoidance coping. Emotion-focused coping was neither present nor associated with any of the therapies, suggesting that in general the men who chose therapy in its various forms would have decided to cope with their problems directly through changing or regulating the source of stress (Endler & Parker, 1990b) instead of evading or dealing with the stressors emotionally. The findings endorse Eisler's (1995) view that male gender role socialisation restricts traditional men's coping repertoires to those that are gender sanctioned (see also Good, Dell, & Mintz, 1989; Nadler, Maler & Friedman, 1984; Robertson & Fitzgerald, 1992).

Despite the men's negative attitude toward seeking help and their preference for coping with depression on their own, when it comes to a choice of therapy techniques, both traditional and non-traditional men seem to be more positive and aware of the various categories of therapies, namely, psychoanalytic therapies, behavioural, cognitive and biomedical, and to have specific preferences. The men in this study said that they like biomedical therapies because at least they provide quick relief, but they prefer non-medical therapies, such as psychological therapies, to deal with depression long term, even though they do not provide the quick relief they want. The men said that medicine is just repressive of the symptoms but does not solve the actual problem, and that psychological problems require psychological therapies.

Establishing rapport and trust is a central matter in helping men to open up in talking about their problems. The traditional men reported a desire to talk about their concerns and troubles, and say that they are willing to talk about depression, even if this will

involve showing their vulnerability, but they need before anything else to trust the help provider, whether the help provider is family, friend or mental health expert. The men reported that what they want in particular is empathy, unconditional positive acceptance and genuineness, what Carl Rogers and the humanistic therapies (deCarvalho, 1999; Moss, 1999; Rogers, 1951, 1957 & 1986; Wickman & Campbell, 2003) consider as the "necessary and sufficient conditions" that enable the individual to spontaneously grow and seek fulfilment and personal change. They are the clinical framework for the humanistic therapies, which may explain the men's preference for classical therapies of psychoanalysis and related therapies.

IMPLICATIONS FOR POLICIES AND PRACTICE

The findings of this study regarding men's seeking help attitudes and preferences for such a grave disorder as depression deserve consideration in the policy arena.

Given the severity of the negative consequences of men's depression for themselves, their loved ones, families and society, and the negative attitude of men toward seeking help in general, it is necessary that governments, mental health services institutes and professionals, the media, and civil organisations coordinate their efforts and increase public awareness about depression, the existing services, service costs, and the expertise of providers, in order to encourage men to use mental health services. Such efforts could potentially go a long way toward creating a supportive and inclusive atmosphere, in which the men could explore and review their gender conflict presentations and emerge from their isolation. This isolation, which usually feeds into the emotional restriction, prevents the men from adapting more healthy behavioural models.

Introducing mental health courses to the curriculum of schools and colleges, and making mental health education obligatory from early school years, can increase men's awareness of depression and other disorders and the value and the importance of accessing services without having to ask for help or to feel or appear dependent and not manly. An important role of these classes should be to educate people on the health risks they face. The courses would need to provide information about health and mental health. In case of depression, the classes need to provide people with information about depression, how to recognise depression and the consideration of gender differences in expression and talking about depression. It could cover training for help such as training on key listening techniques, self-disclosure, how to access professional services, how to intervene with a depressed or suicidal person, how to recognise one's limitations in helping others, and what treatments are available.

Society and families should be made aware of the role they might have in a man's depression and his attitude toward seeking help. They should be alerted to how their patriarchal practices and dictates are associated with psychological distress, gender role conflict, depression in men (Good et al., 1995; Sheppard, 1994) self-silencing (e.g., Good et al., 1995; Newman, 1998) and avoidance of seeking help for depression. Recent highly publicised Australian cases, such as the depression and suspected suicide of the ex-rugby player, Steve Rogers, in January 2006, and the resignation of the Premier of Western Australia, Geoff Gallop, in January 2006, due to depression are testimony that depression is an issue for men and that depression affects different people in different ways. But at the same time, people should be made conscious that support and encouragement of men to set aside much of their masculine socialisation, their fears of mental health stigma and initiating the help-seeking process is needed. Ultimately it could prove essential to a

person's recovery and could even save someone's life. It is important that the message be continuously or persistently propagated and circulated through all the available mediums, e.g. brochures, journals, books, stories, internet, radio, television, cinema or others.

It is important that boards' and societies' administrators, such as psychologists' societies, strengthen therapists' skills and knowledge about male clients, since technical expertise has been found to be a reason why some men prefer certain clinicians. It is crucial to educate healthcare providers and counsellors about men's issues, especially about men's tendencies to conceal vulnerability, a tendency that seems to have misled some medical practitioners and counsellors to under-diagnose men's depression (Potts et al., 1991). It is also important to formulate service policies to enhance the accessibility conditions, particularly constancy of therapy, and to emphasise the employment of brief individual therapy, with the ultimate goal of providing quality services for the patient. Maybe it would also be helpful to consider changing the names of counselling services, as Robertson and Fitzgerald (1992) suggested. Changing the name of services, might help traditional men with strong masculine attitudes to take advantage of them more freely. Rather than "personal counseling", Robertson and Fitzgerald (1992) suggested "classes," "workshops," and "seminars" as potential name substitutes.

With regard to counselling and therapy practice, the results of this study have several implications. The findings in relation to gender role conflict and therapy preferences suggest that referring agents and therapists should pay more attention to assessing their clients' preferences and to accommodate them as much as clinically possible. Those involved in therapy and counselling, might do well to educate themselves on male clients' preferences and men's gender role issues. This would allow them to recognise and overcome the potential limitations placed on them and on their patients by gender role

socialisation. Assessing the level and type of gender role conflict (success, power, and competition; restrictive emotionality; restrictive affectionate behaviour among men; conflict between work and family relations), and acting in response to them, are equally important.

In addition, the findings in relation to gender role conflict and therapy preferences suggest that understanding of traditional male socialisation may be important for academics and therapists, in order to allow them to be able to mentor, supervise, and train male counsellors to recognise and overcome the potential limitations placed on them by this gender role socialisation. Awareness of gender role conflict should also extend beyond counselling and therapy settings, to cover workshop settings, schools, classrooms, and other situations. Having a greater awareness of gender role conflict and the factors associated with it, such as depression, seeking help and coping, may prove to be useful for the development of prevention and treatment interventions. There are a variety of strategies or tools for raising awareness about gender role conflict and preventing the negative factors associated with it. Tutors, school psychologists, clinicians together with the formation of close links with mental health services, general practice divisions and consultation with community health centres can make the general public alert to the dangers of male gender role conflict at an early age and promote the use of healthy behavioural models and effective coping strategies in a variety of settings. The coping strategies can be useful for confronting daily tensions or problems associated with gender role conflict as well as more serious situations, such as depression and avoidance of seeking help for it. The development of effective coping strategies that can reduce the outcome of gender role conflict and prevent depression could be encouraged and integrated into treatment interventions with gender role conflicted depressed adolescents.

In this manner adolescents could widen the range of their coping strategies and develop a sense of competence in the face of the negative consequences associated with gender role conflict and other difficulties and become more receptive and open to seeking help for depression or other mental health problems. This proposition certainly needs to be subjected to more empirical investigation, but policies that would allow for such research would also serve knowledge, mental health sufferers, the public, and the treasury since it has been claimed that entire countries are facing a loss in productivity because of depression (Francis-Cheung & Grey, 2002).

Since, for men, establishing rapport and trust is a central matter in helping them open up, the therapist needs to make the man comfortable and gain his trust. To gain the trust of men, particularly traditional men, counsellors should take into consideration a variety of issues. Counsellors should be aware of both positive and negative emotional reactions toward traditional men. Kelly and Hall (1992) encouraged the adoption of a positive, developmental framework when counselling men, including the assumptions that men are in need of developing dormant strengths and abilities and that counselors must affirm men's assets. Therefore the therapist should recognise and salute the men's decision to seek help as a personal strength. This may assist in decreasing shame, embarrassment, hesitancy and any negative feelings and/or thoughts that may accompany men's decision of seeking help (Courtenay, 2001). Counsellors need to show empathy, particularly with traditional male clients, otherwise it may be difficult for these men to realise their strengths or honor their assets (Brooks, 1998). Counsellors should pay attention to differences in communication between men and be genuine in talking and listening. To be effective as a listener the counsellor should avoid statements that would block the man from opening up, or what Francis-Cheung and Grey (2002) call roadblocks. The

traditional man is very sensitive to issues such as commanding, moralizing, arguing with logic, criticism or sarcasm (Francis-Cheung & Grey, 2002). As Francis-Cheung and Grey (2002) suggested, the help provider responses to what the man says should be structured to always validate what the man says first, followed by reassuring him, and ending with keeping the lines of communication open. For example when he says that he feels that he will never get better, a response like nothing lasts for ever would block him because it denies what he has just said and signals that he is wrong; a reply like “I understand that this is frightening to be in such pain, but feelings come and go. We will get through this together” (Francis-Cheung & Grey, 2002) is a better option. As Shapiro (2001) suggested, careful attention needs to be given to the indirect communication of male clients. The counsellor should try to diminish men’s worries and show them kindness, respect for their independence, and should reassure the man that their problem is not unique and that there is a treatment available, the counsellor should also try to and inspire confidence and hope. It is important to mention that the recommended strategies were used in the current research interviews and were very useful in gathering the information.

The men’s choice of therapy might be based on what they know or on inaccurate or false information related to the stigma associated with mental illness that traditional men try to avoid (Good et al., 2001; Mahalik et al., 1995; O’Neil, 1996; Real, 1997). Furthermore traditional men, after viewing a thought-focused counselling session, changed their attitude and coping strategies and expressed more interest in other therapies than traditional men who viewed an emotion-focused counselling session. Consequently counsellors should be able to persuade clients to change their attitude toward counselling through lowering the clients’ defences or negative coping strategies and replacing them with more constructive and positive coping repertoires. One way of doing so is that the therapists assist them in identifying and confronting the resulting anxiety and help them

to develop appropriate coping skills (Mahalik et al., 1998), partly through educating their clients about the range of treatment options that are available to them, and making them aware of treatment options that are more consistent with their emotional style before starting therapy. Moreover counsellors might use "bridging" techniques (Lazarus, 1981; Wisch & Mahalik, 1995) with gender role-conflicted men, to work in a way that is most comfortable and convenient for the man in the beginning of the therapeutic journey (e.g., de-emphasizing emotions and feelings and focusing on skill development). When the man starts to feel comfortable and less defensive and/or resistant he could then be asked to work in a way that is less comfortable. This can help the client to make more informed choices, and client-therapist matches can be facilitated.

Although the men in this study, particularly the traditional men, prefer one-on-one therapy to group therapy, the counsellor would do well to educate men about group therapy. Also, counsellors working with men who experience gender role conflict might use "bridging" techniques. Bridging techniques may first start with one-on-one and with time move to group therapy, or use one-on-one and in conjunction have a men's support group which is based on the unique type of support and encouragement that men can offer one another (Rabinowitz, 2001). The importance of the group for men is related to the potential for emotionally corrective experiences awaiting traditional men in groups. For example, in the group there is the opportunity to experience and express tender feelings that men have been socialized to regard as inappropriate; there is repeated exposure to an emotional level of interaction, all of which may have a positive effect on reversing some of the socialized beliefs about feelings (Blazina & Watkins, 1996).

Clients showing resistance and expressing a strong preference for a particular form of counselling, as was suggested in Chapter Three (Lam, 2001; Ward et al., 2000), people

should also have the opportunity to be referred to counsellors of that affiliation. Equally, interventions that may be difficult for the client to accept, may usefully be postponed until the client is comfortable and engaged in the process, or the use of self directed therapies such as bibliotherapy, audio therapy, or video therapy. There are also suggestions by Johnson (2001) to include telling stories, using journals, and relating to metaphors in counselling and therapy. Bibliotherapy has been found to be an attractive and helpful tool to traditional men in treatment of depression (Mahalik & Kivlighan, 1988) and in educating them about various issues related to gender (Johnson, 2001).

LIMITATIONS AND DIRECTION FOR FUTURE RESEARCH

While the overall findings of this research may have produced information relevant to counsellors and psychotherapists, the study is exploratory and therefore has limitations. Certainly more research is needed to reconfirm the findings of the current study, to address the limitations and to tackle the questions that emerged from the present research.

A central limitation of the present study is the nature of the research itself. The participants were asked to respond to various therapeutic conditions that they have never experienced. The question remains whether their preferences for the therapeutic modalities would have been different if they had actually been exposed to the treatment conditions. It would be valuable to study the experiences and preferences of men who do use counselling and health services to identify their preferences, and the factors that allow them to seek help when other men do not. With that said, part of the dilemma with gender-role conflicted men is that they have a negative attitude toward seeking help and participating in treatment. As a result, the initial or baseline finding on these men's preferences for therapies is a helpful beginning. It is essential that research programs

develop strategies to reduce the socialisation barriers for not seeking help, such as the stigma of mental health and the pressures to conceal vulnerability. In particular, research could focus on determining the effect of using the media and trained peers to intervene with men in reducing the barriers.

Although the current study involved the recruitment of participants from a broad range of backgrounds, it is not known to what extent the participants from Sydney Metropolitan are representative of Sydney, New South Wales and Australia in general. Thus, more research is needed to evaluate the generalisability of the study, in particular the quantitative stages, for Sydney and Australia. Future researchers should also attempt to replicate the present findings with participants from other countries and include individuals from a wider variety of cultural backgrounds and age groups (current qualitative study interviewee were all in their twenties). Moreover, future research can investigate the influence of the various patterns within the gender role conflict culture and other factors of a person, such as the persons' racial background and ethnicity (Thorn & Sarata, 1998), sexual orientation (Schwartzberg & Rosenberg, 1998), age (Simon, 1996), and socioeconomic status (Jolliff & Home, 1996), all of which may have significant influence on men's level of gender role conflict.

The gender role conflict levels found in the present study, consistent with previous Australian studies (e.g. Llewellyn-Smith, 1999; Theodore, 1998), were considerably higher than samples from the United States of America (USA) (O'Neil, 1997) where most of the studies in relation to gender role conflict have been done. However nine Australian studies (e.g. Gough, 1999; Harris, 1997; Heath, 2005; Llewellyn-Smith, 1999; Mahalik et al., 2001; McAnulty, 1996; Monk & Ricciardelli, 2003; Theodore, 1998; Theodore & Lloyd, 2000; Wall & Walker, 2002) are not enough to draw a comprehensive conclusion whether Australian men may have a different definition of their gender role in

comparison to the other cultures. Consequently, more research is certainly needed about Australian men's gender role conflict.

In the present study the assumption was that gender role conflict affects the men's choice of therapy and influenced attitudes toward seeking professional psychological help. However, more research is needed about gender role conflict in general and in relation to therapy to support the current findings. Future research could look into other important correlates or other contexts in which these correlations occur. This includes looking at the relation between gender role conflict and mental illness, or service utilization; between gender role conflict and psychotherapy outcome; and between gender role conflict and the development of resolution strategies implemented for various problems (such as anxiety, interpersonal conflict, phobia, addiction). Such studies will benefit the mental health system in understanding men's help seeking and their choice of therapy, which is needed to encourage the change of men's attitudes toward therapy and to be able to help the depressed men.

The current study employed no measures of depression, and relied on the participants self-reports of depression so it was not clear how many were technically or clinically depressed or had ever been depressed. Future research should attempt to replicate the present findings using quantitative measures for depression, such as Beck's depression inventory (BDI) or others.

What the present study has shown is that the coping repertoire constitutes a possible avenue for mediating the relation between gender role conflict and preferences of therapy. Future research could look into this issue deeper as this is the first study in that context, and the third study to address the role of coping as a mediator in relation to gender role conflict, after the contradictory results of the studies of Bergen (1996) and Llewellyn-

Smith (1999). Therefore the findings are very unique, investigative, and open to interpretation, needing future examination.

The findings of the current research enrich the literature about men's gender role conflict, and particularly in relation to preferences for therapy, since no studies have been previously carried out on therapy preferences and GRCS. However, more research is needed about gender role conflict in relation to therapy preferences, to support and validate the current findings.

The men who took part in the current qualitative research brought up various significant and sensitive matters, particularly at an emotional level, despite the stereotypes and traditional notions of masculinity and the popular notion that men do not talk about their feelings. Future research should take advantage of the men's willingness to talk and consider qualitative interviews as a method of data collection. Qualitative research that examines gender role conflict in relation to therapy or counselling and within the counselling process and outcome is urgently needed. Such research might provide practitioners with more specific clues about gender role conflict in relation to therapy or counselling (Cournoyer et al., 1995).

Thus, in conclusion, the current research revealed insights into men's experience of depression, their therapy preferences, their coping strategies, the physical and psychosocial barriers that deter them from seeking help, and many practical suggestions for possible interventions to help men cross the barriers and open up. But, as Pollack and Levant (1998) have stated, knowledge of men and masculinity "is still in its early stages". Understanding the traditional man, his socialisation and its impact on depression, on the man's help-seeking behaviour and attitudes, is certainly needed to assist in meeting the needs of men and to influence the transformation of traditional men.

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APPENDICIES

Appendix A

Gender Role Conflict Scale

(GRCS)

Appendix B

Preferences for Therapies

Appendix C

The Attitudes toward Seeking Professional Psychological Help Scale

(ATSPPHS)

The Attitudes toward Seeking Professional Psychological Help Scale

Read each statement carefully and indicate your agreement, probable agreement, and probable disagreement, disagreement. Please express your frank opinion in rating the statements. There are no “wrong” answers, and the only right ones are whatever you honestly feel or believe. It is important that you answer every item.

- 1-although there are clinics for people with mental troubles, I would not have much faith in them.
Agree... Probably agree... Probably disagree... Disagree...
- 2-If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.
Agree... Probably agree... Probably disagree... Disagree...
- 3-I would feel uneasy going to a psychiatrist because of what some people would think.
Agree... Probably agree... Probably disagree... Disagree...
- 4-A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.
Agree... Probably agree... Probably disagree... Disagree...
- 5-There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.
Agree... Probably agree... Probably disagree... Disagree...
- 6-Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
Agree... Probably agree... Probably disagree... Disagree...
- 7-I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.
Agree... Probably agree... Probably disagree... Disagree...
- 8-I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.
Agree... Probably agree... Probably disagree... Disagree...
- 9-Emotional difficulties like many things, tend to work out by themselves.
Agree... Probably agree... Probably disagree... Disagree...
- 10- There are certain problems which should not be discussed outside of one's immediate family.
Agree... Probably agree... Probably disagree... Disagree...
- 11- A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.
Agree... Probably agree... Probably disagree... Disagree...
- 12- If I believe I was having a mental breakdown, my first inclination would be to get professional attention.
Agree... Probably agree... Probably disagree... Disagree...
- 13- Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.
Agree... Probably agree... Probably disagree... Disagree...
- 14- Having been a psychiatrist patient is a blot on a person's life.
Agree... Probably agree... Probably disagree... Disagree...
- 15- I would rather be advised by a close friend than by a psychologist.
Agree... Probably agree... Probably disagree... Disagree...
- 16- a person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.
Agree... Probably agree... Probably disagree... Disagree...
- 17- I resent a person professionally trained or not- who wants to know about my personal difficulties.
Agree... Probably agree... Probably disagree... Disagree...
- 18- I would want to get psychiatric attention if I were worried or upset for a long period of time.
Agree... Probably agree... Probably disagree... Disagree...
- 19- The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
Agree... Probably agree... Probably disagree... Disagree...
- 20- Having been mentally ill carries with it a burden of shame.
Agree... Probably agree... Probably disagree... Disagree...
- 21- There are experiences in my life I would not discuss with anyone.
Agree... Probably agree... Probably disagree... Disagree...
- 22- It is probably best not to know everything about oneself.
Agree... Probably agree... Probably disagree... Disagree...
- 23- If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
Agree... Probably agree... Probably disagree... Disagree...
- 24- There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help.
Agree... Probably agree... Probably disagree... Disagree...
- 25- At some future time I might want to have psychological counselling.
Agree... Probably agree... Probably disagree... Disagree...
- 26- A person should work out his own problems; getting psychological counselling would be a last resort.
Agree... Probably agree... Probably disagree... Disagree...
- 27- Had I received treatment in a mental hospital, I would not feel that it ought to be “covered up”.
Agree... Probably agree... Probably disagree... Disagree...
- 28- If I thought I needed psychiatric help, I would get it no matter who know about it.
Agree... Probably agree... Probably disagree... Disagree...
- 29- It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.
Agree... Probably agree... Probably disagree... Disagree...

Appendix D

Demographic Questionnaire

Demographics

In order to put your replies in greater context could you give us a few bits of information about yourself, please.

Please tick the box that most exactly applies to you.

Age: 18-30 31-45

Social Status: Married Single Divorced widowed Separated

Sexual Orientation: Heterosexual Bisexual Homosexual Other

Economic Status: less than \$AU10, 000

More than \$AU 10,000-Less than \$AU 20,000

More than \$AU 20,000-Less than \$AU 30,000

More than \$AU 30,000-Less than \$AU 40,000

More than \$AU 40,000-Less than 50,000

More than \$AU 50,000-Less than \$AU 60,000

More than \$AU 60,000

Education: Less than 7 years of school

Less than 3 years of High-school

School certificate (or equivalent)

Higher-School certificate (or equivalent)

Partial University (at least one year) or completed trade qualification

Undergraduate degree Postgraduate degree

Occupation: Labourer/unskilled

Semi-skilled

Skilled worker

Clerical

Administration

Manager

Executives/professionals

Student

Current status: Employed

Unemployed

Full time student

Ethnicity and country of birth: (Please indicate the ethnic group you belong to. E.g., Anglo-Celtic, Arab, Chinese, Turk...):-----

Previous experience with depression:

Have you ever felt depressed? Yes No Not sure

Previous experience with seeking help:

1-Did you seek Professional help? Yes No

2-What was this help? General practitioner Psychiatrist Psychologist Other, please specify: -----

3-Was seeking help up to your expectations? Yes NO

Physical problems?

1-Do you have any kind of Physical problems (e.g. Heart problems, cancer, ulcer, etc.) ? Yes No

2-If yes, please specify: -----

Thank you for your cooperation

Appendix E

Information Sheet for Study One



Information Sheet

First study

Human Subjects Research Consent Form
University of Western Sydney (UWS)
Department of Psychology
Letter of Informed Consent

You are invited to participate in a study investigating what men think about themselves in relation to their families, their friends, and their work. As well how they think about the psychological services and what kind of therapy they prefer for depression. This study will be undertaken by myself Zakaria Batty, under the supervision of Dr Jane Ussher and Dr Jim Malcolm. The Study will constitute the thesis component of my Doctor degree (Ph.D) in Psychology at the University of Western Sydney.

If you agree to become a participant you will be asked to complete 4 questionnaires, which will take approximately 30 minutes. You are under no obligation to complete the questionnaire once you have commenced, and you may withdraw at any time. All individual data gathered will be kept strictly confidential.

The results of this research will be presented in summary form in a thesis, which may be published at a later date, in full or part. If you are interested in having a written summary of the findings you can return the postcard provided with the questionnaires on the details listed below after Feb 28,2002.

Confidentiality will be maintained through anonymity and completed questionnaires will be retained in a locked file. The data will be kept secure for a minimum of 5 years, after which time it will be destroyed.

The Following details outline the procedures involved in participating in this research. Please take your time to read these.

-You will be given a package containing 4 questionnaires, which you will be invited to complete. Completion of the questionnaires will take approximately 35 minutes. **The questionnaires are:**

1-gender role conflict scale: measure what men think about themselves in relation to their families, their friends, and their work. The GRCS contains 37 items, each item consists of a statement that the participant responds to on a 6-point Likert-type scale, with responses ranging from "strongly agree" to "strongly disagree."

2- The Attitudes toward Seeking Professional Psychological Help Scale: assess the propensity of an individual to seek psychotherapeutic assistance. The ATSPPH scale consists of 29 statements, which the participant rates on a 4-point Likert-type scale, ranging from "agree" to "disagree."

3-Preferences for therapies: present 22 therapies (Psychotherapy, systematic desensitisation, assertiveness training, rational-emotive therapy, thought-stopping therapy, non-directive therapy, existential therapy, and Gestalt therapy, aversion Therapy, Implosion therapy, token economies, behaviour contracting, and modelling/role playing, chemotherapy, electroconvulsive therapy, and Psychosurgery), with descriptions of the various therapies that a person might consider in an attempt to get help for psychological disorders.

Moreover, 9 questions are going to be included with the Preferences for therapies, covering the participants' preferences in relation to therapies' (modality, length and accessibility), the characteristics they prefer in the therapist (age, gender, race and experience level).

4-Demographic questionnaire: is brief and designed to gather information from participants concerning age, ethnicity, Social Status, Sexual orientation, Economic Status, Education and Profession, Previous experience with depression and seeking help.

- Please notice that some questionnaires (ie. Demographic questionnaire) will address personal questions
- Involvement/non involvement will not affect your job or studies in any way.
- You will be under no obligation to complete the research if you choose to start it.
- If you have any queries while you are completing the questionnaires please direct them to the researcher.
- Once you have completed the questionnaires these should be placed and sealed in the envelope provided.

If you are interested in participation, please sign the consent form and give it to the researcher. And keep the information sheet for future reference.

If you would like further information on the research, its progress, results , more information on gender role conflict and self concept or information about counselling support and services please call me c/- Dr Jane Ussher, Ph 02/91305606.

Thank you for your time and for agreeing to participate in this study

NB: Upon finishing this study, a second will be carried on about the same. You can read about the second study in the Information and Consent form for the second study. If you would like to take part in the second study please forward the postcard in the packet separately, to notify us concerning your participation in the second study. The second study will start after February 2002. Thank you.

Note: this study has been approved by the University of Western Sydney Nepean Human Ethics Review Committee. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics committee through the Research Ethics Co-ordinator (Tel 02 47 360 169). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Appendix F

Consent Form for Study One



Consent Form

First study

Human Subjects Research Consent Form
University of Western Sydney (UWS)
Department of Psychology
Letter of Informed Consent

You are invited to participate in a study investigating what men think about themselves in relation to their families, their friends, and their work. As well how they think about the psychological services and what kind of therapy they prefer for depression. This study will be undertaken by myself Zakaria Batty, under the supervision of Dr Jane Ussher and Dr Jim Malcolm. The Study will constitute the thesis component of my Doctor degree (Ph.D) in Psychology at the University of Western Sydney.

If you agree to become a participant you will be asked to complete 4 questionnaires, which will take approximately 30 minutes. You are under no obligation to complete the questionnaire once you have commenced, and you may withdraw at any time. All individual data gathered will be kept strictly confidential. The results of this research will be presented in summary form in a thesis, which may be published at a later date, in full or part. If you are interested in having a written summary of the findings you can return the postcard provided with the questionnaires on the details listed below after Feb 28,2002.

Confidentiality will be maintained through anonymity and completed questionnaires will be retained in a locked file. The data will be kept secure for a minimum of 5 years, after which time it will be destroyed.

The Following details outline the procedures involved in participating in this research. Please take your time to read these.

-You will be given a package containing 4 questionnaires, which you will be invited to complete. Completion of the questionnaires will take approximately 35 minutes. **The questionnaires are:**

1-gender role conflict scale: measure what men think about themselves in relation to their families, their friends, and their work. The GRCS contains 37 items, each item consists of a statement that the participant responds to on a 6-point Likert-type scale, with responses ranging from "strongly agree" to "strongly disagree."

2- The Attitudes toward Seeking Professional Psychological Help Scale: assess the propensity of an individual to seek psychotherapeutic assistance. The ATSPPH scale consists of 29 statements, which the participant rates on a 4-point Likert-type scale, ranging from "agree" to "disagree."

3-Preferences for therapies: present 22 therapies (Psychotherapy, systematic desensitisation, assertiveness training, rational-emotive therapy, thought-stopping therapy, non-directive therapy, existential therapy, and Gestalt therapy, aversion Therapy, Implosion therapy, token economies, behaviour contracting, and modelling/role playing, chemotherapy, electroconvulsive therapy, and Psychosurgery), with descriptions of the various therapies that a person might consider in an attempt to get help for psychological disorders.

Moreover, 9 questions are going to be included with the Preferences for therapies, covering the participants' preferences in relation to therapies' (modality, length and accessibility), the characteristics they prefer in the therapist (age, gender, race and experience level).

4-Demographic questionnaire: is brief and designed to gather information from participants concerning age, ethnicity, Social Status, Sexual orientation, Economic Status, Education and Profession, Previous experience with depression and seeking help.

- Please notice that some questionnaires (ie. Demographic questionnaire) will address personal questions
- Involvement/non involvement will not affect your job or studies in any way.
- You will be under no obligation to complete the research if you choose to start it.
- If you have any queries while you are completing the questionnaires please direct them to the researcher.
- Once you have completed the questionnaires these should be placed and sealed in the envelope provided.

If you are interested in participation, please sign the consent form and give it to the researcher. And keep the information sheet for future reference.

If you would like further information on the research, its progress, results, more information on gender role conflict and self concept or information about counselling support and services please call me c/- Dr Jane Ussher, Ph 02/91305606.

Thank you for your time and for agreeing to participate in this study.

Zakaria Batty

I (The participant) have read and understand the information above, and any questions I have asked have been answered to my satisfaction. I understand that my participation is voluntary and I agree to participate in this research, knowing that I can withdraw at any time. I have been given a copy of this form to keep.

Participant's

Name:-----(block letters)

Participant's signature:-----Date:-----

NB: Upon finishing this study, a second will be carried on about the same topic. You can read about the second study in the Information and Consent form for the second study. If you would like to take part in the second study please forward the postcard in the packet separately, to notify us concerning your participation in the second study. The second study will start after February 2002. Thank you.

Note: this study has been approved by the University of Western Sydney Nepean Human Ethics Review Committee. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics committee through the Research Ethics Co-ordinator (Tel 02 47 360 169). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Appendix G

Multidimensional Coping Inventory

(MCI)

Multidimensional Coping Inventory

Please circle the number from 1 to 5 in this scale for each of the following items. Indicate how much you engage in these activities when you encounter a difficult or stressful or upsetting situation. (1=never or hardly ever; 5=frequently or very frequently)

1 Schedule my time better	1	2	3	4	5
2 Focus on the problem and see how I can solve it	1	2	3	4	5
3 Try to think about the good times I've had	1	2	3	4	5
4 Try to be with other people	1	2	3	4	5
5 Blame myself for procrastinating (putting things off)	1	2	3	4	5
6 Do what I think is best	1	2	3	4	5
7 Preoccupied with aches and pains	1	2	3	4	5
8 Blame myself for having gotten in this situation	1	2	3	4	5
9 Window shop	1	2	3	4	5
10 Outline my priorities	1	2	3	4	5
11 Try to go to sleep	1	2	3	4	5
12 Treat myself with a favourite food or snack	1	2	3	4	5
13 Feel anxious about not being able to cope	1	2	3	4	5
14 Become very tense	1	2	3	4	5
15 Think about how I have solved similar problems	1	2	3	4	5
16 Tell myself that this is really not happening to me	1	2	3	4	5
17 Blame myself for being too emotional about the situation	1	2	3	4	5
18 Go out for a snack or a meal	1	2	3	4	5
19 Become very upset	1	2	3	4	5
20 Buy myself something	1	2	3	4	5
21 Determine a course of action and follow it	1	2	3	4	5
22 Blame it on myself for not knowing what to do	1	2	3	4	5
23 Go to a party	1	2	3	4	5
24 Work to understand the situation	1	2	3	4	5
25 "Freeze" and don't know what to do	1	2	3	4	5
26 Take corrective action immediately	1	2	3	4	5
27 Think about the event and learn from my mistake	1	2	3	4	5
28 Wish that I could change what happened or how I felt	1	2	3	4	5
29 Visit a friend	1	2	3	4	5
30 Worry about what I am going to do	1	2	3	4	5
31 Spend time with a special person	1	2	3	4	5
32 Go for a walk	1	2	3	4	5
33 Tell myself that it will never happen again	1	2	3	4	5
34 Focus on my general inadequacies	1	2	3	4	5
35 Talk to someone who's advice I value	1	2	3	4	5
36 Analyse the problem before reacting	1	2	3	4	5
37 Phone a friend	1	2	3	4	5
38 Get angry	1	2	3	4	5
39 Adjust my priorities	1	2	3	4	5
40 See a movie	1	2	3	4	5
41 Get control of the situation	1	2	3	4	5
42 Make an extra effort to get things done	1	2	3	4	5
43 Come up with several different solutions to the problem	1	2	3	4	5
44 Take time off and get away from the situation	1	2	3	4	5
45 Take it out on other people	1	2	3	4	5
46 Use the situation to prove I can do it	1	2	3	4	5
47 Try to be organized so I can be on top of the situation	1	2	3	4	5
48 Watch TV	1	2	3	4	5

Appendix H

Information Sheet for Study Two



Information Sheet

Second study

Human Subjects Research Consent Form
University of Western Sydney (UWS)
Department of Psychology
Letter of Informed Consent

You are invited to participate in a study investigating how men view counselling, as well how they think about health services. This study will be undertaken by myself Zakaria Batty, under the supervision of Dr Jane Ussher and Dr Jim Malcolm. The Study will constitute the thesis component of my Doctor degree (Ph.D) in Psychology at the University of Western Sydney.

If you agree to become a participant you will view a 10-minute videotape of a counselling session that focus on vocational and personal problems and complete a measure of attitude toward seeking psychological help, which will take approximately 10 minutes. You are under no obligation to complete the interview once you have commenced, and you may withdraw at any time. All individual data gathered will be kept strictly confidential.

From this information, I will write a research about what men think about themselves in relation to their families, their friends, and their work. As well how they think about the psychological services and what kind of therapy they prefer for depression. The results of this research will be presented in summary form in a thesis, which may be published at a later date, in full or part.

Confidentiality will be maintained through anonymity and interviews will be retained in a locked file. The data will be kept secure for a minimum of 5 years, after which time it will be destroyed.

The Following details outline the procedures involved in participating in this research. Please take your time to read these.

- View a 10-minute videotape of a counselling session that focus on vocational and personal problems.
- complete a measure of attitude toward seeking psychological help, which will take approximately 10 minutes.
- Your real name will not be used at any point of information collection, or in the research; instead, you and any other person and place names involved in your case will be given pseudonyms that will be used in all verbal and written records and reports.
- Your participation in this research is voluntary; you have the right to withdraw at any point of the study, for any reason, and without any prejudice. You will be under no obligation to complete the interview if you choose to start it.
- If you have any queries whether before or during the interview please direct them to the researcher.

If you are interested in participation, please sign the consent form and give it to the researcher. And keep the information sheet for future reference.

If you would like further information on the research on the research, its progress, results or publications details please call me c/- Dr Jane Ussher, Ph 02/91305606.

Thank you for your time and for agreeing to participate in this study.

Note: this study has been approved by the University of Western Sydney Nepean Human Ethics Review Committee. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics committee through the Research Ethics Co-ordinator (Tel 02 47 360 169). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Appendix I

Consent Form for Study Two



Consent Form

Second study

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Department of Psychology
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If you agree to become a participant you will view a 10-minute videotape of a counselling session that focus on vocational and personal problems and complete a measure of attitude toward seeking psychological help, which will take approximately 10 minutes. You are under no obligation to complete the interview once you have commenced, and you may withdraw at any time. All individual data gathered will be kept strictly confidential.

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- Your real name will not be used at any point of information collection, or in the research; instead, you and any other person and place names involved in your case will be given pseudonyms that will be used in all verbal and written records and reports.
- Your participation in this research is voluntary; you have the right to withdraw at any point of the study, for any reason, and without any prejudice. You will be under no obligation to complete the interview if you choose to start it.
- If you have any queries whether before or during the interview please direct them to the researcher.

If you are interested in participation, please sign the consent form and give it to the researcher. And keep the information sheet for future reference.

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Thank you for your time and for agreeing to participate in this study.

Zakaria Batty

I (The participant) have read and understand the information above, and any questions I have asked have been answered to my satisfaction. I understand that my participation is voluntary and I agree to participate in this research, knowing that I can withdraw at any time. I have been given a copy of this form to keep.

Participant's
Name:-----(block letters)
Participant's signature:-----Date:-----
Means of contact (Tel number or address)-----

Note: this study has been approved by the University of Western Sydney Nepean Human Ethics Review Committee. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics committee through the Research Ethics Co-ordinator (Tel 02 47 360 169). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Appendix J

Demographics of the Participants

Descriptive Statistics for the Demographics of the Participants

Demographics		Frequency	Percent	Cumulative Percent
Age	18-30	280	70.53	70.53
	31-45	117	29.47	100.00
	Total	397	100.00	
Marital Status	Married	146	36.78	36.78
	Single	235	59.19	95.97
	Other	16	4.03	100.00
	Total	397	100.00	
Sexual Orientation	Heterosexual	389	97.98	97.98
	Other	8	2.02	100.00
	Total	397	100.00	
Occupation	Blue collar	123	30.98	30.98
	White collar	157	39.55	70.53
	Student	117	29.47	100.00
	Total	397	100.00	
Income	Less Than \$AU 10.000	83	20.91	20.91
	\$AU 10.000-\$AU 30.000	72	18.14	39.04
	\$AU 30.000-\$AU 50.000	205	51.64	90.68
	Greater Than \$AU 50.000	37	9.32	100.00
	Total	397	100.00	
Education	Secondary	53	13.35	13.35
	Post-secondary	197	49.62	62.97
	Tertiary	147	37.03	100.00
	Total	397	100.00	
Current Status	Employed	276	69.52	69.52
	Unemployed	4	1.01	70.53
	Full Time Student	117	29.47	100.00
	Total	397	100.00	
Ethnic Group	Asian	187	47.10	47.10
	Anglo-European	150	37.78	84.89
	Middle Eastern	44	11.08	95.97
	Other	16	4.03	100.00
	Total	397	100.00	
Ever Felt Depressed?	Yes	285	71.79	71.79
	No	51	12.85	84.63
	Not Sure	61	15.37	100.00
	Total	397	100.00	
Did you seek Professional Help?	Yes	45	11.34	11.34
	No	352	88.66	100.00
	Total	397	100.00	
Do you have any physical problems? (e.g. Heart problems , Cancer, Ulcer, ...etc)	Yes	14	3.53	3.53
	No	383	96.47	100.00
	Total	397	100.00	

Appendix k

Ethics Approval



UNIVERSITY OF WESTERN SYDNEY

Locked Bag 1797
PENRITH SOUTH DC NSW 1797

23 October 2001

Zakaria Batty
13/6-10 Inkerman Street
Parramatta NSW 2150

Dear Zakaria

Re: Research Project: *Gender role conflict and self-concepts in men and therapy seeking and preferences for depression* Registration Number HEC 01/153

Your responses have been reviewed and you are advised that your project has now been granted a full ethics approval. The following modifications to the Information letter are required.

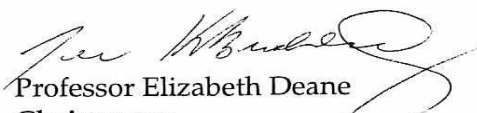
The Information letter should be printed on UWS Letterhead and the Ethics Complaint Clause should be located on the bottom of the Information letter. Counselling should be provided by a counsellor other than the researcher and contact details of a counselling service provided in the letter.

You are advised that the Committee should be notified of any further change/s to the research methodology should there be any in the future. You will be required to provide a report on the ethical aspects of your project at the completion of this project. The form is located on the Research Services Web Page and is also attached.

The Protocol No. HE 01/153 should be quoted in all future correspondence about this project. Your approval will expire 30 December 2003. Please contact the Human Ethics Officer, Kay Buckley on tel: 4570 1136 if you require any further information.

The Committee wishes you well with your research.

Yours sincerely


Professor Elizabeth Deane
Chairperson
UWS Human Research Ethics Committee

University of Western Sydney
Campuses:
Bankstown
Blacktown
Campbelltown
Hawkesbury
Parramatta
Penrith
<http://www.uws.edu.au/>