Exploring working class men's experiences of their social context and its impact on mental health and help seeking behaviour in the South Wales Valleys.

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Abstract

Past intersectional research has suggested that men living in socially deprived areas are 51% more likely to experience major depressive disorder. Furthermore, men have increased rates of mental distress and psychopathology in comparison to individuals from higher socioeconomic status's (Remes, Lafortune and Wainright et al. 2019; Johnson, Cohen and Dohwrenwend, 1999), and for middle aged men, there is an increased risk of suicide (Simms, Scowcroft and Mette et al. 2019). Whilst links between areas of social deprivation and mental health are widely acknowledged within the literature, the mechanisms that underpin these statistics are less understood (Wickham, Shryane and Lyons et al. 2014).

To address this identified gap in the literature, this study explored individual mental health experiences and perceived barriers to engaging with services for working class men in the South Wales Valleys. Six men, ages from 25 - 35 took part in semi-structured interviews, five of which occurred face to face, and one via Microsoft teams. All the participants identified as 'white', 'heterosexual' and as being 'lower' or 'poor' class when asked to identify their socio-economic positioning.

The qualitative study adopted a critical realist and phenomenological approach as the epistemological position, and interpretative phenomenology analysis was employed to explore mental health experiences and perceived barriers to support seeking. Identifying the difficulties in recruiting from a participant population that do not engage well with support services, an intimate partial insider perspective was adopted in which the researcher utilised already established relationships as the basis for investigative research (Ryan, Hoffman and Aaron, 2011).

Twelve themes were developed from the data, eight of which were constructed as subthemes, and four were developed into superordinate themes: **Theme 1** "*It's hard to live around here, I see the Valleys as fight or flight*", **Theme 2** *Questioning the masculinity script "We're not fucking cavemen anymore"*, **Theme 3** *"Self-medicating in the Valleys*" and **Theme 4** *Us and them.* Each superordinate theme contained two sub themes.

The results offer a developed insight into how social, political, and ideological powers and oppressions operate, and how they impact the mental health experiences of six working class men in the South Wales Valleys. Findings indicate normalisation of mental health distress, economic hardship, and poor mental health literacy within the Valleys. Although economic issues such as poor opportunities were identified to impact wellbeing, predominantly individualistic views of mental health difficulties were identified. This was particularly problematic for the participants as it induced feelings of personal responsibility and shame. From an intersectional lens hegemonic masculine ideologies in the socio-political context of the participants experience were identified to create intense intra and interpersonal difficulties for the participants. Professional support for mental health difficulties was conceptualised as an unattractive option for participants until reaching a point of crisis. Distrust and relational difficulties with mental health professionals were identified as emerging from processes of 'othering' that has its roots in unarticulated social power inequalities within the participants relationships with professionals.

This research encourages professionals to consider how individual therapy can be at best be limited and at worst harmful if it doesn't consider the wider challenges to an individual's experience (Bostock, 2017), and encourages psychologists to view individual distress in its social context. It also highlights the need to raise class-consciousness within therapeutic training programs and within individual practice to encourage therapists to take a critical stance on the prevailing individualistic discourses of mental health. By acknowledging the client's socio-political context, and the social power dynamics in professional relationships therapist can avoid replicating oppressive experiences.

Chapter 1: Introduction

Background

The Welsh annual population survey, which asks respondents to score their overall wellbeing on a scale of 0 – 10, identified that in 2020 mental wellbeing in Wales was the lowest of all four nations (Public health Wales, 2020). Area deprivation has been found to widely mediate the prevalence of mental health issues across Wales, 20% of adults in the most deprived areas of Wales reported receiving treatment for their mental wellbeing in comparison to just 8% of adults in the least deprived areas (Watkins, 2021). This begins to highlight the role of social and economic inequalities as mechanisms for cultural and experiential differences which in turn have significant consequences for individuals' health and wellbeing. A report by Public Health Wales Observatory (2020) demonstrated that the least deprived areas in Wales report better outcomes on all mental wellness indicators and the largest gap reported between the most and least deprived areas occurred within the domain of '*high sense of life satisfaction*'. Furthermore, the most recent statistics indicate that the South Wales Valleys, an area marked by significant social deprivation, has one of the highest levels of antidepressant prescribing in the UK with as many as one in six individuals taking antidepressants in some areas (Gulland, 2015).

A review into health inequalities in Wales revealed that a higher proportion of women report depression in comparison to men, and 14% of women report receiving treatment for mental health issues in comparison to just 8% of males. However, significantly more men in Wales than women commit suicide, in 2019 there were 330 reported deaths by suicide, of which 248 were male and 82 female (Watkins, 2021). Stigma around male mental health and mental health help seeking behavior in Wales has been considered to mediate such statistics however, to increase understanding of the factors impacting on the mental health experience of men in the Valleys further research is needed.

Rational

The statistics reported highlight significant disparities in mental health and wellbeing between males and females, and levels of deprivation. Interestingly and concerningly, both gender and level of deprivation appear to be moderating factors of mental health and wellbeing. For example, it has been reported that men living in socially deprived areas have been found to be 51% more likely to experience major depressive disorder than those not living in deprivation (Remes, Lafortune and Wainright et al. 2019). Furthermore, in a review by Wyllie, Platt and Brownlie (2012), it was illustrated that there is an increased risk of suicide for middle aged men who reside within low socio-economic groups. Such links have been regularly acknowledged and reported, often through the lens of categorical rankings that highlight health inequalities. However, whilst informative in identifying where inequalities exist, the mechanisms that underpin the statistics are less well understood (Wickham et al., 2014). Research that explores these identified inequalities at a qualitative level would allow for the generation of rich insightful data that could lead to more effective tailored interventions, that could be used to better reduce reported inequalities.

Proposal

This research aims to better understand the underlaying mechanisms of frequently reported statistics relating to mental health and social deprivation. The proposed research will adopt a qualitative approach to exploring the mental health experiences of working-class men in the Welsh Valleys and will consider the factors that impact how such men seek support for their mental health difficulties. The research will utilise an insider perspective to develop rich, insightful data pertaining to the intersection of culture within the socially deprived Valleys, the experience of mental health difficulties and being a male. Both the insider perspective and the qualitative investigation will offer a new and novel way of considering the lived experiences of these men within the Welsh Valleys.

This study will explore, at an individual level, the men's experience of having mental health issues, the perceived barriers to engaging with services in the Welsh Valleys, and alternative methods of support undertaken. In consideration of the stigma around men's mental health, and the difficulty in engaging with services, an insider approach to this research area will offer the opportunity to give voice to a population that may otherwise be hard to reach and difficult to engage with. The study will provide important and valuable data that can help Counselling Psychologists, healthcare workers and health policy makers understand the mechanisms underpinning the health inequalities in Wales.

Chapter 2: Literature review

Situating the study – The Valleys

The study is situated in the Welsh Valleys which are immersed in wide-spread social deprivation originating from the demise of the area's steel and coal industries in the 1960's. Post-industrial bleakness has perpetuated the landscape and whilst the Valleys were deindustrialised, the local communities remained. The economic blows endured by the Valleys are evident still in the poor availability and quality of public amenities, and within the challenges the residents face in health, emotional and social domains (Byrne, Elliot, and Williams, 2016). In the most recent comparison to the whole of Wales and the UK, the Valleys have typically fared worse in the main socio-economic indicators. The strained socio-economic context of the Welsh Valleys, particularly the Caerphilly borough, the area in which this research was conducted in, has been ranked as the third most deprived area in Wales (Jones, 2019). Due to the harsh economic downturn, areas in the Welsh Valleys have become subject to place-based stigma. In the current neoliberal climate in the UK, there has been a fundamental motivation to move people away from unemployment and into employment without consideration of the availability of work. Through the imposition of government payment sanctions, people who are not engaged with this movement are often conceptualised as '*useless*' to economic recovery, demonising and degrading the individual. Such practices serve to reinforce and legitimise inequalities through the construction of symbolic meanings that become attached to certain areas (Byrne, Elliot and Williams, 2015). Solidaristic institutions such as unions can help address such stigma, however, there has been a demise of people's unions in the Welsh Valleys. When collective forms of actions and means of expression are unavailable to a population, the despairing experience of poverty and exclusion is often individualised (Shildrick and MacDonald, 2013).

Economic downturn, deprivation, and health inequalities in the Valleys often attract media attention who publish disturbing headlines about the area, for example; '*Depressed in the Valleys, a staggering 1 in 3 people in Welsh town on anti-depressants*' (Axenderrie, 2017), '*The unbearable sadness of the Welsh Valleys*' (Easton, 2013), '*There's no life here: A journey into Britain's Precarious Future*' (The Guardian, 2017), and '*The Welsh Village where half the*

kids group up in poverty' (Hayward, 2019). Such representations promote '*othering'* and in the local communities a sense of being '*othered*' is adopted by the residents (Galea and Vlahov, 2005). The Welsh Valleys have been represented on television media through shows such as '*The Valleys*' and Channel 4's '*Skint*', which have come under considerable criticism due to negative portrayals of the area and residents that impact on territorial stigma (Richards, 2015). This can further complicate the support received for mental health issues for individuals from such areas if the healthcare staff are influenced by place-based stigma. Indeed, some studies have demonstrated that mental healthcare staff hold stigmatising beliefs toward individuals with a mental illness (Hansson, Jormfeldt and Svedberg et al. 2013), although it is unclear if such beliefs are apparent in the Welsh Valleys.

Mental health in Wales

In 2009, mental health conditions in Wales accounted for 20% of the total health issues, however, just 12.2% of the public expenditure on health and social care in Wales was directed to the mental health sector (Friedli and Parsonage, 2009). In 2015 the prevalence of mental health conditions had grown without any increase of financial support, and government spending was reported to be disproportionately out of pace with the prevalence of mental health issues experienced by the population (Smith, 2015), by 2021 expenditure for mental health was reduced to 11.1% even though the prevalence of mental health difficulties has continued to increase (Watkins, 2021).

A review of health inequalities in Wales revealed a sporadic provision of appropriately trained staff across the country. From a patient perspective, it found that just 24% of individuals with depression and anxiety disorders receive any form of treatment, 8% of patients with depression had seen a psychologist and 3% a psychiatrist. Twenty percent of people who were successful in a suicide attempt in Wales had been discharged from a healthcare point within the last three months, and 28% missed their last appointment prior to their suicides. It also highlighted issues of difference around gender, higher proportions of women reported depression in comparison to men 14% of women reported receiving treatment for mental health issues in comparison to just 8% of men. However, in contrast to these figures significantly more men in Wales than women carry out suicide (Smith, 2015). Such gender differences in mental health in Wales have been noted in several studies (Mental Health Foundation Wales, 2016; Public Health Wales NHS Observatory, 2020). In 2015, the suicide rate for men in Wales was 19.1 per 100,000 compared with 6.9 per 100,000 for women (Simms and Scowcroft et al. 2019). Higher rates of male suicide have been partially explained by lower rates of help seeking (Biddle et al, 2004), stigma around men's mental health and mental health help seeking behavior has been considered to mediate such statistics (Smith, 2015).

Social deprivation

Across the UK, using individual mental health measures, varying levels of mental health and wellbeing has been linked to levels of social deprivation within the given location (Fone and Dunstan, 2006; Maconick, Rains and Jones et al. 2021). In Wales, area deprivation widely mediates the prevalence of mental health issues. In 2019 20% of adults in the most deprived areas reported receiving professional help for mental health concerns, in comparison to just 8% of adults from the least deprived areas (Watkins, 2021). Such statistics demonstrate how social and economic inequalities are mechanisms for cultural and experiential differences that have significant consequences for health and wellbeing. A report by Public Health Wales (2020) demonstrated that the least deprived areas in Wales report better outcomes on all mental wellness indicators, with the largest gap being between the most and least deprived areas in the domain of '*high sense of life satisfaction*'.

A study by Delgadillo and Asaria, et al. (2016) analysed data from 293,400 cases based within over one hundred psychological services across England. It found a significant correlation between social deprivation and referral rates to services. Whist this was suggestive of a higher need for psychological treatment in areas of deprivation, access rates to such services were not correlated with deprivation. This incongruence between need, and the rate of cases that received treatment was conceptualised as '*access gap*'. Butterworth, Olesen, and Leach (2013) suggest that an increased rates of utilisation of primary care services and prescription of antidepressants exist in areas of socio-economic disadvantage. This argument is consistent with research within the South Wales Valleys which suggests that this area has one of the highest levels of antidepressant prescribing in the UK, with as many as one in six individuals taking antidepressants in some local areas of the Welsh Valleys (Gulland, 2015).

The detrimental impact of social deprivation on mental health has been widely acknowledged in psychological and social literature dating back to the 1930s. Reports suggest that low-income communities have more than the general population's average number of depressed individuals (Kuruvilla and Jacob, 2007). It has further been acknowledged that the most common mental health disorders are anxiety and depression, both of which are the most prevalent among individuals experiencing social deprivation (Weich and Lewis,

1998; Reijneveld and Schene, 1988). This is consistent with the literature which frequently reports that social deprivation is linked with depression (Andersen at al. 2009; Galea et al. 2007; Lorant et al. 2003), and anxiety disorders (Berry et al. 2012; Fryers et al. 2005; Remes et al. 2017). Whilst the link between mental health and social deprivation is widely documented and recognised, including the role of gender in amplifying such statistics, the mechanisms that underpin these statistics are poorly understood (Wickham et al. 2014). In a large-scale UK study, men living in socially deprived areas were found to be 51% more likely to experience major depressive disorder than those not living in deprivation (Remes, Lafortune and Wainright et al. 2019). Whilst statistically such findings are cause for concern, it's difficult to propose interventions when the underpinning mechanisms are poorly understood.

Not only has the onset and maintenance of depression and anxiety been linked to social deprivation, but so too has recovery from mental illness. In 2016 the NHS published statistics demonstrating a reduced likelihood of recovering from depression and anxiety for individuals living in an area of social deprivation. The report indicated that 92,000 referrals were made to mental health services from 10% of the least deprived areas, of which 55% of these patients achieved recovery. Comparatively, 200,000 referrals were made from 10% of the most deprived areas, of which just 35% of patients achieved recovery (NHS Digital, 2018). A systematic review of papers discussing descriptions and models of personal recovery was conducted by Leamy et al. (2005). A conceptualised framework comprising of five interlinking recovery processes were identified; Empowerment and reclaiming control over one's life, rebuilding positive personal and social identities (including dealing with the impact of stigma and discrimination), connectedness (including both personal and family relationships, and wider aspects of social inclusion, hope and optimism about the future, finding meaning and purpose in life. These findings add weight to the argument that recovery and personal growth are dependent on a supportive social environment which can be accepting and enabling for the person (Tew and Ramon et al. 2012). However, research that brings understanding to why recovery rates are lower in areas of deprivation is scarce in the literature, and there is even less clarity regarding how social factors play a part in recovery (Tew and Ramon et al. 2012). Although, it can be hypothesised that the barriers individuals from areas of social deprivation face in making improvements and managing their mental

health, are mediated by social issues such as poor job opportunities and stigma in the community.

Socio-economic status

Links between mental health and socio-economic status are well documented within the literature (Jokela, Batty and Elovianio, 2013). Past research has indicated that the lower an individual's socio-economic status, the greater their risk of experiencing mental illness, which is consistent across the lifespan (Reiss, Meyrose and Otto et al. 2019). It was also identified in a review by the Samaritans (2020), that middle-aged men within low socio-economic groups had an increased risk of suicide compared to middle and upper-class men. Many researchers highlight and call for a need for a sharper focus on the impact of socio-economic factors in the effort to address health inequalities (MaCintyre, Ferris and Gonclaves, 2018). A large UK study of 28,000 individuals demonstrated significant socio-economic inequalities in the prevalence of common mental health disorders. Low socio-economic status variables were associated with a greater likelihood of receiving psychotherapy within the NHS. However, an inverse correlation was noted between low socio-economic status and engagement in private psychotherapy. Dorner and Miltendorfer-Rutz (2017) considered the mediating role of socio-economic status on treatment outcomes in patients diagnosed with a common mental health disorder. They suggest that the interpretation of their results can be considered over two distinct pathways; morbidity related, or treatment related. Low education was found to be a salient comorbidity factor for individuals affected by low socio-economic status. Individuals with a lower education more often received a clinical diagnosis of anxiety or depression and were prescribed medication more often in comparison to individuals with a higher level of education who received more stress related diagnosis.

Some studies have found that individuals with lower socio-economic status (SES) are disproportionately under-represented in psychotherapy services in the UK (Saxon et al. 2007). Two causal pathways can be considered; individual factors of attendance rates to psychotherapy, and issues around referral from services. There have been a number of studies from the UK and US that demonstrate that lower SES correlates with poor attendance rates for first appointments and the attrition rates to treatment (Clarkin and Levy, 2004; Self et al., 2005). Whilst some researchers suggest that the mechanisms that underpin these findings are poorly understood (Self et al. 2005), others have hypothesised that individuals from low income, or working class backgrounds may experience a number of barriers to

effective psychotherapeutic intervention for their psychological distress such as; logistical problems of transportation and childcare, perceived stigma and mistrust of mental health services, and cultural differences and beliefs around help seeking (Goodman, Smith and Banyard, 2010; Krupnick and Melnikoff, 2012; Levy and O'Hara, 2010).

From a service perspective

Much research suggests that mental health care is poorest amongst individuals with low socio-economic status (Krvimaki, Gunnell and Lawlor, 2007; Howard, Cornille and Lyons; Muntaner, Eaton and Miech, 2004). The inverse care law (Tudor-Hart, 1971) states that the availability of good medical care varies inversely with the need for it in the population, and has been demonstrated across a number of studies (Appleby and Deeming, 2001; Langham et al., 2002; Reid, Cook and Majeed, 1999). Findings suggest that there is discrepancy between the distribution of care and clinical need, which in turn mediates the outcomes demonstrating lower treatment rates for disadvantaged groups. Furthermore, some studies have reported evidence that public funded psychotherapy treatment is increasingly offered to individuals from low socio-economic backgrounds, although such studies are limited in their assessment of attrition rates and effectiveness of these interventions (Jokela, Batty and Elovianio, 2013). Whilst research on engagement with services predominantly focuses on individual characteristics of the patient, healthcare staff variables can also be a contributing factor. The positioning of healthcare staff attitudes, ideas, and feelings around working with individuals from low socio-economic backgrounds can act as barriers to effective therapy (Kim and Cardamil, 2012). Smith (2005; 2009) suggests that attitudinal classist barriers may occur as a response of healthcare providers' discomfort in dealing with clients' bleak circumstances, or conscious/unconscious uncomfortableness with facing the pain and suffering produced by economic disparity. Under-representation of low SES individuals in psychotherapy services may relate to such barriers. In a qualitative study by Chew-Graham et al. (2002), care management of individuals from lower socio-economic backgrounds differed to those from more affluent areas due to the perceptions GPs held about the difficulties the individuals faced. GPs often viewed the issues impacting individuals of low SES and those from socially deprived areas as insoluble, relating to wider structural and social factors influencing their situation, whereas depression in more affluent individuals was considered treatable. Health inequalities are considered to be primarily structural, having an impacting and detrimental influence on health via environmental, social, psychological and biological mechanisms (Adler and Stewart, 2010; McCartney et al., 2013). Diderichsen, Hallqvist and Whitehead (2018) propose that within the ranking of health inequalities, poor health amongst the working class is often conceptualised as a result of 'bad behaviors' of the population such as making poor

health choices. Such misconceptions can create missed opportunities to further explore potential differential vulnerabilities between populations. Interpretation into the causal processes that underpin health inequalities are therefore misunderstood and unrecognised (Geyer and Hemstrom et al. 2006).

Although discrepancies between the prevalence of, and recovery from mental illness across socio-economic groups are widely acknowledged in the literature, treatment research, such as psychotherapy research has paid much less attention to such variables (Liu et al., 2004; Smith, 2000; Levy and O'Hara, 2010). The National Institute for Health and Clinical Excellence (NICE) develops national guidance for care services within the National Health Service (NHS) in relation to the delivery of psychological therapies. To do so it adopts a biomedical model to consider issues of mental health. Whilst providing empirical evidence for interventions, it has been heavily criticised for promoting a narrative of practice which assumes a '*one size fits all'* approach (Guy and Loewenthal et al. 2011). This current model of treating mental illness is determined by a biomedical system which excludes considerations from a social perspective. This may reflect the vast majority of research on mental health and wellbeing conducted from a biological, physiological and psychological perspective and there being far less research that considers mental health issues from a social perspective (Tew et al. 2006). This occurs despite numerous theorists and researchers who have discussed the social role embedded in the foundations of mental distress (Horwitz, 2002; Ross and Mirowsky, 2003), with some arguing that no individual can have one single need, rather, individuals have a range of interconnecting needs that span from medical to social issues. Attention to the role of social issues has led to many theorists adopting a biopsychosocial model, a perspective that offers a foundation for holistic, non-reductionist ways of viewing a person and their health issues by suggesting no single patient or illness can be reduced to one single aspect (Read, Mosher and Bentall, 2004).

Current treatment of mental health issues predominantly center on evidence-based practice which relies heavily on the use of empirical evidence conducted in the form of randomised control trials (RCTs). Such methods of investigation within research are often considered to be empirically sound and generalizable to all cultures, even when their findings are based on studies which utilise participants from one culture group (Gordon and Hall,

2001). Cooper (2008) highlights that although trials are predominantly focused on exploring the efficacy of psychological interventions, 75% of treatment outcomes are dependent on individual client factors. For example, research that focuses on help seeking behaviors, has been primarily developed from middle class world views (Liu, 2001). Therefore, ideologies and knowledge derived from such investigation cannot generally be applied to working class individuals from areas such as the South Wales Valleys. Stigma has been highlighted by some researchers as the underpinning mechanism that mediates men's lack of engagement with mental health services in Wales (Smith, 2015). To address such issues a consultation with the pre-existing literature around stigma is needed. However, studies exploring mental health stigma have been conducted utilising participants from privileged backgrounds such as white University students (Feldman and Christian, 2007) and middle- aged white women (Boyson, 2017), all of whom are more likely to be predominantly middle class (Feldman and Christian, 2007). This poses significant issues in the generalizability of these findings needed to develop policies and treatment pathways for individuals of low socio-economic status and/or from socially deprived areas.

It can be argued that all psychological knowledge is culturally situated and located in cultural traditions (Teo and Febbraro, 2003). This is particularly important when considering the interventions and services on offer to those presenting with mental health distress. Levy and O'Hara (2010) explored psychological interventions targeted at low-income populations and suggested that interventions need to be adapted to the specific characteristics of the target population. The efficiency and generalization of psychotherapeutic models is often assumed following significant findings from empirical research. Although, the sociocultural contexts in which these findings have occurred are often not considered (Gordon and Hall, 2001). Intra cultural variations, such as socio-economic status may also be present, which psychological and psychotherapeutic research have not considered. Therefore, the generalisation of theoretical frameworks and models may be limited for certain sub-groups of cultures (Gordon and Hall, 2001).

The lack of empirical research into social influences on mental health may explain why a social context element is missing from many treatment models currently used. Tew et al. (2006) emphasis an inherent complexity in researching the social aspects of mental

health which offers a potential understanding for a lack of such empirical evidence within the field. However, the role of social research in the delivery of effective and recovery-orientated mental health services has gained increasing recognition. The value base for such research is proposed by Tew et al (2006) to cover five overarching themes; Partnership which relates to the involvement of stakeholders such as, service users, carers and practitioners in core aspects of the research; Standpoints and distance which was conceptualised as researchers utilising experiential-based knowledge and insights of service users and carers in frameworks that allow for rigorous analysis; holism not reductionism, which considers individual's experience as part of their wider social context emphasising a focus on social change alongside individual recovery; recognition of social diversity, this acknowledges the impact of social diversity on subjective experience, and is mindful about generalisations of research across social or cultural groups; and emancipatory purpose which considers how research can produce evidence and theory that can aid service users and carers to develop awareness of holistic experiences to enable individuals to make informed choices, gain more control over the direction of their lives and increase engagement in social, economic and political life for service users and to further challenge stigma, injustice and social exclusion alongside practitioners and the wider community. The work by Tew highlights the missing value set within much of psychological research today. Derived from NICE guidelines, the current healthcare system adopts an evidence-based practice approach. However, there is an increasing recognition within the field of health care for a practice-based evidence movement. This is reflected in the merging of the Social Care Institute for Excellence with NICE (SPRING, 2009). Such research adds weight to arguments proposed by Joshi (2001) for policy response of macro-economic policies and local area targeting to reduce health inequalities.

In contrast to the prevailing medical model of pathology, alternative models to mental health, and disability in general, such as the '*social-relational model*' (Palmer and Harley, 2012) and the '*interactional approach*' (Riddle, 2013) have emerged. Both emphasis the relationship between the subjective experience of disability such as mental illness, and the social conditions in which it forms. The social-relational model focuses on the specific personal and social effects of what it terms an 'impairment', whilst maintaining that this is largely dependent on the attitudes within the societal context (Palmer and Harley, 2012). The

interactional approach however, securely locates the ‘disability’ within the individual but looks to integrate external factors from the wider social and environmental context (Riddle, 2013).

Men and mental health

Historically, Research on men has been centralised on normative reference for behavior rather than an exploration into the gendered human experience (O'Neil and Renzulli, 2013). Traditionally much of the research in this area has focused on disproportionate representations of males in problematic areas of health wellbeing and development, for example, young boys experience behavioral problems in school to a higher degree than girls and, men are overrepresented in prisons and are more likely to commit or be victim of violent crime (Biderman et al. 2005). However, in recent years researchers and theorists have recognised the need to explore the ecological and sociological factors that influence the mental wellbeing of boys and men. This has culminated into what has been termed the new psychology of men (Levant and Pollack, 1995). The increasing concern for the mental health of men in recent years has been underpinned by statistics outlining the increasing rate of male suicide in the UK that has been described as a '*silent epidemic'* (BBC News, 2008).

Intersectional research has suggested that men living in socially deprived areas are 51% more likely to experience major depressive disorder than those not living in deprivation (Remes, Lafortune and Wainright et al. 2019). Men have increased rates of mental distress, and psychopathology in comparison to individuals from higher socio-economic status's (Johnson, Cohen and Dohwrenwend, 1999), and for middle aged men, they have an increased risk of suicide (Samaritans, 2020). A review into health inequalities in Wales revealed that a higher proportion of women report depression in comparison to men, and 14% of women report receiving treatment for mental health issues in comparison to just 8% of men, however, significantly more men in Wales than women carry out suicide (Smith, 2015).

Often for men, distress can often manifest as anger toward the self or others (Wilkins, 2010), or can mediate an increase in risk taking behavior (Courtney, 2010). The expression of mental health difficulties such as depression within men is considered to be predominantly externalised, resulting in aggression and substance abuse issues whereas women are considered to experience this internally (Price, Greg and Smith et al. 2018; Smith, Mouzan and Elliot, 2018; Rice, Aucote and Eleftheriadis et al. 2018; Rice, Fallon and Aucote et al. 2015). This results in men being diagnosed less often with illnesses such as depression as they do not

fit with gender stereotypical assumptions about men's emotionality (Addis, 2008). Generally, men are more likely to receive an externalized diagnosis such as conduct disorder, or substance use disorders (Cochran and Rabinowitz 2000). External and internal experiences of depression have also been found to moderate men's motivations to seek professional support, and they are considered to mediate reluctance to engage with services more so than when compared to internal expressions (Call and Shafer, 2018).

Masculine Identities

Within much of the literature, masculinity is depicted as a broad conceptualisation of men as being strong, invulnerable, resilient, independent and emotionally inexpressive (Addis and Mahalik, 2003; McCusker and Galupo, 2011; Noone and Stephens, 2008; O'Brien, Hunt, and Hart, 2005). Whilst there are varied conceptualisations of masculine ideologies, there is a consensus on categorical aspects of the identity including anti femininity, achievement, resistance to the appearance of weakness, adventure, risk, and violence. These have been referred to collectively as traditional masculine ideology (Levant and Richmond, 2016). The social constructionist perspective encapsulates the notion of culturally specific identities. This position was foundational in the work of Australian sociologist Raewyn Connell (1995) who introduced the concept of hegemonic masculinity which he defined as "*Currently the most honored way of being a man*" (Connell and Messerschmidt, 2005). It highlights that men are not a homogenous sample, and whilst there often appears to be consensus around the impact of a unified concept of masculinity on mental health issues, sociological literature suggests that multiple forms of masculinity can exist within the male population which adds an often-unconsidered complexity to the issue (Morgan, 1992; Connell, 1995). Connell (2005) suggests that the intersection of hegemonic masculine identities varies dramatically between cultures. The work of Connell (2005) incorporates the notion of power, and how this may be mediated through masculine identities. For some men, local masculine identities will enact a position of privilege while others may become marginalised (Connell, 2005). There are significant differences within societies between social classes, and research has indicated that messages about gender norms are communicated through active, non-linear processes of social interaction (Connell, 2005). The term '*social norms'* relates to the implicit and informal rules and expectations of behavior for specific members of a group or society (Bicchieri, 2006), that are accepted, and abided by, by most members of that population (Cislaghi and Heise, 2016). Socio-economic context can influence social norms; therefore, multiple variations of social norms can exist and are varied on factors such as the class, ethnicity, sexuality and age of the group. In Wales, it has been broadly suggested that there is an embarrassment and stigma for men seeking help for mental health conditions (Smith, 2015) suggesting that help seeking sits outside of the social norms that are allocated and accepted by men in relation to how they manage their mental health concerns. An intersectional lens on this matter may offer a more

developed understanding of the stigma through an exploration of the locally defined conceptualisations of masculinity, and through consideration of factors of power and privilege that may be impacting on experience for men in the Valleys through their economic and social positioning.

Masculinity and help seeking

There is an extensive body of research integrating the concepts of masculinity and men's perceptions of help seeking behavior (Galdas, Cheater and Marshman et al. 2005), and it is widely acknowledged that men tend not to engage with psychological services when experiencing mental health distress (Yousaf, Popat and Hunter, 2015). Many studies have documented a reluctance for men to seek out both formal and informal support for their psychological and emotional difficulties (Addis and Mahalik, 2003). Men often carry the belief that they should tolerate their distress, or independently resolve their issues (Jeffries and Grogan, 2012). Negative perceptions of help seeking can lead to long delays between acknowledging the problem and engaging in help seeking behavior (Johnson and Oliffe et al. 2012), therefore potentially intensifying the issues they face.

Adherence to traditional masculine social norms (Levant and Wimer, 2014), and the role of social stigma have been significant mediating factors for this phenomenon. For many men, holding masculine identities poses a significant barrier to help seeking (Yousaf, Popat and Hunter, 2015). For men who prescribe to traditional masculine identities that denote help seeking and talking about emotions as a non-masculine phenomena, and also experience ideas around help seeking behaviors, gender role conflict can occur, which is defined and developed via culturally embedded conceptualisations of masculinity (Vogel and Wester et al. 2014). The intersections of gender norms, socio-economic hardships, social change, service provisions and issues such as marginalization and discrimination are important to consider when examining help seeking behaviour (Gough and Novikova, 2020). It has been suggested that a lack of visible, available, gender informed therapeutic services that men can turn to in times of distress can create barriers to help seeking (Gough and Novikavo, 2020). Within the literature, there is a lack of qualitative methods of enquiry into the factors impacting men's help seeking behaviour (Galdas, Cheater and Marshman et al. 2005). This may be related to the reluctance men have in engaging with support services, who are then less available to researchers. Of the studies that do exist many do not account for variations such as socio-economic status (Galdas, Cheater and Marshman et al. 2005). Traditionally much of the research in this area has consistently lacked a consideration of the intersection between masculine identities and other identity dimensions such as age, race or sexual orientation, the

impact of significant life events, and wider social determinants of psychological wellbeing (Gough and Novikova, 2020).

Stigma

Mental health stigma is an umbrella term to encapsulate stigma ranging from social (public), self (perceived) and cultural positions. The earliest conceptualisation of stigma comes from Erving Goffman (1963, p.3) who suggests that stigma is: *'an attribute that is deeply discrediting*" that reduces someone "*from a whole and usual person to a tainted, discounted one*", which encapsulates the notion of stigma as being a construct that '*spoils one's identity*'. Within the social work literature, Dudley (2002), developing Goffman's definition, suggests that stigma is characterized by stereotypical views attributed to a person (persons) who are considered to differ from, or are inferior to societal norms. Stigma through the lens of a social and public consideration is conceptualised by some theorists as an accumulation of misperceptions of mental illness often signifying weakness of character. These ideas initiate negative and disapproving attitudes toward individuals with mental health issues (Chatmon, 2020). Stigma is a multifaceted construct which has wide-ranging impacts on an individual's life. The devastating effects of mental illness can be conceptualised as occurring within two broad domains; the direct cognitive, emotional and behavioral difficulties that pervade the individuals life and, the effects of stigma associated with mental illness that impinge on interpersonal relationships (Lefley, 1989), social rejection (Corrigan and Edwards, et al. 2001), and a fractured self-identity (Link, Struening and Neese-Todd et al. 2001; Feldman and Christian, 2007). Even if an individual can manage their psychological difficulties and maintain functioning, their attempts to engage in their social environment may still be impeded by discrimination manifested through a range of societal reactions (Rusch, Angermeyer and Corrigan, 2005). Stigma can also be considered to impact the intrapersonal relationship when cultural stereotypes and prejudices about mental illness become internalised (Watson and Corrigan et al. 2007). When such ideas are accepted and then turned against the self, the individual's self-confidence can be eroded, and a process of self-stigma enacted. The WHO (2001) identify stigma as a key barrier to successful engagement and sustaining participation with treatment services. Social stigma is widely acknowledged as one of the key factors negatively impacting men's help seeking behaviors and the subsequent delivery of psychological services for men (Hammer et al., 2013; Mackenzie, Gekoski, and Knox, 2006; Mahalik et al., 2012). In 2015, the suicide rates between for men in Wales were 19.1 per 100,000 compared with 6.9 per 100,000 for women (Simms

and Scowcroft et al. 2019). Stigma around men's mental health and mental health help seeking behavior in Wales has been considered to mediate such statistics (Smith, 2015) however further investigation into the factors that impinge on the mental wellbeing for men in Wales is needed.

Aims and research questions.

The following study aims to explore the individual mental health experiences and help seeking attitudes and behaviors of working-class men, as defined by low socio-economic status in the South Wales Valleys. Over the years, the Valleys have suffered great economic losses, the repercussions of which are still very much alive and ongoing for the residents. Areas of low socio-economic status, social deprivation, poor work opportunities and high levels of mental health and substance use issues manifest into an intersectional uniqueness. This research seeks to understand the meaning and impact of these social and cultural factors for men who experience mental health difficulties in the Valleys. It further aims to explore culturally specific conceptualisations of masculinity and considers how they impinge on men's ideas, beliefs, and experiences of seeking help and support for mental health issues. The study will explore the lived experiences of men within the subculture of the South Wales Valleys communities, and to highlight shared understandings of mental health and mental health seeking behaviors of men in this area.

The research was shaped by three overarching questions:

- How does the social context within the South Wales Valleys impact on men's mental health?
- How does the culture in the Valleys impact on masculinity?
- What are the barriers men in the South Wales Valley face to achieving and maintaining mental wellbeing?

Personal and professional interest in the project

Coming from a very much working-class background, raised, and still living in an area of high social deprivation, I have been witnessed to and have experienced many problematic and systemic issues that oppress and disadvantage individuals. Historically these experiences have manifest in me as an anger, underpinned by a sense of injustice. With a subjective lens of social disadvantage, I have taken a critical stance on the practice of psychology and research within the field. This has initiated two distinct processes occurring simultaneously within me. Firstly, as I become increasingly aware of social inequalities and biases that permeate the practice of psychology and the field of mental health, I realise the impact they have on me and those around me and am ever more pained by some areas of the profession. Secondly however, concurrently I am also growing, developing, and formulating ideas about change which seek to eliminate inequalities and am finding a home for this in divisions of psychology such as counselling and community psychology. I have invested in exploring an aspect of a social inequality that I am personally and professionally embedded in. Therefore, this project is a manifestation of the integration of my personal and professional development as a counselling psychologist.

I feel that my training as a counselling psychologist and the underpinning values of the profession support me in my journey to engage with and lead this project. Throughout my training I have become increasingly aware of, and have further developed my own passion for social justice. The Division of Counselling Psychology Practice Guidelines (2005, p.2) states that counselling psychologists should "*Recognise social contexts and discrimination and to work always in ways that empower rather than control and also demonstrate the high standards of anti-discriminatory practice appropriate to the pluralistic nature of society today*". Some theorists have argued that concern for social justice issues is at the heart of the counselling psychology profession and encourage practitioners in the field to take an active leadership role to promote social justice (Tribe and Bell, 2018). Counselling psychology holds value in a strength-based view of the individual as situated in their cultural context. Inevitably then, considerations of how counselling psychologists can help individuals from a lens of subjectivity, directly lead to motivations to relieve social inequalities that systematically harm and oppress individuals (Fassinger and Shullman 2017).

Contributions to the field of Counselling Psychology

This study seeks to address the gap in the literature pertaining to the lack of knowledge regarding the lived mental health experiences of men characterised as having a low socio-economic status in the Valleys, an area of high social deprivation and mental illness. This research engages a hard-to-reach population that are substantially under-represented in psychological literature and therefore, considerations of the specific needs that occur within this group are unattended to in mental health policy and service model designs. The research will seek to understand the reasons men experience difficulties engaging with services. Whilst it is not the intention of the research to generalise results, the findings can contribute deep and rich knowledge to the field of enquiry that explores health inequalities between different socio-economic groups. This study aims to explore, at an individual level, the experience of having mental health issues as a man, the experiences of and perceived barriers to engaging with services, and alternative methods of support undertaken by men in the South Wales Valleys. Results emerging from this inquiry can offer an in-depth understanding needed to inform policy regarding the delivery of psychological services in the area, and across Wales. Potential implications for practice and health policy will be suggested.

Chapter 3: Methodology

Introduction

This section will begin by describing the intimate insider position adopted by the researcher. Challenges, advantages, and ethical considerations emerging from this position will then be explored. Further considerations of the researchers' positioning, and how it impacts upon the project are attended within the reflexive account. The chapter then moves on to describe Interpretative phenomenological analysis (IPA) and explores the suitability of this method of analysis for this project. A consideration of participants demographic details, recruitment process and interviews then follow. The chapter concludes by offering detailed overviews of the research and analytical processes undertaken.

The intimate insider

The intimate insider is a methodological approach which conceptualises the individual undertaking the research as both the researcher, and a member of the population under investigation (Brannick and Coghlan, 2007). For many researchers, the binary positioning of the researcher as either insider or outsider has become a problematic concept. It is increasingly recognised that the researcher sits on a continuum (Heslop, Burns and Loblo, 2018), determined by both closeness to the subject under investigation, and dominant socio-demographic characteristics such as; gender, age, ethnicity, religion, social class, education, profession, culture, sexual orientation, aspects of self-identity within the participant and researcher (Mercer, 2007; Trowler, 2011). Terms such as '*total insiders*' and '*partial insiders*' have emerged reflecting the multiple identities that individuals can hold, and the potential for the researcher to meet the participant in some, or all, of these areas (Chavez, 2008).

Traditionally positivism has promoted the researcher as an outsider as the optimum position, in its attempts to ensure objectivity and reduce potential bias (Dwyer and Buckle, 2009). However more recently, participatory, and emancipatory research has brought an opportunity for a shift in the value of objectivity. Within these fields, lived experiences are prioritised, and the insider position is considered integral to conducting ethical and effective research (Heron and Reason, 1997). Insider research can offer many advantages to qualitative

inquiries particularly those that are positioned within a participatory or emancipatory paradigm including; ease of access to a hard to research population, expediency of the development of rapport, a nuanced and depth of understanding of the wider community norms and values, and a richness within the interpretation of the data produced via deep knowledge of the social political and historical context (Chavez, 2008). Taylor (2011) utilises the term 'intimate insider' to conceptualise the researcher who engages with already established relationships to explore research questions under investigation (Taylor, 2011). It has been suggested that it is through a shared common narrative that uses anecdotes and stories, the researchers intimate positioning becomes an effective tool in research (Alsup, 2004). In the research conducted by Taylor (2011) exploring the queer culture, it suggests that it was the intimate insider position that facilitated a deep exploration of the subject topic which may have otherwise emerged as a more superficial narrative.

As an intimate insider in the current project, I share the colloquial dialect and am familiar with the language used by the target population group to express themselves. Such positioning proves advantageous as it facilitates a conceptual understanding of the participant group (Nicholas and Wheatley, 2013). Shaghaghi, Bhopal and Sheikh, (2011) suggest that knowledge about the participant group is also beneficial to the research as the researcher has insight into potential challenges in recruiting participants and collecting data.

Challenges as an insider

Whilst an insider position for the researcher brings many advantages, it can also illicit ethical considerations and challenges to the reliability within the research. The potential for the researcher's subjectivity to pollute the process of analysis is acknowledged as a concern for research that has adopted an intimate insider methodology (Green, 2014). They suggest that this is likely to occur to a greater degree if the researcher does not address his or her own reflexive positioning (Dwyer and Buckle, 2009; Adler and Adler, 1987). In consideration of such issues, I have engaged with reflexivity via journal keeping throughout the project.

Whilst beneficial for rapport and familiarity, shared understanding originating within the insider research positioning may curtail explicit discussions being shared within the interview (Green, 2014). To mitigate these potentially problematic occurrences I facilitated a discussion with each participant prior to the interview in which it was agreed that myself and participants will approach and discuss topics as though we had not spoken about them previously.

The role of social desirability, particularly in qualitative research, could potentially inadvertently introduce biases into the data and therefore must carefully be considered (Stacey and Vincent, 2011). To control for social desirability effects, I discussed the aims of the research during the contracting stage prior to the interview. This offered the opportunity to revisit, with the participant, the intentions of the interview, which were to focus on the participants' lived experiences and subjectivities. The participant was invited to speak freely and openly and encouraged to not be concerned for saying '*the wrong thing*'. Disclosing the aims of the research can help to promote sharing (Bonner, and Tolhurst, 2002) and develop trust (Humphreys, 2001) in the research relationship.

Ethical considerations for research from an insider perspective

Attempts to ensure informed consent (Unluer, 2012) and confidentiality (Wiles et al. 2008) can become compromised by pre-established peer or professional relationships that may occur within the duality of the insider position (Mercer, 2007), or the local network (Parr and Philo, 2003). The likelihood of ethical challenges when conducting insider research can emerge when the research occurs in close knit communities. For research conducted in small rural communities' active gossip networks and increased social proximity can become problematic (Parr and Philo, 2003). In consideration of these potential challenges, I informed each participant that whilst there may be other people they know who partake in the study, their information would not be shared, and I would not disclose, or discuss any information about other participants.

Some participants may feel obliged to participate due to their pre-existing relationship with myself as the researcher (McConel-Henry et al. 2010; Robinson et al. 2005). The potential for this was addressed via the methods of approaching and inviting potential participants to engage with the study, and through obtaining informed consent. The researcher held such ethical considerations in mind and was conscious go ensure a clear message of invitation to participate was delivered, rather than a request or demand. Contracting with the participants offered the opportunity to discuss confidentiality and engage in conversations around how information would be explored i.e., as if this is the first occasion the research and participant have discussed the topics within the interview. Ensuring participants were aware of methods of withdrawal from the study and knowing that declining to participate would not have any negative repercussions were critical practices that were undertaken to maintain the ethical integrity of the research (National Health and Medical Research Council, 2007). Within the project information regarding withdrawal processes was offered and participants were assured that there would be no negative repercussions should they declined the invitation to participate or withdraw from the study. This information was also provided to participants via the participant information sheet.

Reflexive statement

The intimate insider positioning undertaken in this study acknowledges that I have similar personal characteristics and have shared many of the same experiences as the participants. We are of the same generation and have all grown up in low-income households, in the South Wales Valleys. On a social hierarchy I would be considered, and would self-identify as 'working-class, the same as the participants. This means we have been exposed to the same cultural context, at times belonging to the same social circles and have socialised together. We also share a less obvious internal experience in that we all recognise that at some point we have struggled with our mental wellness. The (previous, in my case) use of substances also acts as a common factor between myself and the participants who all recognise how these were used as a coping mechanism for our difficulties. These internal, and external components contribute to my identification as an 'insider' within this research. This reflexive account explores my subjectivity as the researcher, including my intimate insider identity, and the impact of this within the research process.

During my teenage and young adult years I experienced my own mental health issues. I had difficultly accessing and accepting support, and struggled to engage with support services. My troubles stemmed from a difficult home life and were perpetuated by a lack of constructive coping mechanisms and poor knowledge of mental health. As a teenager and young adult, I utilised alcohol and drugs as a means of coping with my distress and externalised much of this through challenging behaviors, much of this was known to the participants in the research. Having these shared experiences with the participants, and their knowledge of this, proved a crucial factor for the interview process. During the interviews the participants knowledge of my history with alcohol and drugs helped facilitate their willingness to share their own experiences. The interview data evidenced this idea by illustrating how the participants have a mistrust of professionals and individuals deemed as 'outside' to the Valleys culture. After the interviews the participants stated that it was unlikely that they would have engaged in this project if approached by a professional person. Trust and safety in the research relationship were established through the recognition of me as an insider to the participants' experience which facilitated their engagement with the project, and their willingness to be open. After the interviews many of the participants shared that they would have been unlikely to engage in the project if they did not have an already established

connection with myself. Those statements support the practice of utilising the insider position for hard-to-reach populations such as the participants in this research.

When I was a teenager, and young adult I had predominantly male friends. I recognise my identity at that time as being aligned more with traditional masculinity than with femininity. I would dress and act very much in line with the males around me. As a woman I recognise that I am separate to the intersectionality that develops from being a man within this context however, I feel closely connected to many of the male oriented experiences described in this research. I believe my alignment with a masculine identity comes from a resistance to accepting the traditional female role apparent in my social culture. In an early relationship I had battled for a more equal footing and left the relationship when this proved unattainable which was also known by the researchers. My resistance to these social norms could have occurred as an attempt to mediate the social norms they experience, with not wanting to offend me by expressing views of women that contrast with my identity. In this sense I think my impact as a strong woman inhibited some part of the dialogue which may have occurred without the fear of offending me. However, my identity as a woman may have encouraged and facilitated the clients to connect with their vulnerability. Many of the participants noted that it is easier to talk with a woman and also described an anxiety of being vulnerable in front of other men. With elements of both a masculine and feminine identity my positioning in relation to the participants is fluid in nature. Within different points of the research, I move along the scale becoming more, or less identified with the participant depending on which aspect of identity is being related to.

Though part of my identity aligned with the participants, other parts sat in quiet contrast. Through my professional training I have stepped outside the Valleys culture and developed an identity that is quite distinct from the social and self-image I held in my younger and most difficult years. The change in identity stemmed from attempting to heal my wounds by enrolling on a counselling course in college in my early-mid 20's. Half-way through I fell pregnant which, in conjunction with the learning I acquired on the course and concurrent personal therapy I engage in, significantly changed the trajectory of my life. I became less aligned with '*the boys'*, softened by motherhood and vulnerable then in a different way. Having a daughter, along with the self-awareness I developed on the counselling course led

me to access and accept support from services and make healthier choices which were suddenly much easier to make as there was something of enormous value and worth in my life at last. Whilst I was still embedded within the Valley's culture, I was also experiencing and tentatively exploring, new ways of being. This continued and developed. I progressed onto a University Degree and then got a job working in the NHS as a therapist helping others. The process was long, complex, and not anywhere near linear as I struggled, and still do sometimes, to integrate these two somewhat contrasting identities. I kept the two worlds quite separate, at university or at work I would feel like I an outsider and uncomfortable with a '*professional identity*', and in the Valley's I was quiet about my professional life, feeling as though I would be rejected or misunderstood somehow for being so soft, and different to both my social peers and my former self. I believe that these experiences, and my own difficulties integrating the personal and professional identities helped inform my understanding of the difficulties with professionals that the participants describe. I recognise my own journey of stepping inside and outside of my culture as influencing how I understood the participants narrative and the subsequent construction of theme 'Insiders and Outsiders'.

I found that conducting the interviews was one of the rare occasions that I was able to integrate both identities. On one level it was a personal relationship embedded in a common history of Valleys culture and personal struggles, on the another it was a professional interaction that brought forward my professional identity and skills. I felt a slight anxiety starting the interviews, on later reflection and during the very early stages of the interviews many of the participants also noted feeling highly anxious. The participants' anxiety was tied to a lack of familiarity with talking in-depth about their experiences or fearing saying the wrong thing. I was able to draw on my skills as a therapist to sit outside of my anxiety and put the interviewee at ease. I felt incredibly warmed and privileged to be able to share this part of myself with the interviewee and for it to be received and accepted by them. I also felt that I was able to connect to each participant on such a deep level, something that we had not achieved in our prior relationship. Some of the men noted this during reflection and suggesting that we were talking more in depth than we had ever done which was framed as a positive aspect of the interview process. Three of the men reflected afterwards that they

had felt better for talking and thanked me for the interview which I was, and still am deeply moved by.

Interpretative Phenomenological Analysis

This qualitative study uses a critical realist and phenomenological approach as the epistemological position. Critical realism suggests that the specific social context impinges on the way that an individual makes meaning from their experiences (Braun and Clarke, 2006). This fits with the design of the study which is concerned with understanding how the Valleys as the social context impacts on how the participants relate to and understand mental health. Interpretative phenomenological analysis (IPA) meets the aims and objectives for the study as it offers a position which prioritises the participant's subjective experience of the research matter. This project the guidance for IPA by Smith, Flowers and Larkin, (2009), however, during the process of this research an updated 2nd edition of Smith Flowers and Larkin (2021) was published. It is beyond the scope of this research to have utilised this new version as the analysis had already been completed.

IPA incorporates the fundamental principles presented within phenomenology, ideography, and hermeneutics. These epistemological assumptions suggest that a real and knowable world exists that can be accessed within research through engagement with the subjective and socially located knowledge (Madill et al. 2000: Braun and Clarke, 2013). IPA as an approach is underpinned by a phenomenological perspective which is both; a philosophy, and a research method concerned with unearthing and understanding the human experience (Leahey, 1994). Phenomenology is considerate of how the world is experienced by individuals within a specific and subjective context and time period and considers how these intertwine during the production of meaning (Zahavi and Simionescu-Panait, 2014). IPA, embedded in a phenomenological perspective has evolved out of the work of Hursserl (1931) who developed the approach to understand the context of the lived experience of his subjects and their meaning making. Manen (1990) who extended the work of Hursserl (1931), developed the approach into the realms of hermeneutical phenomenology, which is concerned with both the phenomenological element (the lived experiences) and the hermeneutics (way in which this is interpretated by the researcher). Based on the work of Giorgoi (1994) IPA takes a holistic position when interpretating the research material from which units of meaning can be developed. These units serve to develop the lived experiences of the participant into

conceptual psychological expressions which are illustrated as the 'essence' of the participants narrative and are written in a reflective and descriptive manner.

IPA has been chosen as from a phenomenological basis, there is an intentional positioning of understanding of the narrative from the insider's perspective, and the acknowledgment of the researcher's subjectivity in the interpretation (Willig and Stainton-Rogers, 2008). Through its exploratory nature, IPA is considered to have the potential to provide insight into topics that researchers have little prior understanding (Smith, Flowers and Larkin, 2009; Thompkins and Eatough, 2012), and thus offers a suitable framework for the intentions of this research. Whilst other phenomenological approaches such as grounded theory require the researcher to 'bracket off' any preconceived assumption, IPA takes an alternative position in considering these aspects of the research as implicit, and necessary to the analysis (Willig, 2012). Such assumptions compliment and facilitate the insider perspective undertaken by me. IPA has also been chosen as the method of analysis as it seeks to understand the lived experiences of individuals (Smith et al.,2009). Whilst discursive approaches are primarily concerned with language and text, the individual is often omitted from the analysis. Conversely IPA focuses on the individual behind the text (Reid, Flowers and Larkin, 2005). The essence of IPA IS that through a process of engagement with transcripts of data, the researcher is seeking to illuminate the meaning contained within individuals' narratives (Smith, 2011).

Participants

Men aged 18+ of low socio-economic status, who live in the South Wales Valleys and have experienced barriers to accessing support for their mental health difficulties were invited to participate in the study. Typically, individuals from disadvantaged groups, such as those included in the research who have a low socio-economic status and live in an area of social deprivation are under-represented in research (Bonveski, Randall and Paul, 2014). Intimate insiders such as peers or local researchers can help address any researcher mistrust or doubt (Ryan, Kofman and Alan, 2014) and thus increase the potential to address the bias within the current literature by conducting research with hard-to-reach populations.

The participants were known to myself through my own social networks. Four of the participants, Greg, Matt, Sam and Carl (pseudonyms used to protect anonymity) are from the same community as me and have belonged to the same social circle as me for over ten years. Jack is the partner of one of my close friends, and Steve is the cousin of my husband. The men were approached and invited to participate in the study as they have expressed their difficulties and/or reluctance in seeking professional help for their mental health concerns. One of the six, Gary, had at the time of the interview been successful in obtaining the support he felt he needed to manage his mental health after a prolonged period of facing barriers to accessing support. The participants are hard to reach and difficult to engage with research due to having a mistrust of services and being affected by mental health stigma. Whilst reflecting on the interviews, many of the participants suggested that they would not have engaged with the research if they had seen a poster or had been approached by a stranger. Whilst traditional research approaches to sampling may suggest this sample is small, within professional doctorate research that utilises an IPA methodology, sample sizes between 4 and 10 are often recommended as sufficient (Willig, 2012).

Participant demographics

Table 1 provides demographic details of the 6 participants as described by the participants. Participants were all male, white, heterosexual, working class, ages ranging from 25 to 35 and worked across various industry sectors. All participants were residents of the Caerphilly Borough in the South Wales Valleys and had been since birth.

Table 1: Demographic details of individuals who participated in the study.

Code name	*Age*	*Industry*	*Sexuality*	*Ethnicity*	*Nationality*	*Economic Status*
Carl	30	Construction	Heterosexual	White	Welsh	Lower class
Greg	35	Sick	Heterosexual	White	Welsh	Poor class
Jack	34	Retail	Heterosexual	White	British	Lower class
Matt	32	Construction	Heterosexual	White	British	Lower class
Sam	34	Barber	Heterosexual	White	British	Lower class
Steve	25	Disabled	Heterosexual	White	British	Lower class

Recruitment

As the study is utilising an IPA perspective, six participants were deemed sufficient (Smith et al. 2009) and were recruited via the researchers own social network. Participants were informed about the study via word of mouth to initiate a snowball effect with the researcher's social network. In a previous study evaluating different recruitment methods to engage with hard-to-reach populations, word of mouth was found to be the most effective method (Gledhill, Abbey and Schweitzer, 2008). Upon receiving expressions of interest, an invitation to take part was delivered in a private, confidential manner considering potentially perceived difficult or sensitive topics for the participant to talk about. Individuals known to the researcher who met the eligibility criteria for the study were invited to partake in the research via a personal discussion with the researcher. A summary of the key information outlined on the participant information sheet was discussed and a full version of the document was provided to any individual who expressed an interest in the project.

Interviews

Interviews adopted a semi-structured approach to allow for sufficient opportunities for the researcher to follow new pathways of exploration that emerge in the narrative of the interviewee (DiCicco-Bloom and Crabtree, 2006). This method of data collection is advocated within an IPA framework which supports the practice of modifying and developing questions in response to the dialogue that occurs between the researcher and participant (Eatough and Smith, 2008). To facilitate this, the interview questions were designed to be open ended, encouraging detailed responses from the participant whilst mitigating the risk of forcing a disclosure that the individual may be uncomfortable with (Knox and Burkard, 2009). Such practices embedded in conducting semi-structured interviews can contribute to the development of a good researcher / participant relationship. This is vitally important as it provides a mechanism through which individuals can share what they may feel to be is sensitive and personal information (Miles and Gilbert, 2005).

Five of the interviews were conducted face to face in a convenient location, and one remotely utilising Microsoft Teams software based on participant preference. Whilst Braun and Clarke (2013) suggest that face to face engagement is the best way to conduct interviews, they acknowledge that there are circumstances in which this method of data collection is less suitable, particularly with difficult to reach, or hard to engage populations. Traditionally, in-person, face to face interviews have been considered as the '*gold standard*' to interview data collection methods (McCoyd and Kerson, 2006). However, more recently the use of online methods of interviewing such as video calling, and instant messaging instead of, or in combination with face-to-face interviews have grown in popularity. Internet interviews are considered to preserve more contextual naturalness in which participants can utilise more of their everyday language (Shuy 2002, p.541).

As to not further constrain an already hard to reach population, the researcher intended to take a flexible approach to undertaking the interviews. This allowed participants to ensure they were comfortable enough to have open discussions around sensitive topics. Participants were offered the option to engage online, or face to face. One online interview was conducted via Microsoft Teams, the remaining five occurred face to face which were done in a private office space, to ensure safety and confidentiality. All UWE lone working

policies were attended to. During the time of conducting this research, COVID – 19 restrictions were in place and all social distancing measures, and government guidelines were adhered to.

Developing interview questions and pilot

The intention of the research is to utilise a semi-structured interview, thus allowing for the dialogue between researcher and participant to be guided rather than directed by predetermined topics (Smith, 1996). A loose framework was developed that would be used to outline the hopes for what would be explored within the interview. In generating questions, it allowed the researcher to engage in a thoughtful process of how to frame the inquiry in a sensitive and meaningful manor. Developed from the research aims, broad overarching questions were generated and then developed into the most appropriate sequential order. Broad overarching questions about the participants environment were addressed first leaving more sensitive questions toward the end. This ordering allowed for individual rapport to be generated throughout the earlier parts of the interview process, in the hope that it would facilitate the client to become more at ease and able to discuss more sensitive questions towards the end. The research supervisor was invited to review the first draft of the interview schedule and offer feedback prior to it being used.

A pilot interview was conducted with the first participant. A pilot study is widely accepted as beneficial to the research process as it offers an opportunity to test the interview questions (Majid, Othman and Fatimah et al. 2017). The recording of the interview was shared with the research supervisor who was able to confirm that the research interview had been productive in its aims. It was decided that the interview schedule had been helpful as a guide within the interview and no subsequent adaptions were made. The pilot interview was identified by researcher and supervisor as having rich and valuable data, therefore, it was included in the overall analysis.

Process

Participants of known eligibility for the research were approached by the researcher, informed about the study, and invited to participate. The option for online interviews over platforms such as Microsoft Teams, or face to face interviews that would abide by social distancing policies, was presented to each participant. Subsequently five interviews were conducted face to face in a convenient location for the participant, and one was conducted via Microsoft Teams.

Prior to the interviews being conducted an information sheet (see **Appendix 1**) and consent form (see **Appendix 3**) was provided to each participant, which outlined the study aims and ethical considerations. All participants were asked whether they had read the information sheet and if they had any questions about the research before beginning. The interviews were audio recorded and transcribed verbatim. Participants were ascribed pseudonyms to protect their anonymity and all identifiable information such as consent forms were kept separate from the interview data. All data was stored in line with the Data Protection Act 1998 and UWE's data protection policy. Participants were given the right to withdraw from the study at any point in the first six months. After each interview was completed, the participants received a debrief form **(Appendix 2)** which outlined sources of support for any psychological distress experienced by the participant.

The researcher recorded individual reflections about the interview stage in a reflexive diary. During the phase of data analysis, further entries to the reflexive diary were also made. This occurred at three main points of analysis: when reading the transcribed interviews, during the phase of coding the data and subsequent reflections after coding.

Analysis

The active part of the researcher is emphasised within IPA methodology in recognising that the themes and meaning are identified through a phenomenological lens. Phenomenology is considered how meaning is uncovered; however, hermeneutics is understood as the process by which it is interpreted (Bäckström and Sundin, 2007). Themes are not considered to emerge from the data rather, they are understood to be generated through the researcher's sensemaking of the participants narrative (Pringle, John and McLafferty et al. 2011). This is otherwise described as a double hermeneutics that is characterised by a two-fold sensemaking process (Smith, 2004).

The analytical process within this IPA project followed Smith et al's (2009) 6 steps for conducting IPA research:

1. **Reading and re-reading the data**: The researcher transcribed the data verbatim to ensure accuracy of the transcription, and to familiarise themself with the data. Once transcribed, the researcher reread the data focusing on both structure and content.
2. **Initial noting**: Annotations were made in the right-hand margin of the transcriptions outlining initial interpretations and free associations. The researcher concurrently added to a reflexive diary, documenting their reactions and responses to the process and content of the data (see Appendix 5 for an example).
3. **Developing themes**: The initial notes were then collated and organised into a theme that gave understanding to the data. At this point all notes, observations and analysis were included.
4. **Searching for connection across the data**: The data was explored for connected themes occurring within the participants interview data. These were then collated in tables with outlining superordinate and sub themes identified.
5. **Repeating process**: This process was repeated with each set of interview data.
6. **Patterns across the whole data set**: A main table was generated that encapsulated the prominent and pertinent themes relevant to the research

project. As a result, super-ordinate and sub themes were developed from the participants' data in relation to the research questions.

Superordinate and sub themes that emerged from the data.

The analytic process developed four superordinate themes each with two sub themes (**Table 2.**).

Table 2: Overview of the Subordinate and Sub Themes developed for the analytical process.

Super ordinate themes	**Sub themes**
Superordinate theme.1 Culture and economic landscape: *"It's hard to live around here, I see the Valleys as fight or flight".*	**1.1** Surviving in the Valleys: *"Its dog eat dog"*
	1.2 Trapped: *"There's no breaking the chain".*
Superordinate theme 2. Problems with the masculinity script: *"we're not fucking cavemen anymore"*	**2.1** Men and mental health: *"Bloody hell, I think his heads gone, and that's as far as it goes".*
	2.2 Is it just easier for women?

Superordinate theme 3. *"Self-medicating in the Valleys"*	**3.1** The cost of survival
	3.2 *"Men only get the support when they are broken"*
Superordinate theme 4. Us and Them	**4.1** Trust and understanding: *"You have to be from the Valleys to speak to someone from the Valleys".*
	4.2 The expert by experience

Chapter 4: Findings

Summary of themes

Superordinate theme 1 – Culture and Economic Landscape: "I*t's hard to live around here, I see the Valleys as fight or flight*" contextualises the participants experiences in the cultural and economic landscape of the Welsh Valleys. It provides insight into the link between mental health issues and the social environment, forming the backdrop for the **sub themes 1.1** and **1.2**. **Sub theme 1.1** focuses on how social identity and status act as protective factors in a threatening environment, **Sub theme 1.2** then explores the static nature of the Valley's culture perpetuated by transgenerational issues, ideas and practices.

Superordinate theme 2. Masculinity and mental health: *"*we're not fucking cavemen anymore*"* explores the participants at times contrasting and contradictory views on culturally specific conceptualisation of masculinity and mental health. It offers a framework for **sub theme 2.1** which demonstrates an awareness of high levels of mental health issues in the community and illustrates the superficial nature of discussion around mental wellbeing. **Sub theme 2.2 Is it just easier for women?** highlights the participants sensemaking of gender differences in their community and demonstrates a perception of greater compassion for women who experience mental health issues in comparison to men.

Within superordinate theme 3. Self-medicating in the Valleys: independent attempts at coping with distress and barriers to help seeking are explored. **Sub theme 3.1** "when coping comes at a cost" evaluates individual attempts of surviving a harsh environment through the intersection of masculinity, mental health, and community experience. It demonstrates how attempts at managing distress often results in the participants suffering in some way. **Sub theme 3.2** then illustrates the critical crisis point that men must often reach prior to receiving professional support and considers factors that mediate and restrict this phenomenon.

Superordinate theme **4. Us and them** offers an underpinning understanding to the problematic relational issues between the participants and mental health professionals. Categoric insider and outsider positioning characterise both **sub themes 4.1** and **4.2** and is identified as creating barriers to engagement with mental health services. **Sub theme 4.1** speaks further to the problematic relational dynamics at play between the participants and

health care professionals and emphasises the desire to relate to helping others that are perceived as insiders to their experience. **Sub theme 4.2** demonstrates the value the participants place on lived experiences of mental health issues in developing knowledge and understanding about mental illness.

Many of the themes and sub themes interlink and help bring understanding to one another. This will be further explored within the discussion section.

Description of themes

Superordinate theme 1: "*It's hard to live around here, I see the Valleys as fight or flight*"

"Some places are nice, but you have got some rough areas which can also affect your mental health. I don't think it's the area, it's the people in themselves, and the people that's around them." (Steve)

The interpersonal atmosphere in the Valleys and its link to mental wellbeing underpins this superordinate theme and interweaves throughout both sub themes. Broadly, the Valleys were identified as an intense environment where personal struggle defines the identity of the area. All six participants brought focus to the Valleys bleak economic positioning and talked about the levels of social deprivation and financial struggles of the residents.

"The Valleys, well they are rough and ready […] deprived. Life is about money, and some people take their lives due to struggling. That's painful, especially when its family that does it" (Sam)

Sam reflected on the significant and sometimes catastrophic impact of financial pressures on mental health that he has been witness to. Poor opportunities for work, growth and development were described by the men in **sub theme 1.1** and a sense of oppression emerged within Matt's narrative exploration of what mental illness means to him "Its, being pushed down, not given a chance".

Broadly, the Valleys were described as a threatening environment that impacts on the mental wellbeing of the residents. All the participants referred to violence and aggression as common place in the community and the feeling of being evaluated and judged by others was a prominent concern for all. Greg described the community to be in a state of hypervigilance "People in the Valleys, they're on edge, they're always looking about". Sam conceptualised the Valleys as "Rough and ready" where people use physical violence as a method to resolve interpersonal disputes "the answer around here is do that and I'll beat your father up", and

cope with their mental health distress through substance use, often resulting in people are "kicking off".

Interestingly, when exploring ways of coping with mental health difficulties all the participants referred to wanting to escape their cultural surroundings which further emphasizes its impact on mental wellbeing:

"You know, if I didn't bother with them, if I moved to Newcastle or something, those issues will be gone. I could deal with them myself. But when you live around everyone, those issues are always alive" (Jack)

"I just go home and shut the door and shut everything and everyone out" (Sam)

"My thing is, I lie on the settee I put a blanket over my head and I just got like a peak hole and that's me. I sort of distance myself from everything and everyone" (Greg)

However, contrasting perceptions of the community as being supportive also emerged within Jack`s and Matt`s accounts. Both men reflected on the availability of shared resources in the community. Matt understood this as an empathic reaction linked to the sheer prevalence of hardship in the area:

"In deprived areas people will give you their last fiver, I mean we will do that" (Jack)

"It's old time struggles, people have been there themselves, so you will, you'll help other people who are struggling" (Matt)

Sub theme 1.1 - Surviving in the Valleys

This theme explores how the participants made sense of their survival in response to a perceived threat in the environment. Social identity and status emerged as significant and protective factors in the participants experiences. A hardened social identity was acknowledged by Carl to be his primary protective factor in response to a harsh and critical environment.

"There's a lot of idiots in the Valleys, you know, a lot of bullies […] "People will be nasty and horrible, which I suppose happens everywhere, but it is massively that way in the Valleys, you know it is […] they've, I've seen it, they've drove some people into the ground, like they make you anxious. Like personally myself I make myself try to look tougher than what I am 'cause you know like in my workplace, they all know I suffer with depression, but they don't care about that, but like you know, I don't let my guard down, I don't show my weaknesses." (Carl)

Social identity was interlinked with the sense of being judged which relates to Greg's concept of community hypervigilance. For Steve this felt like a familiar experience "it's like everybody is looking at you and it makes you think that they are judging you". Sam also felt that his mental health suffered due to people in his community making judgements regarding his family's personal history:

" 'cos I think they do tar you with the same brush so I can't handle that feeling. Like my head goes, I start thinking like shit, what the fuck. and I want to move away, I just want to get out of that area"

An idealised social identity was depicted by many of the participants which reflected a hierarchal status, wealth and power were theorised to define one's positioning. Matt reflected on this phenomenon in comparing the Valleys to a less deprived, more affluent area:

"I think they beat their chests in different ways, I suppose if we were living in a posh area, beating your chest might be how successful you are, whereas beating your chest here is more like how manly you are in."

Matt describes a more primitive context specific conceptualisation of social status. Carl and Jack attend to culturally specific definitions of wealth which they feel is demonstrated materialistically in Valleys and is often related to drugs.

"You got to be of money, or a drug dealer to be cool around here" (Carl)

"Getting a car turning up at the local pub with a bit of coin on you. You got the car, you go to the toilets have a sniff That's just the way it is. So a bit of money and like having like things in life like a car or and that gives you a bit of status. For men, Yeah, makes you 'cause no one listens to someone who haven't got nothing" (Jack).

Greg reflected on his social identity and status and outlined the desire to maintain his positioning as a means of survival. He described the fear of entering different communities where his status isn't recognised and therefore can't keep him safe. He explored how problematic this was in the Valleys which is defined by small sub communities. This highlights the difficulty that men experience when needed to travel outside their home village.

"Sometimes going outside that you're in fight mode cause there's a bit more of a threat […] because you have to find your place again" (Greg)

Sub theme 1.2: "*There's no breaking the chain*".

This theme encapsulates the sense of being trapped that pervades the narrative accounts of the participants. This was explored from both an economic and social perspective. Economically many participants highlighted the high levels of deprivation and poor opportunities for work in the area "It's a dead- end place" (Carl) and explored the impacts of this on an individual level.

"Nine times out of Ten, if your Dad is a brick layer you're going to end up as a bricklayer or a butcher, that's what you're going to be, there's no up and down, you just grab whatever job you can and try and stick to it. […] Dad goes out to get any job he can and you're stuck in the circle then, you're not improving, your just doing the same thing your Grandad done, there's no breaking the chain." (Matt)

Matt's account illustrates the barriers he perceives individuals of low socio-economic positioning face and the battle required to develop out of personal and environmental poverty. Financial pressures often deter or make it impossible for individuals to engage in occupational training of their choice. The lack of economic growth that underpins the poor availability for opportunities in the Valleys was also attended to by Greg.

"There's none, it's like shitty little opportunities, like where do the uni people go? people whose training, they all stay in the city don't they. They don't spread out to the Valleys because it feels like the Valleys means less to them 'cause all the opportunities for everybody are outside the Valleys" (Greg)

Greg touches on a notion that the Valleys have been forgotten and that there is little motivation for individuals to move to the area. This highlights a potential understanding for the stagnant cultural growth described by some of the participants particularly within the realms of substance use. This interlinks with an underpinning mechanism for the perpetual transgenerational issues many of the participants described:

"[…] It's like a vicious cycle. The parents drink, not all parents but you know the ones who do, I suppose they got their own traumas, and then their kids are learning from them.

They grow up hearing all sorts of stuff, so without understanding, you're understanding why they are drinking all the time." (Greg)

Alcohol and drug use was one of the biggest intergenerational issues explored by the participants. Both Carl and Sam described how they had been exposed to alcohol and drugs from a young age. They both linked this exposure to how they now as adults use alcohol and drugs as a way of coping with their mental health problems:

"My mother used to send me to the shop when I was 13, I used to grab her beers and she got me some. It all started from there really." (Sam)

"Umm… I didn't have a very good upbringing, you know, I started drinking from the age of 15. I don't know, I seen a lot growing up, you know. I was around a lot of drugs" (Carl)

However, whilst transgenerational messages about substance use were highlighted by all the participants, both Jack and Matt introduced a different perspective. Matt described being brought up around men who were abusive, violent and who used alcohol and drugs as a way of coping. Matt suggested that when looking for a man to look up to in his younger years the males he had available to him were either bad guys or men who were suffering themselves with traumatic incidents. For him, this experience has influenced a core aspect of his self-identity and defined what he did not want to be. Both Matt and Jack described how their childhood experiences deterred them from certain ways of being:

"I am protective over women, after seeing my mother being beat up by men for half my life why wouldn't I be." (Matt)

"Like my father was a heroin addict. So, I seen lots of stuff growing up, so that's why I never went to that. I always knew, no I'm not doing that. But some people they just haven't got that, that thing about them, they just give in to certain things and I've seen, yea I've seen a lot of people go down that road, they deal with their mental health through alcohol and drugs" (Jack)

Superordinate theme 2: Questioning the masculinity script - "*we're fucking not cavemen anymore*".

This theme is built upon the narrative portrayal of Valley culture with specific focus on gender roles. Traditional and hegemonic male identities have been illustrated throughout the analysis, this section homes in on the conflicting and challenging perspectives to these that the participants at times presented. It considers also the role and position of women within this culture and the impact it has on men. The participants drew awareness to many conflicting aspects of the masculinity script alive in their community and toyed back and forth between the cultured expectations of men and, at times, the contrasting realities and ideas they have experienced. Interestingly, whilst reflecting on the interviews three of the six men raised their concern about being perceived as offensive or sexist, a concern that may have initiated by the researcher's female gender, and through knowledge of the researchers own positioning on traditional gender norms in the community (See **reflexive account**), this may have inhibited a deeper exploration of perceived female status. Just one participant, Steve, directly referred to a perceived cultural idea that women were less dominant than men.

"Like what people say, because it's sexist, men got more dominance than women, but that's not true. Women can have more dominance than men. There's no difference between men or women at all, I don't think" (Steve)

The male positioning in the Valleys culture was explored by some of the participants. Financial pressures and being responsible for the family were described as falling upon the man of the house. Being strong, resilient, and invulnerable were also characteristics of the perceived male role within the Valleys.

*"And if you want children as well, mum needs to stay at home, could you have no time whatsoever at all to even think, or breathe half the time so Dad goes out and gets any job he can and you're stuck in that circle then, not even improving, you're just doing exactly the same thing as your grandad and dad have done." (*Matt)

Many of the men also brought awareness to an uncomfortableness in being perceived as 'weak' when dealing with their own distress. Sam noted that one of the hardest parts of losing his father was carrying the pain of the loss whilst not wanting to appear as '*weak*'. The

contrast between cultural expectations and the realities that men experience was attended to by Matt:

"They don't cry, they deal with stuff. Well, it's the complete opposite […] other people look at you as weak or you're not a man, so there's a conflict in you."

"You're not allowed to have problems, you just got to suck it up and get on with it, you have to be the strong one, the tough guy"

"*we're not fucking caveman anymore. Men have feelings just as much as anybody else, you don't have to put the front on or think oh I'm somebody else, you need help, you need help you need to go and get help, that will be my advice to any other man you're allowed to cry you're allowed her feelings. It's not what they want to hear but I think that's what they need to you hear*" (Matt)

Jack reflected on the origin of his ideas around gender role expectation by highlighting the transgenerational messages about masculinity that he had been familiarised to by his father. He noted how these internalised messages have affected his way of relating to himself, how they impact on his own parenting style, and his desire to abandon these ideals for the sake of his own son.

"I think it's from when you or a kid and you know like, especially in the 90s or you know the 2000s, they would like you to get on with it and you know, it was a sign of weakness. You know I think that's what it is I mean, but I try to be different with my kid, but I still got that bit me that goes get up stop crying. But I should be like, but it's like me from when I was a kid saying you should be tough and get on with it" (Jack)

A contrasting position of women in the culture was also illustrated within interviews. Sam's perspective introduces a further conflict in the script that centres on women being the homemaker, gentle, vulnerable and nurturing. He drew on his own life experience of his father being his primary care giver, and him being a single parent for much of his children's lives to illustrate the differences he had experienced. Jack also reflected on his family dynamic and identified his mother as a prominent figure of strength a further digression from the cultural script placing women as the 'weaker' sex:

"I always seen my mother as someone who pushed forward, she got the job done. She divorced my father, she's done things you can't do unless you are mentally strong and she never touched drugs, she never drunk, my father was complete opposite, he was the alcoholic, the heroin addict. so it's mad how those two people met, but you see it all the time in the Valleys, a lot of people they will fall involved with someone who's suffering" (Jack)

In Jack's experience it was a woman who was the strength in the relationship, and who supported his father, a common occurrence he felt in this area. Carl also supported this idea, he offered insight into how he perceives the gender dynamic within relationships in the Valleys:

"I know a lot of good women behind the man, the woman, they are the backbone, and the brilliant. So I believe that women are tougher and more harder than us men." (Carl)

Sub theme 2.1: "*Bloody hell, I think his heads gone, and that's as far as it goes*"

This theme emerged from how the participants thought about mental health in their community. Notably, the prevalence of mental health concerns was widespread. A sense of normalisation of suffering with psychological distress was apparent in many of the participants accounts where much of the participants social network struggled with mental health concerns. The participants also reflected on the high volumes of pharmaceutical intervention to treat mental health in the community.

"All my family, my mother suffers with it, and I do as well." (Steve)

"I haven't got many friends that haven't got mental health problems" (Matt)

"So many people around here are on tablets for depression, most of my cousins are" (Sam)

There was an absolute consensus within each person's account regarding the levels of depth of understanding of mental health in the community. All participants described a superficial understanding that was perpetuated by a reluctance to delve into personal accounts of mental illness. Many participants described how individuals would often bring attention to the fact they were struggling with mental health difficulties however they would not go into any detail.

"So what you do is tell your best buddy, you know but that only gets talked about for literally a few minutes and they go don't worry about that it's, it's going to sort itself out, And that's it we think you done but is still there in the back ahead but there's no like depth for men around this area I don't think but I think just about the basics we talk about the basics and that's it" (Jack)

"I have been around a few people having a drink and I don't know, they just turn a bit scatty like say things like 'ah fuck it I don't care, my heads fucked', but they don't go into why they feel that way" (Sam)

Both Greg and Carl made sense of superficial attention to mental health in the community as being mediated by poor levels of understanding.

"There's a lot of people out there who are ignorant to it. Not because they want to be, it's because they don't understand it" (Greg)

"there's just a lot of people with mental health but don't have much understanding, whereas in other communities there might still be lots of mental health problems, but they have a better understanding of metal so they can support each other so" (Steve)

Steve illuminates a lack of understanding as one of the potential mediating factors for increased levels of mental illness in the South Wales Valleys. Many of the other participants also acknowledged that regardless of social context, mental health issues can arise anywhere.

Sub theme 2.2: '*Is it just easier for women?*'

Sub theme 2.1 is built upon the elements of the interviews that spoke to the perceived gender differences and inequalities that the men were aware of in their community. Differences were discussed from both an individual level, where women were theorised to naturally have a better ability to cope with mental health issues, and a societal position which related to the idea that society treats women more compassionately and favourably than it does men. The community and cultural surroundings that men in the Valleys find themselves in, was demonstrated to be more accepting and compassionate to women who struggle with mental health concerns compared to men. Throughout the research, participants depicted a high level of antipathy toward mental health by other men within the Valleys. This theme explores the nuances within this cultural positioning and illustrates that compassion toward mental health is primarily available for women, whereas men are not afforded the same level of support and understanding.

" People do I think, they do have different views on women. It's like they agree with women, but then with men it's like yeah man grow up or get over it or stuff like that but then I think it's a bit sexist to be honest […] people feel sorry for women and then you got the same problem" (Steve)

Women were described as "*a lot more open to talk about problems*" (Matt) and many of the ideas about women's ability to better cope with mental illness centred around the idea that women are more able to communicate than men.

"*I think they deal with it very easily. Get on the phone, they talk about it. You know they communicate*" (Jack).

"it's hard to talk to my dad because. He doesn't like talking about that. But my mother she will. She will sit there for hours and just talk and talk and talk It was a man it's easier talking to women than other men" (Steve)

"but men who is suffering, or anything like that, it's much easier to tell a woman than it is a man, which I find well, that's easier for me anyway "(Jack)

From a social perspective, Sam felt that there is a leniency towards women in his community. He highlighted the notion of women being prioritized over men by services. He felt that whilst women engage in the same behaviors that get men in trouble with police and social services, they are treated far more leniently. Sam suggested that both men and women equally experience mental health distress and externally express this through violence and aggression to the self and others "We're all mad here", Sam narrated his own personal experience of this, he described how he fought for full custody for his own children when they were removed from their mother and placed in care. He felt that the process was made more difficult for him as a man, he was offered less support from social services, and the children's mother was supported to a greater degree than what a man would be in her situation. Jack also reflected on this point, suggesting that the role of the father in the family is not prioritised to the same degree as the mother. Matt touched on an inequality that he had experienced in relation to a significant and traumatic life event. Matt's daughter was three months old when she died. At the time, his partner received help and support from mental health service whilst he was not offered any.

Superordinate theme 3: "*Self-medicating in the Valleys*"

Independent attempts at coping with distress formulate theme three. Help seeking behaviour, and the barriers to this were explored by many of the participants as redundant until a crisis point is reached. The men interviewed demonstrated a good awareness of the encouraged forms of coping and many reflected on how they recognise the value of talking about their difficulties however, they also noted how this practice was not generally part of the Valley's culture.

"I think a lot of people that come from the Valleys, they think you gotta just deal with it yourself, you know, get on with it. But as times go on now, I really like I've seen it so many times, and I think, well, you know you gotta talk about it" (Jack)

The participants describe the community generally adopting more independent methods to cope with their distress through alcohol and drugs:

"sometimes to me, opening the fridge and having a can of beer that's what helps" (Carl)

"I wouldn't advise it to anybody, but sometimes it does help, I mean everyone has their own coping mechanism, there always dealing with things, but sorry to say mine is alcohol, is probably the wrong way of dealing with things but again if you have got the right help I suppose maybe my outcome would have been different." (Matt)

Alcohol and drugs were depicted as being highly normalised within the community "It's as normal to have a bag of cocaine as it is to buy a domino's" (Carl) and engaging with services far less normalised *"I don't think we speak about it. Like Oh yeah, well, I've gone to the Doctors"* (Matt). High availability of drugs and alcohol in the environment offers insight into potential explanations for why drug and alcohol use have become a primary method of coping with psychological difficulties. Jack introduced another perspective complementing this in how he made sense of the rationale for excessive drug use in the Valleys.

"It's much easier to spend £5 on a gram of phet or something you know, keeps you up for three days, then it is to go and just by bottle of wine and chill out" (Jack).

Jack contextualized this argument in an economic landscape by demonstrating how financial pressures might influence people's choices to utilise alcohol and drugs. He illustrates how, when individuals who are deterred from professional help, seek out effective methods of coping, drugs can offer the most economically viable option.

Whilst many of the participants narrated their attempts at engaging with services, a poor and hopeless relationship to mental health organisations was the undertone many of the stories. Often feeling like *"Just a number"* (Matt) or *"let down by the Doctors"* (Carl), perpetuated by the concepts explored in theme 2.1 of otherness, results in these men 'losing hope' (Matt) in services. They described being disconnected from services, they were unsure of what was available in their area and none of the participants made immediate links to the Doctor as a means of accessing mental health support. Just one of the participants Greg, could draw on a personal experience of receiving adequate and effective support for his mental wellbeing however, he described having to battle with services for over two years to get the help he needed. **Theme 3.2** explored the delay of help seeking experienced by men in the Valleys and suggested that distress had to reach its pinnacle before it could be prioritised as endeavour toward resolution of mental illness.

Given the fractured relationship with mental health services, the participants identified substance use as the primary solution for their difficulties which was widely available and economically viable. With little other options available to many individuals in the Valleys it is reasonable to understand why.

"Self-medicating in the Valleys is at an all-time high" (Matt).

Sub theme 3.1: The cost of coping

Theme 3.1 holds together the collective idea that coping with distress comes at a cost. It encapsulates all the explored methods of coping with mental health concerns and gives voice to the participants sense making of their options for dealing with such challenges. The problematic issue of time was embedded in many of the responses around seeking support via engagement with GP services, often described as having excessive wait times to reach a point of contact. The weight of financial pressures balanced against the need to have time off to book and attend mental health appointments, meant that for many of the men getting help for their distress could not be prioritised.

"There are other strains on you, you have to choose whether to feed your family or go get help […] you gotta chose between bread or medicine, and bread is always going to win" (Matt)

Mark reflected on the practical issue of attending appointments, he illustrated the dilemma that he faced of whether to prioritise his mental health needs or go to work and in money for his family. Practicalities of attending appointment was considered by Steve who articulated an underlying fear of being sacked if you were to have time off to attend mental health appointments, and also by Carl who narrated his experience of having to attend a counselling appointment via telephone, sat in a work van during his break, and his uncomfortableness with the potential to be overheard by others. Sam introduced the idea that engagement with services would initiate a sense of shame for some men who had external expressions of their distress:

"They probably don't want anyone to know what they've been up to, obviously you have to tell the truth yeah, so like they might be ashamed of some of their behaviour" (Sam)

Interestingly, help seeking behaviours were not directly described by the men in this study as a reflection of being '*weak*' however, all of the men gave insight into how they perceived others in the environment to be judged help seeking as weakness. This may interlink and speak to the implications of **superordinate theme 3** which illustrates a perceived segregation between those who personally experience mental illness and those that do not. Steve suggested that the experience of having mental health difficulties made him feel 'weak'

however, this reflected his measurement of the self against the perceived cultural hegemonic expectations.

"It makes it hard for them to go and get help because people are expecting them to be the macho man, they don't look at them as weak. They got to be strong and that's it. That's what they want." (Greg)

"Going To a doctor […] would put you down a few pegs, your status would then be affected […] it would make them feel a bit less manly to go and get help for their psychological needs." (Matt)

Ways of coping with the external world was captured in part in **theme 1,** many of the participants talked about how a hegemonic masculine identity was a necessity, to protect against potential threats and vulnerabilities. Greg highlighted how this initiates an internal conflict in him where two contrasting and competing identities had influenced his mental wellbeing:

"And that's what wore me down in the end, 'cos that's not me, and that's not who I wanted to be. The person I wanted to be is totally different to the personal I was trying to be" (Greg)

Many participants described feeling that disclosure of mental health difficulties would require a drop in their defence against their harsh environment which would put them in a vulnerable position:

"The thing is, as soon as you show a bit of weakness, if you speak about mental health, people will jump on that you know, and start to take the piss." (Greg)

"So, if you talk to your friends like they could turn around and make fun of you or say or your baby grow up or stuff like that I think" (Steve)

Steve presented an insight into the difficulties he has experienced when attempting to talk to friends. He describes a critical and viscous response to his attempts to seek support from friends.

"It's like, well, Ive told people about my mental health and then they turn around say well go hang yourself or something that's wrong […] So if you talk to your friends like they could turn around and make fun of you or say or your baby grow up or stuff like that I think. That's why men bottle it up" (Steve)

In **theme 3** alcohol and drug use as a means for coping was presented as the most common, although costs to this were acknowledged by the participants such as the potential for losing jobs, and difficulties in interpersonal relationships. Even so, this method as a means for coping with mental illness is perpetuated throughout the Valleys.

Sub theme 3.2: "*Men only get the support when they are broken*".

Theme 3.2 centres around the idea that men only seek out professional help for their mental wellbeing after distress acclimatizes and reaches a pinnacle point. Matt, Steve and Carl all narrated painful memories of their experiences leading up to seeking help. For these men, distress had acclimatised to the point of making attempts on their own lives before they engaged with support services.

"It actually takes someone to have either a mental breakdown or go through a serious depression or serious illness min life for them to actually open up." (Matt)

In general, it was outlined that men in the Valleys 'are expected to just carry on' (Matt), and cope by 'bottling things up' (Steve). Matt reflected on his sense of his culture's attitudes toward mental health. He suggested that there is an expectation of men to be able to manage their lives and all their stress without any psychological suffering.

"You're not allowed to have problems, you just got to suck it up and get on with it, you have to be the strong one, the tough guy" (Matt)

The men often described accumulation of small difficulties building up over the years. "lots of things lead up to that actually, becoming a mental health problem, it's a build up from small events which end up creating larger events later on in life" (Matt). The process of suppression was often cited as a mechanism of delayed support seeking.

“Could be like friends dying or something like that and men don't talk about it, so it builds up and builds up and I think that's when it all hits” (Steve)

“'I keep holding and all in. And then you just get to that point, and it just blows and your your head just goes” (Steve)

Steve introduced an alternative perspective on why men may only get the help they need when they become significantly distressed. He narrated a recent attempt he had made on his life that resulted in him being hospitalised:

*“To me they I think they view me to say that now they've seen it and where they've been in hospital. They've actually seen that I'm bad, and they've actually viewed it that I need help.” (*Steve*)*

His position suggests that he felt he may not have been offered any help if his need wasn’t so significant. He conveyed an essence of confidence in there now being proof to evidence the level of distress he is in. Carl also demonstrated a similar position when thinking about difficulties he has experienced in seeking help, he described wondering whether they ‘believed’ he was depressed.

Superordinate theme 4: Us and them.

This theme offers insight into how the participants position themselves in relation to individuals perceived to be outside their cultural environment. Both on individual and community-based levels, the Men explored how they felt separate from other people, predominantly professionals and those who were perceived to not be of low socio-economic status. Underpinning this experience of difference was positions of power and privilege. While many of the participants acknowledged that class and economic status would not prevent the onset of mental health issues, they suggested that access to financial resources would facilitate the process of recovery.

> *"I think it's going to be equal wherever you live, and you know there's always some problem, you're going to have in life whether you poor rich yeah*." (Sam)

> "*Well, if you haven't got money, how can you have the best [help*]" (Matt)

The concept of an insider to the participant's experience and culture came to life in many of their discussions about the normal experience of individuals in the Valleys. A sense of struggle seems to characterise the Valleys identify. A difficult financial position was also reflective of a core part of this identity, and occupation played somewhat into this concept with broad ideas about professionals, and individuals educated to university level being conceptualised as outsiders to the participants. Insider and outsider positions within the two sub themes mediate the participants relationship with individuals in their community and those perceived outside of this. Overall, perceptions of an individual as an outsider acted as a barrier to communication. This was based on the perception that without personal lived experience of either being a member of the Valleys culture, or having personally struggled with a mental health difficulty, prevents an individual from having an accurate and in-depth understanding of the phenomena. Interestingly, the participants all recognise me as a member of their culture and are also aware of my position as a professional.

Sub theme 4.1 "*You have to be from the Valleys to talk to someone from the Valleys*"

Feelings of separateness on a community-based level characterise this sub-theme. Many of the participants reflected on a feeling that their community, and the people within the community was different to other people and places. A fractured relationship with mental health services was defined as being constructed based on this difference. Often described as an overloaded, underfunded organisation the NHS lost its appeal to the participants through the conceptualisation of the staff as '*other'* to them and their experience. This was a particularly potent issue raised by Greg, Carl and Jack;

"They just haven't got the reality, they haven't lived there […] when they sit up straight, prim and proper, you get turned off by that. […] I think that if you walked into a place, and there was a guy with his tie off and his feet up, you'd get a much better reaction. […] I think you have to be from the Valleys to talk to someone from the Valleys, we have all been there, we've all seen it and done it." (Jack)

"All I can see of him was rich Mammy and Daddy, wasn't from the Valleys, haven't suffered with it himself" (Carl)

"It's hard to explain what it's about, you got to live in the Valleys to know how the Valleys work, it's hard to explain, they can't read about it in a book or at Uni you can't really know just from that. If you talk to someone not from here brought up with a silver spoon in their mouth from a posh area, you can't tell them what it's about, they won't get the picture and I don't think they believe it, and it's not paid any attention. You know the struggle is real" (Greg)

The men touch on the idea that professional people are perceived as outsiders to themselves which acts as a barrier to their engagement with the services. The barriers discussed centre around the perceived inability of professionals to fully appreciate the participant cultural context and struggle. The participants further explored this in the context of relatability issues in relationships with helping professionals and positioned professional workers as coming from privileged backgrounds. Matt made links to the economic struggle people face and how this facilitates a sense of otherness:

"People will do things in the Valleys, which they probably wouldn't normally do if it weren't in the Valleys, they don't want to, they want to earn money as much as anybody else" (Matt)

Greg reflected on the lack of opportunities in the Valleys and perceived the Cities to have better chances for growth, he also felt that this segregated individuals, he conceptualised that people living outside the Valleys were categorically different to Valley's residents: *"It's like I don't know the values are totally different to the cities. No? I think City city people got more opportunity with You know, seeing someone or understanding a little bit more about how they are, you see city people totally different"* (Greg)

"Where do Uni people go? They all stay in the city don't they, they don't spread out to the Valleys because it feels as if the Valleys means less to them." (Greg)

Greg touches on the notion that the Valleys have been forgotten. That the world is moving forward and developing which facilitates the comparative element of the participants accounts. It could be argued that this perception, underpins the previously explored ideas the participants hold about outsiders, namely professional persons having experienced less suffering.

Sub theme 4.2 The expert by experience

This theme is encapsulated by the concept of personal experience being the only source of valid knowledge and understanding for mental health concerns. All participants acknowledged the role of their own personal experience as the sole factor for the development of their awareness of mental health issues. It also interlinks with **theme 2.1** which segregates '*professional persons*' and '*Valley people*' by suggesting that those who have engaged in professional training sit outside their culture populated by those facing life's greatest hardships. Their outsider position and knowledge about mental illness was perceived as significantly limited and the sense that professionals could not know or understand their struggles was conveyed. This may have been signified to the participant as being projected through their positioning in a 'professional job' demeanour and perceived financial freedom.

"How do you know? Well, I've been there myself" (Jack)

"When you get older you understand more of what's gone on and how you learn to deal with it better" (Sam)

"You can see it more when you struggle yourself, I can, I'm aware of a lot of people like that" (Greg)

Greg also felt that his own experiences of struggling with mental health meant that he was more able to identify and understand the mental health concerns of others. Communication about mental health concerns was widely stunted in the community out of fear of judgement and negative reactions. Individuals in the Men's environment could act non-compassionately toward men struggling with mental health difficulties. A lack of personal experience of mental illness was conceptualised as the mediator for such reactions.

"Because they don't suffer from mental health and they don't know. Or it's like I think that's why they judge more because they're not going through it yourself. If they went through it, I think they'd be exactly same as" (Steve)

"Someone may roll their eyes, or you know tell me to get on with it […] if you've never gone through it you can't understand it, so I don't blame them really" (Carl)

Steve described how a relationship with a friend, in which he is able to openly talk about mental health, was only facilitated once they both had experienced some level of psychological distress:

*"Only one because he's going through the same. Now he's going through a bad breakup after 12 years. And he got the same point as me and you just can't stop crying. But since me and him been going through the same I've been talking to him. It's been a lot better. It's like if I want to go out and talk. I'll go down and see my mate. That's the only one I can't talk to the rest of them I can't because they will judge." (*Steve*)*

Sam also reflected on this notion and explored how he can communicate with his clients in his work as a barber. He felt that it was therapeutic in a sense. Within his narrative he identified that it was the shared experience of having mental health difficulties that allowed him to communicate.

"They tell you stuff like, you tell them […] it's quite therapeutic like" (Sam).

Individuals who were perceived as not having personal experiences of mental health difficulties were conceptualised as either threatening and unemphatic, or particularly in the case of professionals in service, were identified as being clueless.

"When I first met my worker I wouldn't give in to nothing, I had a pop at her you know, you're saying all this because this is what you've read in Uni, you don't even believe in the work you're doing and uh, she had a pop back. She said all this and that and she's done the work in her personal life as well. I was like woah, I got talking back and I trusted her. I trusted that so I was wrong in what I was thinking, I was." (Greg)

Greg's account depicts the tentative process he engaged in to develop a relationship with a mental health professional. His initial perception of his healthcare worker illustrates the perceived ideas around healthcare professionals as being unfamiliar with the everyday struggles that individuals in the Valleys of low socio-economic status face.

Chapter 5: Discussion

Research aims.

This research set out to explore the experiences of working-class men in the South Wales Valleys who have experienced mental health concerns. It aimed to consider the following three overarching research questions:

- How does the social context within the South Wales Valleys impact on men's mental health?
- How does the culture in the Valleys impact on masculinity?
- What are the barriers men in the South Wales Valley face to achieving and maintaining mental wellbeing?

Summary of findings

These findings speak from a position of societal inequality. Widespread mental health concerns contextualised in an area of economic hardship and social deprivation were normalised by the participants. The participants often demonstrated a comparative awareness of differences between themselves and more privileged individuals and communities. It appears that much of the distress explored in this research has its roots in these social inequalities felt at both a conscious and unconscious levels. This research evidences the significant role inequalities play on the development and maintenance of psychological distress that is widely acknowledged in the literature (Pickett and Wilkinson 2006) and explores the nuances within this relationship. The concept of power and the impact of its negative operation experienced by these working-class men in the South Wales Valleys can be drawn upon to understand the findings of this research. Economic power, relating to a lack of opportunities to achieve financial freedom, and political power such as neo-liberalism has been understood to mediate experiences of both inter and intrapersonal difficulties in the Valleys, the experience and development of mental health concerns, and barriers to help seeking behaviour. Ideological power was identified in the form of traditional masculine ideologies which were found to generate gender role strain for the participants which, through intersecting with the participants lack of economic power creates feelings of

pressure and failure which create mental health difficulties. Both forms of power can highlight the social origins of psychological distress, and that cultural experiences and economic factors play a primary role in shaping the mental health experiences of the participants.

Social hierarchies demonstrate the personal is indeed political.

Economic and financial concerns have interwoven many of the themes presented in this research. This highlights the significant role poverty and deprivation play in the experience of mental health issues (Marmott 2010). Also, very much alive in this project is the issue of social injustice and the effects of financial inequality. Poverty and living in a country with high income inequality has been found to have strong links to experiencing emotional and behavioural difficulties (Wilkinson and Pickett, 2018). This research provides evidence that the link between social issues such as poverty and social deprivation, and mental health difficulties are indeed causal and originate within social structures. Social hierarchy, one of the most prominent social structures in society, is widely acknowledged to be of great concern for individuals and thought of as being highly impactful to individual experience (Bostock, 2017). In collecting the demographic data for this project participants were asked their views on whether class structure exists, and if so where they would position themselves in within its hierarchy. All participants agreed that the class structure exists, Matt suggested that 'the income gap is so big now that just two classes exist, the rich and the poor', he assigned himself to the 'poor class'. Greg stated that class hierarchies don't exist within the Valleys, only in comparing the Valleys to other places, he suggested that everyone in the Valleys is lower class. Overall, all participants identified themselves as being 'lower' or 'poor class'. Interestingly none of the men used the term 'working class', and instead conceptualised their position through hierarchal comparative means that held a dichotomous undertone of inferiority/superiority. However, whilst economic status and themes of oppression and privilege permeated the interviews, obvious conceptualisations of social class were unattended to outside this initial discussion. Yet, social class as a concept framed much of the narrative within the interviews such as in **Theme 4**, where participants discussed their experiences by drawing on 'insider and outsider' dynamics that have roots in social hierarchal structures. Manstead (2018) argues that working class individuals are less likely to define themselves through economic identities suggesting that this may not be a conscious framework for their experience. This was also mirrored by Fisher (2017) who suggests that the assumption of inferiority that is imposed on the lower classes, and superiority to upper classes may not be directly felt, and instead functions as an unconscious frame shaping and conditioning experiences. A further consideration is that the neoliberal endeavour to suggest

that the class system has disappeared has resulted in diminished discourse around the concept and impact of social class (Manstead, 2018), and may have influenced the lack of conscious discussion of the subject. Being embedded in an increasingly less visible class structure further individualises the struggle that such systems create. Implicit in this impactful yet invisible system lies a continuum of inferiority to superiority on which individuals are assigned by themselves, and by others. This process induces a process of 'othering' creating divisions between people which are felt by whole communities (Galea and Vlahov, 2005). This becomes evident in **Theme 4, '*Us and Them*'** where the participants describe a difficulty in relating to professionals who they perceive to be outside of their social class category.

Inhibition of the concept of class in everyday thought and language can be considered to have impeded the participants ability to explore the mechanisms underpinning their distress, this also may have encouraged the participants to rely more heavily on the prominent individualistic discourse around mental health. The findings highlight superficial knowledge about mental health in the communities, negative individualistic perceptions of the person experiencing mental health concerns as weak, and high levels of psychopharmaceutical intervention. This suggests that mental health understanding is influenced by a predominantly medicalised model of distress which is consistent with the literature outlining excessive psychopharmaceutical intervention for mental health experiences in the Valleys (Gulland, 2015).

Smail (2005) argues that the mental health industry perpetuates these individualistic perspectives and negates the social and material mechanisms impacting the individual's experience. This divorces the individual from their social context and encourages individual focused treatment intervention. The invisibility of class structures has allowed the impact of class to be realised in ever more brutal ways (Fisher, 2017) such as the individualisation of the struggles of the working class conceptualised as personal failures, or bad choices (Smail, 2005). These findings suggest that the participants have an acute awareness of the wide-spread issue of financial pressures experienced by individuals of low socio-economic status in the valleys however, whilst the participants recognise lack of opportunity for personal growth, poor job prospects and financial pressures as important and impactful to experience, they link these oppressors to individual experiences such as feelings of depression and indeed in one

participant's description, suicide. Fear around having their mental health concerns being perceived as 'weaknesses', and experiences of shame around mental health issues also spoke to the individualisation of responsibility for mental health concerns and, offers insight into why mental health discourse in the Valleys is severely limited. This suggest that responsibilisation has been attributed at the individual level of personal failure or defectiveness rather than to the social structures that produce these situations. Smails (2005) concept of '*magical voluntarisms*' speak to this phenomenon. He suggests that within dominant discourse an ideology of capitalism is perpetuated through mainstream media, there political agendas propose that we all have the power to be whatever they want to be and such messages are filtered down to individual experience. This retracts from any notion that an external oppression exists and therefore leaves the individual personally responsible for their situation.

The division of 'Us' and 'Them' as a barrier to mental wellness

Within **Theme 4, *'Us and them'***, it was demonstrated that participants often felt a sense of being 'other' to professionals and those who were conceptualised as coming from privileged backgrounds. This was identified as a barrier to seeking out support for mental health concerns. These findings suggest that the participants in this project assess the status of professionals they interact with based on their presentation and demeanour. This demonstrates how the participants tune into cultural signifies of a particular way of life (2008), these ranged from obvious indicators of financial wealth, to how an individual dresses, their occupation and behavioural presentation. Identification of the other as an '*outsider'* to their experience was suggested to inhibit the participants trust in the professional.

Within social hierarchies, feelings of dominance and subordination, superiority and inferiority affect the way we see and treat each other (Wilkinson and Pickett, 2017). Considering how personal measures of status are developed through our positioning in relation to others, and define the success of a social interaction (Halevy, Chou and Galinsky, 2011), it can be argued that within the interactions the men in this research have with professionals, their otherwise unconscious awareness of the social hierarchy they referred to in the demographic section comes more into conscious thought. However, the participants describe a resistance to this positioning in which the professional's 'superiority' is challenged. The participants described experiencing the outsider/professional as being inferior to them in domains such as life experiences and competence to understand 'real life struggles'. Foucalt (1979, p. 95) argues that '*wherever there is power there is resistance'* and these narrative accounts demonstrate such a resistance through reconceptualising and redefining '*superiority*' through means other than just wealth and professional status. The participants also describe "*being turned off*' (Jack) by professionals and having preferences to not interact or being vulnerable in front of those who lack insight to their experience, further demonstrating a resistance to the hierarchal structures.

This research has given a voice to the intersection of '*working class'* and masculinity, and instead of entirely victimising the participants experiences, it demonstrates an aversion to being received through a potentially stigmatising lens. However, the narratives within **Theme 4** highlight significant relational difficulties that impede help seeking behaviour. This

proves problematic as it reduces access to social support, reinforcing the detrimental effects of the social hierarchy and poverty, which is described by one of the participants in this research as having the potential to lead to suicide. Reintroducing the concepts of class can offer an insightful lens to the meaning of the participants discourses.

Findings within **Theme 4** also bring understanding to the issues explored in **Theme 3 "*Self-medicating in the Valleys*",** and both sub themes by offering a rationale for why men in the Valleys do not access support for their mental health concerns until a point of crisis and may choose to self-medicate to ease their emotional and psychological distress with substances as they have little faith in the support services available. Although substance use was acknowledged to be problematic, it reflects an independent attempt of coping with distress that does not expose the individual to potential feelings of being judged or misunderstood. Services were thought to be insensitive to the needs of the men in this research in offering nine to five appointment times. Being self-employed and under financial pressures to support their families, Matt conceptualised the choice to take time off work to go to appointments as having to choose between bread or medicine, highlighting the dilemma imposed on him by services who do not take into consideration financial impact of a nine to five service model.

The findings describe not only distrust and relational difficulties in speaking to professionals, but also illustrate a lack of confidence in the professional's ability to understand and work with the participants difficulties. Knowledge of mental health issues generated from professional training was devalued, lived experience and being an insider to the Valleys culture was identified as a primary source of competence to understand the mental health struggles of these men. This value of insider experience has been acknowledged and built upon within the peer mentor movement. Peer support has emerged in recent years as there has been a growing recognition for the felt effects of a significant gap between individuals who experience mental health distress and healthcare professionals (Shalaby and Apyaolong, 2020).

Consideration of the operation of social power, and its impact on therapeutic relationships has been neglected within therapeutic literature with few exceptions (Balmforth, 2009; Trott & Reeves, 2018; McEvoy, Clarke & Thomas, 2020). Balmorth, (2009)

found that for low-income, or working-class clients, class differences can induce feelings of shame and powerlessness for the client that permeate the therapeutic relationship. Research from the US by Thompson et al. (2012) highlighted that low-income clients perceived their own economic position to be in stark contrast to that of their therapists who were considered by the clients to have more privileged lifestyles. This generated interpersonal difficulties within the relationship between therapist and client where feelings of jealousy toward the therapist were found to be a common theme.

During the interviews in this research Sam suggested that people would not like to disclose things to professionals out of fear for being judged. Similarly in research by Trott and Reeves (2018) clients reported feeling as though their therapist would judge them on certain aspects of their lives and suggested that they would not disclose things to a middle-class therapist that they would to a working-class therapist. However, when therapists have been conscious and considerate of the clients' experiences in the context of their socio-economic positioning, class differences were facilitative aspects of the relationship (Thompson et al. 2012; Trott & Reeves, 2018). Whilst this highlights the importance of acknowledging class differences in the therapeutic relationship, and the client's social context, many therapists do not prioritise this within their practice. Indeed, in a qualitative investigation by McEvoy, Clarke and Thomas (2020) sought to explore therapists accounts of how they perceive social class to operate within therapy, its impact on the relationship between therapist and client, and the relationship between social class and mental health. Out of 87 practising psychologists, counsellors and psychotherapists that completed an online survey, just a small group of therapists located mental health difficulties within the wider socio-political context of the individual and considered class differences between therapist and client as something that cannot be overcome by the therapeutic relationship. The larger group considered psychological distress through an individualistic lens that divorced the individual from their wider socio-political context, this group felt that class differences were something that could be overcome via the therapeutic relationship. The research concludes that such 'oppression blind' practice highlights a need for the fields of counselling, psychotherapy and psychology to raise class consciousness in therapeutic practice that relocates mental health difficulties within their socio-political context and acknowledges the therapists own social power in therapeutic relationships.

Community anxiety and social status

The voices within this research speak from an acute awareness of intense social anxiety and hypervigilance in the community. Interweaved within all the themes is the notion that there is little social solidarity in the community, and that high levels of judgement and feelings of being monitored are experienced. Interpersonal difficulties and distrust in communities are influenced by media and political messages about the poor, the unemployed and the working poor which amplify divisions and set people against one another in disadvantaged societies (Bostock, 2017). Whilst this was depicted by the participants, they also highlighted a sense of shared hardship and commonality which encourages support and sharing of resources that may not occur in less deprived communities. While interpersonal trust was identified as problematic by the participants, practical and material support was considered common behaviour. Indeed, the sharing of resources within poor communities has also been identified in other research (Lewis, 1963) which demonstrates that low-income communities often survive due to their local and social networks. This also supports the findings suggesting that working class people have higher levels of empathy and are more likely to help others (Manstead, 2018). Higher economic status has been found to be associated with more unethical behaviour in research by Piff et al. (2012) who found that drivers of more expensive cars were less likely to give way to pedestrians or to other cars, and higher status individuals were more likely take sweets they had been told were intended for children, they also had a greater sense of entitlement and were less generous in an economic game.

Within **Theme 1** the participants describe anxiety at a community level underpinned by social judgement. The findings highlight how the participants experience and perceive others to experience a constant state of hypervigilance in which they feel conscious of being judged by others. Originating in inequality, people judge one another and become increasingly concerned with themselves and how they are seen and perceived by others (Wilkinson and Pickett, 2017). Social status was considered to mediate the participants anxiety and was described as significantly important to men in the Valleys. In societies where larger material difference exist social distance grows, and feelings of superiority and inferiority increase leaving social status as a significant concern for individuals (Wilkinson and

Pickett, 2017). One explanation for this phenomenon is that human beings have a dominance behavioural system (Johnson et al. 2012).

The dominance behavioural system is part of our evolved psychological make-up, and almost universal in mammals. It is a system for recognising and responding to social ranking systems, hierarchy, power and subordination (Bostock, 2017). A wide range of mental health concerns may originate this system, anxiety and depression from this perspective are considered to be attempts to avoid, or responses to subordination (Johnson et al. 2012). This could offer insight into the high levels of mental health difficulties within the Valleys. Anderson and Cutis (2012) argue that a significant effect of income difference between classes is the issue of superiority and inferiority, and dominance and subordination. The findings in this research demonstrate that when sources of wealth and social power to provide status are limited, status is realised through what may be conceptualised in mainstream thought as 'bad or problematic behaviour' such as violence, drug taking and traditional masculinity. Therefore, entering psychological or indeed other support services that seek to 'correct' such behaviours can be considered as counter-productive for some individuals. For example, traditional masculine ideology was discussed in **Theme 2** as problematic due to how it limits opportunity for social support for the men's mental health issues, however **Sub theme 1.1** ***'It's dog eat dog***' suggested that a hegemonic masculine identity enhanced social status and acted as a protective mechanism in a community where aggression and violence is commonplace. With a lack of understanding of mental health concerns, the potential for being attacked via a drop in survival defences and feelings of shame being initiated because of deviating from the social norm, it is understandable why 'speak out' campaigns are often not taken up by this population. Individually aimed targets encouraging men to speak out about mental health issues can result in a response that could potentially worsen their experience.

Masculine ideologies and gender role strain

Within **Theme 2** the participants discussed perceived social norms and ideological views of masculinity, mental illness and the intersection of the two. Ideological masculine assumptions are generated by cultural belief systems about the masculine identity which are organised at both the individual and socially constructed level, which then become internalised (Pleck, 1995). The findings spoke to this process and the participants described how both trans generationally, and socially, they have received messages about what it means to be a man. The findings are consistent with much of the literature around the psychology of men that outlines how common it is for boys to be taught from an early age that there will be negative consequences for deviating from masculine role norms (Reigeluth and Addis, 2016). **Theme 2 *'We're not fucking cavemen anymore'*** illustrates what the participants feel they are 'allowed/not allowed' to do in relation to having mental health problems such as, '*not being allowed to have problems, cry or have feelings*' which speaks to an awareness of an ideological masculine identity.

In the intersection of ideological hegemonic masculinity and limited economic power, financial pressures falling upon the '*man of the house'* manifest into an insurmountable challenge for men in the Valleys which has psychological and emotional consequences. Indeed, psychological or emotional distress can occur for the individual who is influenced by a masculine identity that conceptualises the man as the breadwinner, and finds themselves in a position of economic austerity, unemployment or low-income work (O'Donnell and Richardson, 2018; Wiley and Platt et al. 2012). However, the findings illustrate that when masculinity and mental health concerns intersect in the Valleys, it is met with antipathy in the community. The participants described how others in their community take an individualistic view of men's mental health problems, conceptualising suffering as a personal failure and viewing the individual as 'weak'. This image lies in opposition to the masculine ideology depicting the man as 'strong and invulnerable' that was identified. The participants explored and discussed their experiences and thoughts around being measured against these standards, which were discussed as both an external process, being judged and criticised by others, and an internal process, sometimes in resulting in self judgement and criticism or

conflictual ideas about masculinity and mental health. The internal process can be understood as an enactment of gender role strain (Pleck, 1995).

The gender role strain paradigm (Pleck, 1981) suggests that gender roles are developed from socially learned stereotypes and norms that are often unrealistic or contradictory. Later work by Pleck (1995) highlights masculine ideologies as fundamental mediators in the experience of gender role strain. Findings within **Theme 2** demonstrate that the men in this study feel impacted by impossible expectations for emotional behaviour such as, not being allowed to have feelings or cry. Pleck's theory acknowledges that emotional and psychological distress can occur when individuals violate the standards and norms set out in societies, thus creating a vicious cycle of emotional and psychological distress such as described by the participants in this study. Gender roles have been widely acknowledged to be socially constructed, a notion that has become a prominent perspective in the psychology of men (Levant and Richmand, 2016). Gender role conflict, a component of gender role strain was also attended to within the findings. Many of the participants described conflictual feelings about opening up and sharing their mental health experience.

Whilst women were thought to have a natural ability to be able to speak about their problems, conflicting ideas also emerged in which the participants questioned whether this reflective of a culture that offers women a better opportunity to manage their mental wellbeing. Many of the men disclosed that they would easily and preferably communicate their emotional difficulties to women. Therefore, the lack of male discourse around men's mental health can be thought of as more of an external issue, which is reflective of the notion that men have less potential and fewer opportunities to communicate their mental health concerns to a non-judgemental listener. The findings suggest that for the experiences of the men in this study ideological masculine powers are enacted not only in the cultural norms within the communities but also by systematic organisations such as the police and social services that are perceived to be more compassionate to women.

Theme 4 offers insight into the internal conflictual ideas around mental health that the participants describe. Personal experience of mental health difficulties was thought to mediate a shift in mental health education for the individual. This conflictual narrative conveyed a sense of isolation however, even though the participants generate knowledge and

compassion for mental health struggles through personal experience, being embedded in an uncompassionate society that has alternative views on the mental health experience of men, limited their opportunity and confidence in talking about their mental health experiences. Whilst the interview process offered the men an opportunity to voice their perceptions of mental health that contrasted with the cultural expectations for men, it also highlighted that there is little to no space outside the interviews for them to reflect on and share these opposing ideas. The findings in **theme 4** revealed a motivation to resist the masculine ideology the participants describe and a desire to share alternative, more compassionate ideas around the concept of masculinity and mental health.

Recommendations

The findings in this project support the notion that psychological distress has origins in the social and material world. Change should be directed at transforming the power relations that are operational rather than just targeting individual levels of distress. Community psychology is underpinned by the idea that human functioning and health concerns can only be understood through the social context in which an individual is placed. Therefore, it is recommended that Community psychology ideas should be considered in developing targeted interventions to disadvantaged communities. This would involve analysis and intervention being targeted beyond the individual and their immediate interpersonal relationships (Orford, 2008 p.xii). This, however, causes a conundrum for professionals embedded in systems that operate from a more individualist if not medical model of distress, which is the predominant approach in many institutions and indeed our national health service. Having only the individual in the room to work with and limited access to the wider social context, it could be argied that the profession of psychological support is ill equipped to deal with underpinning mechanisms of distress routed in the social world.

However, raising class-consciousness within therapeutic training programs and within individual practice can help therapists take a critical stance on the prevailing individualistic discourses of mental health. By acknowledging the client's socio-political context, and the social power dynamics in therapeutic relationships therapist can avoid replicating oppressive experiences. The use of formulation can offer a way of empowering individual's and moving away from a medicalised and pathologizing model of distress. The power threat meaning formulation (PTM) (Johnstone et al. 2012) acknowledges how generally individuals are encouraged to blame themselves for their failures to meet the standards that are promoted in society. It suggests that psychology and psychiatry play a major role in this by suggesting that the causes of distress lie in our personal characteristics, psychological dysfunctions and 'mental illnesses' or 'disorders'. This in turn disconnects these problems from the social and economic policies and help preserve the status quo. The PTM framework takes an alternative stance of human distress and asks instead of asking 'what's wrong with you?' it asks, 'what's happened to you?'. It is a multifactorial and contextual approach that thinks about the client's whole life rather than just their presenting issues. It includes social, biological and

psychological factors to help understand and explain distress, and therefore offers an alternative approach that is inclusive of the role of social, economic and political forces on individual experience.

Moving forward this paper proposes, in line with a social materialist understanding of human distress, that it would be helpful to an individual's suffering to restore the link between personal distress and social context by using such approaches as the PTM. Such perspectives develop both 'insight' which focuses on internal mechanisms and gives consideration to what has been termed 'outsight' which raises awareness of the social and material origins of problems (Smail, 2005). The social- feminist movement of 'consciousness raising' offers another strategy for tackling the problematic issues of embedded, normalised and invisible destructive forces of distal power on individual experience. Through collective generation of new discourses around the experiences of mental health concerns, suffering can become depersonalised, and attention can be directed to the underpinning power sources from which distress is originating. Smails (2005) work encourages us to hold a space between therapy and political action in which class consciousness can be revived. Familiarisation with his ideas which can offer an outline for future directions for a social materialist endeavour. To evaluate psychological and social interventions, David Smail offers five key questions to help target interventions to the underpinning mechanisms of distress discussed in this research.

- What resources are available to this person/family/community?
- What material, social and economic power is accessible to them?
- What are their experiences of services, systems and organisations?
- What possibilities for change are afforded by their situations and environments?
- In whose interest is this intervention? Will potential change for this person be affected by the interests of others?

These questions promote outsight and orientate thinking into the wider social and political factors, making the invisible, visible. Encouraging the visibility of class structures allows individuals to understand that they are not entirely responsible for what happens in their lives despite what neoliberalism enforces. A shift in thinking that facilitates awareness of social factors of distress offers the opportunity to engage in more preventive measures to

alleviate psychological suffering. When preventative approaches are adopted in psychology, they are often within the domain of secondary prevention which target the early identification of problems. A primary prevention, however, can be conceptualised as targeting the causes of distress so the issues don't ever arise (Harper, 2017). This research calls upon psychologists to adopt a preventative, psycho-social population level focus (Harper, 2017). This can be achievable via an integration of community psychology ideas within the NHS (Harper, 2017) and Local authorities who could draw on the work of researchers such as Biglan and Hinds (2009) to work to improve the quality of life in neighbourhoods.

Limitations/further research

The research highlights contrasting perceptions of mental illness which are theorised by the participants to occur between those that have personal experience of mental health concerns and those who have not. Whilst personal experience of mental health difficulties was considered a mediator for compassion, there was little understanding of how this process occurs. Further research would be needed to understand the nuanced journey the participants describe in developing a new understanding of mental health.

As social factors and political factors were found to be significantly impactful in the development and maintenance of psychological and emotional distress, further research with a larger less homogenous sample for example, the inclusion of women could offer a wider understanding for this experience to ascertain whether these are linked to the intersection of masculinity alone. Therefore, an alternative method of analysis would need to be employed.

The use of IPA in this study also presents certain limitations. It can be argued that due to the double hermeneutic of the methodology, which involves the researchers sense making of the participants material, the analysis offers just one interpretation born out of the researcher's subjectivity. It is possible that a different researcher may have uncovered new meanings from the data.

Conclusion

These findings speak from a position of societal inequality. Widespread mental health concerns contextualised in an area of economic hardship and social deprivation were normalised by the participants who demonstrated a comparative awareness of differences between themselves and more privileged individuals and communities. It appears that much of the distress explored in this research has its roots in these comparisons which reflect social inequalities felt at both, conscious and unconscious levels. This is consistent with the literature that demonstrates the impact of social inequalities on mental health concerns (Pickett James and Wilkinson 2006). The findings illustrate a significant link between social context, mental health issues, and help seeking behaviour. The link between social environment and mental health difficulties can be understood via a consideration of the operation of power (Boyle, 2022). The negative operation of power impacting the lives of the participants has been demonstrated throughout the findings of this research. Social and economic power has mediated the participants mental wellbeing and has created barriers to seeking support from professionals for mental health concerns. Masculine ideology as a power was explored in-depth by the men in this study and its negative operation was identified as highly impactful to their experiences. This can be understood when considering that distal powers such as the economic, political and ideological, are often the most impactful, yet most invisible force (Smail, 2005). The political drive that is neoliberalism has encouraged us to see these issues as individualised forms of psychological distress. Interventions are targeted at individuals from a pathological perspective, often situated in a medicalised model of distress which dramatically draws away from viewing the cultural, societal and economic landscape we are all embedded in. This research demonstrates the conundrum that the participants face in seeking help for their emotional and psychological concerns. Whilst gender role conflict offers an insight into the problematic nature of help seeking that often occurs for men, this research presents a nuanced understanding of this phenomena that is multifaceted, and that is embedded in social and political domains.

Chapter 6: References

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Chapter 7: Appendices

Appendix 1: Participant information sheet

Study: Men's experience of mental health and help seeking behaviour in the South Wales Valleys

You are being invited to take part in a study undertaken to explore how working-class men in the South Wales Valleys experience mental health difficulties, and what it is like to seek help and support for mental health issues. My name is Tonia Mcginty, I am a Counselling Psychologist in training at the University West of England and live in the Valleys. I have an interest in exploring how men in this community experience mental health difficulties. This study seeks to do just that and has been reviewed by an ethical review board within the NHS to ensure best practice standards are being met, it is also being supervised throughout by Dr Toni Dicaccavo , a lecturer at the University. Before you decide whether to take part it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully and discuss it with the researcher if you wish. If there is anything that is not clear or if you would like more information, please contact the researcher on the details given below. Take time to decide whether you wish to take part. Thank you for reading this.

What is the purpose of the study?

At present, most of the current research on men's mental health in Wales looks at statistics and there is no research that gives men from the Valleys a voice, or shares the personal experience of what it is like to have mental health difficulties and seek help. This study will offer a new perspective on the experience of men's mental health in the Valleys by documenting lived experiences, and demonstrating from an individual perspective how mental health is experienced.

Why have I been chosen?

You have been approached to participate in the study as you are a male and live within the South Wales Valleys. If you have experienced difficulties with your mental health, have experienced difficulties in accessing support, and feel comfortable engaging in the research you are invited to take part in this study.

What will happen if I take part and what do I have to do?

If you agree to take part you will need to sign the consent form and provide a code word, this will help keep your data confidential. You will then need to download the Microsoft teams app. To utilise this, you will need to have an email address and smart phone, tablet, or laptop. The researcher will then arrange a suitable time for the interview to take place and .an invite will be sent to your email address.

During the interview you will be asked questions about your experiences of having mental health issues, and how your attempts to engage with support services, and what kind of ideas and thoughts you have relating to the topic. The researcher will guide you through the interview by asking you different questions about your experience.

Anything you disclose in the interview will be confidential, with the exception of any information that indicates potential danger to yourself or to others, any child protection issues or disclosure of intent to commit a criminal offense relating to acts of terrorism.

The interviews will be recorded on a secure recording device which will be encrypted and stored in a secure format. The data will be transcribed by the researcher and direct quotes may be utilised from the interviews in publications however, this will be and anonymised so it will become non identifiable and the recordings will be deleted.

We can stop the interview at any time should you feel unable to continue. The researcher will also offer you helpline numbers for immediate support should you feel distressed or may become distressed following the interview

Will my taking part in this study be kept confidential?

All information which is collected about you will be stored under the Data Protection Act.

How will we use information about you?

We will keep all information about you safe and secure.

Once the study is complete, some of the data will be kept so we can check the results. Reports will be written in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- The information you provide is very important and will be treated with due care. If however you do have any concerns please discuss them with myself or my supervisor. You are able to withdraw from the study at any point up until data analysis without giving a reason by either informing the researcher in the interview, or contacting them via email. After however, if the research data has already begun being analysed it will not be possible to extract your data.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.
- If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study.

What will happen to the results of the research study?

The information collected about you may be used to support other research in the future and will be stored in a secure system. The data you provide will not be identifiable and may be shared anonymously with other researchers.

The results may inform the generation of new knowledge. The generation of new knowledge in an area is sometimes referred to as intellectual property. Any intellectual property created by the study will belong to the researchers

If there is anything further you would like to know, please contact the researcher on the details below

Contact for Further Information

Researcher: Tonia Mcginty - tonia.mcginty@wales.nhs.uk

Supervisor: Dr Toni Dicaccavo - toni.dicaccavo@uwe.ac.uk.

You will be given a copy of this and the signed consent form to keep.

Many thanks,

Tonia Mcginty

Appendix 2: Debrief form

Thank you for your participation in this study, your time and the information you have provided is greatly appreciated.

If you have any further questions or concerns about the research, and/or the data you have provided you can contact the researcher or the research supervisor with the details provided on the information sheet.

If you would like some support for your mental health please visit the Melo website. You can find courses, apps, videos and websites all local to the South Wales area. All resources are free and in Welsh where available. The resources will help you develop new skills that will support you when life is difficult.

If you are experiencing distress, and feel you need additional support, please contact your G.P. If you need more immediate support and are concerned about your ability to keep yourself safe, please seek an emergency appointment with your G.P or attend an A and E department.

https://www.melo.cymru/about-us/

Appendix 3: Consent form

CONSENT FORM

Title of Project: Men's experience of mental health support seeking in the South Wales Valleys; An IPA study.

Name of Researcher: Tonia Mcginty

Please initial box

☐ I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected..

☐ I understand that the information collected about me may be used to support other research in the future, and may be shared anonymously with other researchers

☐ If I take part in an interview, I understand that direct quotations of the data I provide will be used in the research and this will be anonymised making me non identifiable

☐ I agree to take part in the above study.

Name of Participant Date Signature

Please provide a code word for your data _____

Appendix 4: Semi structured interview schedule

Interview schedule:

- How would you describe the Valleys?
- How would you describe the people around here?
- What are their habits ?

  - Thinking about your local community, how often would you say the community as a whole talks about mental health?

How do you understand mental illness?

What has helped you come to understand it in this way?

- What level of awareness do you feel your local community has towards mental health?
- Are there events that often promote awareness?
- How do you feel your communities understanding of mental health is similar and/or different to other communities?
  - Are there occasions where you have been present/involved with/not involved with but overheard conversations around mental health in your social circle, or in your community?

- What kind of mental health difficulties do you think men around here face?

    - From your experiences, do you feel that views on mental health differ between women and men
        - If yes, How do you feel it is different for a man
    - Would you say that these differences between men and women are more common in your community than others?
        - Why do you think that is
    - Do people have different views on men's mental health compared to women's?
    - How is it different being a man?

- How do men in this area cope with their psychological distress?
- What kind of things do they do?
- What kind of things encourage them to do that?

- What is it like for men in the Valleys to seek support from services?
- Do you think it differs for men from more affluent areas?
- How so?
- How could the service change to better meet the mental health needs of men in the Valleys

- What is it like for you, as a man, to experience your own psychological distress?
- Do you think being male makes a difference to your experience of having psychological distress?

- How do the ideas about mental illness in your environment affect your experience of psychological suffering?
    - How do you feel about people being aware of your problems in this area?

- What are the ways in which you have tried to deal with your problems?
- What influenced you to do this?
- Has this changed over time?
    - What has caused the change?

- How do you feel about mental health services in your area?
- Has this changed over time?
- What has affected this change?
    - What do you think caused the change?
    - How do you think mental health services view you?
    - Has this changed over time?
    - What kind of things caused this to change?

- What have been your experiences of seeking help for psychological distress?
- What did/didn't you do?
- What made you decide to do that/not do that
- What happened – how did you feel?
- Were you prescribed meds? – what kind?

    - How did your ideas about masculinity affect your help seeking?
    - How did being from the Valley's area affect your help seeking?
    - What did you/do you need to help you better manage your mental health?

- What do the services need to offer you or do differently to allow you to manage your mental health better?

- How did you find the experience of discussing your mental health today?

Appendix 5: Theme development with initial coding extract

Theme development extract: Process of theme development with transcript and initial comments

Extract	Initial comments	Potential theme
00:00:39 Speaker 2 *But personally, with me like mental health, has been depression. It's like being pushed down, not given a chance.* *Lot of things that lead up to that*	Mental health was conceptualised as an inner struggle. He also reflects on the concept of oppression in suggesting that external factors have shaped his mental health experiences.	Definitions of mental health
00:04:02 Speaker 2 *Most people I know have mental health problems. So, when it when it comes to thinking about the Valleys, I think it shows, if I haven't got many friends that haven't got mental problems. I think the numbers speak for themselves.* 00:04:20 Speaker 1 *Do you think that the community talks openly about mental health in general?* 00:04:27 Speaker 2 *I don't think men do, not as much as what they should.* 00:04:55 Speaker 1 *Yeah, So what kind of understanding do people have of mental health?* 00:05:01 Speaker 2	Matt reflected on the widespread prevalence of mental health issues in his community but limited discourse and understand of mental health concerns. He suggested that discussions around mental health issues for men, in particular do not occur as often as are needed. His comment of 'hiding away' mental health is also suggestive of there being negative connotations or consequences for the individual who shares their mental health concerns.	Breadth versus depth The intersection of masculinity and mental health

Not much, I don't think. A lot of people do hide that away.		
00:08:54 Speaker 2 *It actually takes someone to have either a mental breakdown or go through serious depression or serious issues in life for the actual open up to anyone.*	Matt reflected on the significant distress an individual has to reach before they will open up and talk to anyone	Tipping/crisis point
00:09:06 Speaker 2 *I think a lot of people are embarrassed about talking about mental health problems, I still am, I don't like talking to strangers, or sometimes even friends, people look at you differently*	Matt suggested that he believes that many men, including himself, experience a sense of shame in relation to having mental health difficulties. He identified the fear behind telling people about his struggles is that people may look at you differently. This highlights the importance of social image and how cultural ideas about mental health can shape experience by inhibiting discourse.	Mental health stigma and shame
00:10:09 Speaker 2 *It's Groundhog Day. You go to work, come home, sort your problems out, bed, work, and it's a constant.* *You don't get time to have two minutes to think this is my time now I need to sort my problems out. You don't have time to think about it, right? I need to do this. How do you do that? Just get on with it, so your problems are suppressed.*	To Matt, life in the Valleys is repetitive, and never changing. He suggests that personal issues can never be prioritised due to financial pressures. As a result, he feels that individuals are focused on surviving and not thriving, and that mental health problems become supressed.	There's no breaking the chain. Surviving instead of thriving

00:13:55 *So, Dad goes out to get Any job he can, and you're stuck in that circle then. Not even improving, you're just doing exactly the same thing as your granddad and Dad have done There's no breaking the chain.*	Matt reflected on the lack of opportunities for growth and change in the Valleys. Feelings of being stuck and hopelessness pervade his narrative. This also reflects transgenerational issues.	There's no breaking the chain
00:21:49 Speaker 2 *I think they beat their chest in different ways. For example, I mean like. If he was living in a posh area, I suppose beating your chest would be how successful you are. Whereas beating your chest is more like how manly you are in comparison. So, I think like going to a doctor or going to a mental health Doctor would put you down a few pegs, your status then would be affected.* *Yeah, so people around you, it would make them feel a little bit less manly to go and get help for their psychological needs. But somebody from a more affluent area might not necessarily*	Matts discussion highlights how masculinity might be conceptualised differently within different communities. He suggests that within the Valleys an idealised masculine identity is one in which accessing support for mental health concerns may be perceived as less manly. He contrasts this with his perceived ideas around how masculinity may be conceptualised within more affluent areas. In this comparison he considers how mental health needs may be more easily addressed when they do not conflict with masculine ideologies.	Community conceptualizations of masculinity. The importance of social identity.
00:22:58 Speaker 2 *I gotta be the strong one. I'm going to be the, yeah, the the tough guy. Problems don't bother me, but truly that isn't the realism of how mental health works*	Matt reflected on his sense of his culture's attitudes toward mental health. He suggests that there is an expectation of men to be able to manage their lives and all their stress without any psychological suffering. He conveyed an unwritten but widely accepted and enforced rule - that men just need to carry on.	Masculinity in the Valleys

00:31:53 Speaker 2 *Well, men must be strong and then they don't. They don't cry, they deal with stuff.* *Well, it's the complete opposite. I mean it's hard hiding it away, but ultimately, you might still do it, even knowing that maybe you shouldn't. Because of other people who look at you as, as weak or you're not a man. So, there's like a conflict in you*	Inner conflict between what you he is experiencing and the cultural ideas about how a man should behave. A hegemonic masculine identity is idealised within the community where men don't show any vulnerability.	Inner conflict of being a man

Appendix 6: Journal Article

Abstract

Past intersectional research has suggested that men living in socially deprived areas are 51% more likely to experience major depressive disorder. Men from low socio-economic backgrounds have increased rates of mental distress and psychopathology in comparison to those of higher socio-economic status's (Remes, Lafortune and Wainright et al. 2019; Johnson, Cohen and Dohwrenwend, 1999), with an increased risk of suicide for those who are middle aged (Samaritans, 2020). Whilst links between areas of social deprivation and mental health are widely acknowledged within the literature, the mechanisms that underpin these statistics are less well understood (Wickham et al. 2014).

To address this identified gap in the literature, this study explored individual mental health experiences, and perceived barriers to engaging with services for working class men in the South Wales Valleys. The qualitative study adopted a critical realist and phenomenological approach as the epistemological position, interpretative phenomenology analysis was employed to explore health experiences and perceived barriers.

Six themes were developed from the data, four of which were constructed as subthemes, and two were developed into superordinate themes: **Theme 1** "*It's hard to live around here, I see the Valleys as fight or flight*", **Theme 2** *Questioning the masculinity script "We're not fucking cavemen anymore".* The results offer a developed insight into how social, political and ideological powers and oppressions operate. Findings indicate normalisation of mental health distress, economic hardship and poor mental health literacy within the Valleys. The individual problems highlighted within this paper were found to have their roots firmly grounded within the wider social and political factors experienced by the participants. Findings from this research support the conclusion that political factors are indeed embedded within personal experiences.

Literature review

Between 2013 and 2018 Wales had the worst mental health results for all four UK nations (Smith, 2015), and rea deprivation in Wales has been found to widely mediate the prevalence

of mental health issues. Social and economic inequalities are acknowledged mechanisms for cultural and experiential differences that have significant consequences for health and wellbeing. A report by Public Health Wales Observatory (2020) demonstrated that the least deprived areas in Wales reported better outcomes on all mental wellness indicators, with the largest gap being between the most and least deprived areas in the domain of 'high sense of life satisfaction'.

In Wales, The National Institute for Health and Clinical Excellence (NICE) develops national guidance for primary care services within the National Health Service (NHS) to guide recommendations for the delivery of psychological therapies. To do so it adopts a biomedical model to consider issues regarding mental health. Whilst providing empirical evidence for interventions, it has been heavily criticised for promoting a narrative of practice which assumes a 'one size fits all' approach (Guy and Loewenthal et al. 2011). The current model, determined by this biomedical system excludes considerations from a social perspective and, typically individuals from disadvantaged groups, such as individuals from the South Wales Valleys who have a low socio-economic status are under-represented in such research (Bonveski, Randall and Paul, 2014). This occurs even though reports dating back to the 1930's suggest low-income communities have more than the general populations average numbers of depressed individuals (Kuruvilla and Jacob, 2007), and it is widely accepted that the most common mental health disorders, anxiety and depression, are most prevalent among individuals experiencing social deprivation (Weich and Lewis, 1998; Reijneveld and Schene, 1988) suggesting that mental health experiences are mediated by issues such as social deprivation, and socio-economic status. The links between areas of social deprivation and mental health are widely acknowledged within the literature however, much of the research pertains to documenting health inequalities between areas via ranking and/or categorical or nominal data, whilst the mechanisms that underpin these statistics are less well understood (Wickham et al. 2014). The gap in the existing research further extends to the understanding of why recovery rates are lower in areas of deprivation, with even less clarity regarding how social factors play a part in recovery (Tew et al. 2012). Not only has the onset and maintenance of depression and anxiety been linked to social deprivation, but so too has recovery from mental illness. In 2016 the NHS published statistics evidencing that the

likelihood of recovery from depression and anxiety is reduced if the individual is living in an area of social deprivation.

Intersectional research has suggested that men living in a socially deprived areas are 51% more likely to experience major depressive disorder than those not living in deprivation (Remes, Lafortune and Wainright et al. 2019), have increased rates of mental distress, in comparison to individuals from higher socio-economic status's (Johnson, Cohen and Dohwrenwend, 1999), and for middle aged men there is an increased risk of suicide (Samaritans, 2020). A review into health inequalities in Wales revealed that a higher proportion of women report depression in comparison to men, 14% of women report receiving professional support for mental health issues in comparison to just 8% of men however, compared to women significantly more men in Wales carry out suicide (Smith, 2015). In 2015, the suicide rates for men in Wales were 19.1 per 100,000 compared with 6.9 per 100,000 for women (Simms and Scowcroft et al. 2019). Stigma around men's mental health and mental health help seeking behaviour in Wales has been considered to mediate such statistics (Smith, 2015). There is much research that suggests men in particular, experience difficulty engaging with services and do not report mental health difficulties as often as women (Smith, 2015). This is commonly explained by the idea that men hold stigmatised beliefs about engagement and mental health. Stigma has been considered a prominent factor mediating the difficulties many people face in seeking help for their mental distress (Rusch, Angermeyer and Corrigan, 2005), and is considered to compromise the therapeutic relationship the individual has with their healthcare provider (Riffle and Chen, 2020) causing delays in help seeking (Riffle and Chen, 2020).

To address such issues, a consultation with the pre-existing literature around stigma is needed. However, many such studies exploring mental health stigma have been conducted utilising participants from privileged backgrounds such as white University students (Feldman and Christian, 2007), middle aged white women (Boyson, 2017) all of whom are likely to be predominantly middle class (Feldman and Christian, 2007). This poses significant issues in the transferability of these findings needed to develop policies and treatment pathways for individuals of low socio-economic status and those from socially deprived areas.

Aims

The proposed research will adopt a qualitative approach to exploring how working-class men in the Valleys experience, and seek support for mental health difficulties. It will utilise an insider perspective to develop rich insightful data pertaining to the intersection of culture within the socially deprived Valleys, the experience of mental health difficulties and masculinity. Both the insider perspective and the qualitative investigation will offer a new and novel way of considering the lived experiences of these men.

This study aims to explore at an individual level, the experience of having mental health difficulties, and perceived barriers to engaging with services. In consideration of the stigma around men's mental health, and the difficulty in engaging with services, an insider approach to this research area will offer the opportunity to give voice to a population that may otherwise be hard to reach and difficult engage with. The study will provide important and valuable data that can help both Counselling Psychologists, therapists and health policy makers understand the mechanisms underpinning the health equalities in Wales.

Method

The intimate insider

The intimate insider is a methodological approach which conceptualises the individual undertaking the research as both the researcher, and a member of the population under investigation (Brannick and Coghlan, 2007). As an intimate insider in the current project, I share the colloquial dialect, and am familiar with the language used by the target population group to express themselves. Such positioning proves advantageous as it facilitates a conceptual understanding of the participant group (Nicholas and Wheatley, 2013). Shaghaghi, Bhopal and Sheikh, (2011) suggest that knowledge about the participant group is also beneficial to the research as the researcher has insight into potential challenges in recruiting participants and collecting data.

Reflexive statement

The intimate insider positioning undertaken in this study acknowledges that I have similar personal characteristics and have shared many of the same experiences as the participants.

We are of the same generation and have all grown up in low-income households, in the South Wales Valleys. On a social hierarchy I would be considered, and would self-identify as 'working-class, the same as the participants. This means we have been exposed to the same cultural context, at times belonging to the same social circles and have socialised together. We also share a less obvious internal experience in that we all recognise that at some point we have struggled with our mental wellness. The (previous, in my case) use of substances also acts as a common factor between myself and the participant who all recognise how these were used as a coping mechanism for our difficulties. These internal, and external components contribute to my identification as an 'insider' within this research

Interpretative Phenomenological Analysis

This qualitative study uses a critical realist and phenomenological approach as the epistemological position. Critical realism suggests that the specific social context impinges on the way that an individual makes meaning from their experiences (Braun and Clarke, 2006). This fits with the design of the study which is concerned with understanding how the Valleys as the social context impacts on how the participants relate to and understand mental health.

Interpretative phenomenological analysis (IPA) meets the aims and objectives for the study as it offers a position which prioritises the participant's subjective experience of the research matter. Interpretative phenomenology analysis (IPA) (Smith, Flowers and Larkin, 2009) incorporates the fundamental principles presented within phenomenology, ideography and hermeneutics. During the process of this research an updated 2nd edition of Smith Flowers and Larkin (2021) was published. However, it is beyond the scope of this research to have utilised this new version as the analysis had already been completed.

Participants

Participants were all male, white, heterosexual and working class and worked across various industry sectors, their ages ranged from 25 to 35. All participants were residents of the Caerphilly Borough in the South Wales Valleys and had been since birth.

Interviews

Semi-structured interviews were used in the study (see appendix 5). This allows the opportunity for the researcher to follow new pathways of exploration that emerge in the narrative of the interviewee (DiCicco-Bloom and Crabtree, 2006). This method of data collection is advocated within an IPA framework which supports the practice of modifying and developing questions in response to the dialogue that occurs between the researcher and participant (Eatough and Smith, 2008). To facilitate this, the interview questions were designed to be open ended, encouraging detailed responses from the participant whilst mitigating the risk of forcing a disclosure that the individual may be uncomfortable with (Knox and Burkard, 2009).

Process

Participants of known eligibility for the research were approached by the researcher, informed about the study and invited to participate. The option for online interviews over platforms such as Microsoft teams, or face to face interviews that would abide by social distancing policies, was presented to each participant. Subsequently five interviews were conducted face to face in at a convenient location for the participant, and one was conducted via Microsoft teams.

Prior to the interviews being conducted an information sheet (see appendix 1) and consent (see appendix 2) form was provided to each participant, which outlined the study aims and ethical considerations. All participants were asked whether they had read the information sheet and if they had any questions about the research before beginning. The interviews were audio recorded and transcribed verbatim. Participants were ascribed pseudonyms to protect their anonymity and all identifiable information such as consent forms were kept separate from the interview data. All data was stored in line with the Data Protection Act (1998) and UWE's data protection policy. Participants were given the right to withdraw from the study at any point in the first six months. After each interview was completed, the researcher outlined sources of support for any psychological distress experienced by the participant.

The researchers personal reflections during the interview stage were recorded in a reflexive diary. During the phase of data analysis, further entries to the reflexive diary were made. This occurred at three main points of analysis; when reading the transcribed interviews, during the phase of coding the data and subsequent reflections after coding.

Analysis

The analytical process within this IPA project followed Smith et al's (2009) 6 steps for conducting an IPA research:

1. Reading and re-reading the data: The researcher transcribed the data verbatim to ensure accuracy of the transcription, and to familiarise herself with the data. Once transcribed, the researcher re-read the data focusing on both structure, and content.
2. Initial noting: Annotations were then made in the right-hand margin of the transcriptions outlining initial interpretations and free associations. The researcher concurrently added to a reflexive diary, documenting her reactions and responses to the process and content of the data.
3. Developing themes: The initial notes were then collated and organised into themes that gave understanding to the data. At this point all notes, observations and analysis were included.
4. Searching for connection across the data: The data was explored for connected themes occurring within the participants interview data. These were then collated in tables outlining superordinate and sub themes identified.
5. Repeating process: This process was repeated with each set of interview data.
6. Patterns across the whole data set: A main table was generated that encapsulated the prominent and pertinent themes relevant to the research project. As a result, super-ordinate and sub themes were developed from the participants' data in relation to the research questions.

Findings

The analytic process developed two superordinate themes each with two sub themes (**Table 2.**).

Table 2: Overview of the Subordinate and Sub Themes developed for the analytical process.

Super ordinate themes	**Sub themes**
Superordinate theme.1 Culture and economic landscape: *"It's hard to live around here, I see the Valleys as fight or flight"*	**1.1** Surviving in the Valleys: *"It's dog eat dog"*
	1.2 Trapped: *"There's no breaking the chain"*
Superordinate theme 2. Problems with the masculinity script: *"we're not fucking cavemen anymore"*	**2.1** Men and mental health: *"Bloody hell, I think his heads gone, and that's as far as it goes*
	2.2 Is it just easier for women?

Description of themes

Superordinate theme 1:

"It's hard to live around here, I see the Valleys as fight or flight"

"Some places are nice, but you have got some rough areas which can also affect your mental health. I don't think it's the area, it's the people in themselves, and the people that's around them." (Steve)

The interpersonal atmosphere in the Valleys and its link to mental wellbeing underpins this super ordinate theme and interweaves throughout both sub themes. Broadly, the Valleys were identified as an intense environment where personal struggle defines the identity of the area. All six participants brought focus to the Valleys bleak economic positioning and talked about the levels of social deprivation and financial struggles of the residents.

"The Valleys, well they are rough and ready […] deprived. Life is about money, and some people take their lives due to struggling. That's painful, especially when its family that does it" (Sam)

Sam reflected on the significant and sometimes catastrophic impact of financial pressures on mental health that he has been witness to. Poor opportunities for work, growth and development were described by the men in theme 1.1 and a sense of oppression emerged within Matt's narrative exploration of what mental illness means to him *"Its, being pushed down, not given a chance.".*

Broadly, the Valleys were described as a threatening environment that impacts on the mental wellbeing of the residents. All the participants referred to violence and aggression as common place in the community and the feeling of being evaluated and judged by others was a prominent concern for all. Greg described the community to be in a state of hypervigilance *"People in the Valleys, they're on edge, they're always looking about.".* Sam conceptualised the Valleys as "*Rough and ready*" where people use physical violence as a method to resolve interpersonal disputes *"the answer around here is do that and I'll beat your father up"*, and cope with their mental health distress through substance use, often resulting in people are "*kicking off*".

Sub theme 1.1 - Surviving in the Valleys

This theme explores how the participants made sense of their survival in response to a perceived threat in the environment. Social identity and status emerged as significant and

protective factors in the participants experiences. A hardened social identity was acknowledged by Carl to be his primary protective factor in response to a harsh and critical environment.

"There's a lot of idiots in the Valleys, you know, a lot of bullies […] "People will be nasty and horrible, which I suppose happens everywhere, but it is massively that way in the Valleys you know it is […] they've, I've seen it, they've drove some people into the ground, like they make you anxious. Like personally myself I make myself try to look tougher than what I am 'cause you know like in my workplace, they all know I suffer with depression, but they don't care about that, but like you know, I don't let my guard down, I don't show my weaknesses." (Carl)

Social identity was interlinked with the sense of being judged which relates to Greg's concept of community hypervigilance. For Steve this felt like a familiar experience "*it's like everybody is looking at you and it makes you think that they are judging you*". Sam also felt that his mental health suffered due to people in his community making judgements regarding his family's personal history:

" cos I think they do tar you with the same brush so I can't handle that feeling. Like my head goes, I start thinking like shit, what the fuck... and I want to move away, I just want to get out of that area"

An idealised social identity was depicted by many of the participants which reflected a hierarchal status in which wealth and power were theorised to define one's positioning. Matt reflected on this phenomenon in comparing the Valleys to a less deprived, more affluent area:

"I think they beat their chests in different ways, I suppose if we were living in a posh area, beating your chest might be how successful you are, whereas beating your chest here is more like how manly you are in."

Matt describes a more primitive context specific conceptualisation of social status. Carl and Jack attend to culturally specific definitions of wealth which they feel is demonstrated materialistically in Valleys and is often related to drugs.

"You got to be of money, or a drug dealer to be cool around here" (Carl)

"getting a car turning up at the local pub with a bit of coin on you. You got the car, you go to the toilets have a sniff That's just the way it is. So, a bit of money and like having like things in life like a car or and that gives you a bit of status. For men, yeah, makes you 'cause no one listens to someone who haven't got nothing" (Jack).

Greg reflected on his social identity and status and outlined the desire to maintain his positioning as a means of survival. He described the fear of entering different communities where his status isn't recognised and therefore can't keep him safe. He explored how problematic this was in the Valleys which is defined by small sub communities. This highlights the difficulty that men experience when needed to travel outside their home village.

"Sometimes going outside that you're in fight mode cause there's a bit more of a threat […] because you have to find your place again" (Greg)

Sub theme 1.2: "There's no breaking the chain"

This theme encapsulates the sense of being 'trapped that pervades the narrative accounts of the participants. This was explored from both an economic and social perspective. Economically many participants highlighted the high levels of deprivation and poor opportunities for work in the area "*It's a dead-end place*" (Carl) and explored the impacts of this on an individual level.

"Nine times out of Ten, if your dad is a brick layer you're going to end up as a bricklayer or a butcher, that's what you're going to be, there's no up and down, you just grab whatever job you can and try and stick to it. […] Dad goes out to get any job he can, and you're stuck in the circle then, you're not improving, you're just doing the same thing your Grandad done, there's no breaking the chain." (Matt)

Matt's account illustrates the barriers he perceives individuals of low socio-economic positioning face, and the battle required to develop out of personal and environmental poverty. Financial pressures often deter or make it impossible for individuals to engage in occupational training of their choice. The lack of economic growth that underpins the poor availability for opportunities in the Valleys was also attended to by Greg.

""There's none, its like shitty little opportunities, like where do the uni people go? People who's training, they all stay in the city don't they. They don't spread out to the Valleys

because it feels like the Valleys means less to them 'cause all the opportunities for everybody are outside the Valleys" (Greg)

Greg touches on a notion that the Valleys have been forgotten and that there is little motivation for individuals to move to the area. This highlights a potential understanding for the stagnant cultural growth described by some of the participants particularly within the realms of substance use. This interlinks with an underpinning mechanism for the perpetual transgenerational issues many of the participants described:

"[…] It's like a vicious cycle. The parents drink, not all parents but you know the ones who do, I suppose they got their own traumas, and then their kids are learning from them. They grow up hearing all sorts of stuff, so without understanding, you're understanding why they are drinking all the time." (Greg)

Alcohol and drug use was one of the biggest intergenerational issues explored by the participants. Both Carl and Sam described how they had been exposed to alcohol and drugs from an early age. They both linked this exposure to how they now as adults use alcohol and drugs as a way of coping with their mental health problems:

"My mother used to send me to the shop when I was 13, I used to grab her beers and she got me some. It all started from there really." (Sam)

"umm… I didn't have a very good upbringing, you know, I started drinking from the age of 15. I don't know, I seen a lot growing up, you know. I was around a lot of drugs" (Carl)

Superordinate theme 2:

Questioning the masculinity script - "we're fucking not cavemen anymore"

This theme is built upon the narrative portrayal of Valley culture with specific focus on gender roles. This section homes in on the conflicting and challenging perspectives to these that the participants at times presented. It also considers the role and position of women within this culture and the impact it has on men. The participants drew awareness to many conflicting aspects of the masculinity script alive in their community and toyed back and forth between the culture's expectations of men and, at times, the contrasting realities, and ideas they have

experienced.Financial pressures and being responsible for the family were described as falling upon the man of the house. Being strong, resilient, and invulnerable were also characteristics of the perceived male role within the Valleys.

"and if you want children as well, mum needs to stay at home, cos you have no time whatsoever at all to even think, or breathe half the time so Dad goes out and gets any job he can and you're stuck in that circle then, not even improving, you're just doing exactly the same thing as your grandad and dad have done."

(Matt)

Many of the men also brought awareness to an uncomfortableness in being perceived as '*weak'* when dealing with their own distress. Sam noted that one of the hardest parts of losing his father was carrying the pain of the loss whilst not wanting to appear as 'weak'. The contrast between cultural expectations and the realities that men experience was attended to by Matt:

"They don't cry, they deal with stuff. Well, it's the complete opposite […] other people look at you as weak or you're not a man, so there's a conflict in you."

"You're not allowed to have problems, you just got to suck it up and get on with it, you have to be the strong one, the tough guy"

"we're not fucking cavemen anymore. Men have feelings just as much as anybody else, you don't have to put the front on or think or I'm somebody else, you need help, you need help you need to go and get help, that will be my advice to any other man you're allowed to cry you're allowed her feelings. It's not what they want to hear but I think that's what they need to hear"

(Matt)

Jack reflected on the origin of his ideas around gender role expectation by highlighting the transgenerational messages about masculinity that he had been familiarised to by his father. He noted how these internalised messages have affected his way of relating to himself, how they impact on his own parenting style, and his desire to abandon these ideals for the sake of his own son.

"I think it's from when you or a kid and you know like, especially in the 90s or you know the 2000s, they would like you to get on with it and you know, it was a sign of weakness. You know I think that's what it is I mean, but I try to be different with my kid, but I still got that bit me that goes get up stop crying. But I should be like, but it's like me from when I was a kid saying you should be tough and get on with it"

(Jack)

Sub theme 2.1: "Bloody hell, I think his heads gone, and that's as far as it goes"

This theme was developed from how the participants thought about mental health in their community. Notably, the prevalence of mental health concerns was widespread. A sense of normalisation of suffering with psychological distress was apparent in many of the participants accounts where much of their social network struggled with mental health concerns, yet discourse around the topic was limited. The participants also reflected on the high volumes of pharmaceutical intervention to treat mental health in the community.

"All my family, my mother suffers with it, and I do as well." (Steve)

"I haven't got many friends that haven't got mental health problems" (Matt)

"So many people around here are on tablets for depression, most of my cousins are" (Sam)

There was an absolute consensus within each person's account regarding the levels of depth of understanding of mental health in the community. All participants described a superficial understanding that was perpetuated by a reluctance to delve into personal accounts of mental illness. Many participants described how individuals would often bring attention to the fact they were struggling with mental health difficulties however they would not go into any detail.

"So what you do is tell your best buddy, you know but that only gets talked about for literally a few minutes and they go don't worry about that it's, it's going to sort itself out, And that's it we think you done but is still there in the back ahead but there's no like depth for men around this area […] we talk about the basics and that's it" (Jack)

"I have been around a few people having a drink and I don't know, they just turn a bit scatty like say things like 'ah fuck it I don't care, my heads fucked,' but they don't go into why they feel that way" (Sam)

Both Greg and Carl made sense of superficial attention to mental health in the community as being mediated by poor levels of understanding.

"There's a lot of people out there who are ignorant to it. Not because they want to be, it's because they don't understand it" (Greg)

"there's just a lot of people with mental health but don't have much understanding, whereas in other communities there might still be lots of mental health problems, but they have a better understanding of metal so they can support each other so" (Steve)

Steve illuminates a lack of understanding as one of the potential mediating factors for increased levels of mental illness in the South Wales Valleys. Many of the other participants also acknowledged that regardless of social context, mental health issues can arise anywhere.

Sub theme 2.2: Is it just easier for women?

Theme 2.1 is built upon the elements of the interviews that spoke to the perceived gender differences and inequalities that the men were aware of in their community. Differences were discussed from both an individual level, where women were theorised to naturally have a better ability to cope with mental health issues, and a societal position which related to the idea that society treats women more compassionately and favourably than it does men. The community and cultural surroundings that men in the Valleys find themselves in was demonstrated to be more accepting and compassionate to women who struggle with mental health concerns compared to men. Throughout the research, participants depicted a high level of antipathy toward mental health by other men within the Valleys. This theme explores the nuances within this cultural positioning and illustrates that compassion toward mental health is primarily available for women, whereas men are not afforded the same level of support and understanding.

"I think they do have different views on women. It's like they agree with women, but then we men it's like yeah man grow up or get over it or stuff like that […] Some people feel sorry for women and then you got the same problem"

"People do I think, they do have different views on women. It's like they agree with women, but then with men it's like yeah man grow up or get over it or stuff like that but then I think it's a bit sexist to be honest […] people feel sorry for women and then you got the same problem"

(Steve)

Women were described as "*a lot more open to talk about problems*" (Matt) and many of the ideas about women's ability to better cope with mental illness centred around the idea that women are more able to communicate than men "*I think they deal with it very easily. Get on the phone, they talk about it. You know they communicate*" (Jack).

"it's hard to talk to my dad because. He don't like talking about that. But it's my mother and She will. She will sit there for hours and just talk and talk and talk"

"It's easier talking to women than other men"

(Steve)

"but it's men who is suffering, it's much easier to tell a woman than it is a man, which I find well, that's easier for me anyway"

(Jack)

Discussion

Community anxiety and social status

The voices within this research speak from positions of acute awareness of an intense socialised anxiety and hypervigilance in the community. Interweaved within all the themes is the notion that there is little social solidarity in the community, and that high levels of judgement and monitoring are experienced. The literature suggests that in more unequal societies individuals are more 'out for themselves' (Wilkinson and Pickett, 2017). However, the findings also depict a sense of shared hardship and equality which encourages support

and sharing of resources that may not occur in less deprived communities. Higher economic status has been found to be associated with more unethical behaviour in research by Piff et al., (2012) who found that drivers of more expensive cars were less likely to give way to pedestrians or to other cars, and higher status individuals were more likely take sweets they had been told were intended for children, they also had a greater sense of entitlement and were less generous in an economic game. While interpersonal trust was identified as problematic by the participants, practical and material support was considered common behaviour. Indeed, the sharing of resources within poor communities has also been identified in other research (Lewis, 1963) which demonstrates that low-income communities often survive due to their local and social networks. This also supports the findings that suggest that working class people have higher levels of empathy and are more likely to help others (Manstead, 2018) however, it can be argued that the social cohesion is inhibited by anxiety and significant social judgement, mediated by a social hierarchal system which increases levels of distrust in the community and reduces social cohesion. This distrust is further influenced by media and political messages about the poor, the unemployed and the working poor which amplify divisions and set people against one another in disadvantaged societies (Bostock, 2017).

Within theme 1 the participants describe anxiety at a community level underpinned by social judgement. The findings highlight how the participants experience and perceive others to experience a constant state of hypervigilance in which they feel conscious of being judged by others. Originating in inequality, people judge one another and become increasingly concerned with themselves and how they are seen and perceived by others (Wilkinson and Pickett, 2017). Social status was considered to mediate their anxiety and was described as significantly important to men in the Valleys. In societies where larger material difference exist, social distance grows, and feelings of superiority and inferiority increase, leaving social status as a significant concern for individuals (Wilkinson and Pickett, 2017). One explanation for this phenomenon is that human beings have a dominance behavioural system (Johnson et al. 2012). The dominance behavioural system is part of our evolved psychological make-up, and almost universal in mammals. It is a system for recognising and responding to social ranking systems, hierarchy, power and subordination (Bostock, 2017). A wide range of mental disorders may originate in a 'dominance behavioural system', anxiety and depression from

this perspective are considered to be attempts to avoid, or responses to subordination (Johnson et al. 2012). This could offer insight into the high levels of mental health difficulties within the Valleys. Anderson and Cutis (2012) argue that a significant effect of income difference between classes is the issue of superiority and inferiority and dominance and subordination. The findings in this research demonstrate that when sources of wealth and social power to provide status are limited, status is realised through what may be conceptualised in mainstream thought as 'bad or problematic behaviour' such as violence, drug taking and traditional masculinity. Therefore, entering psychological or indeed other support services that seek to 'correct' such behaviours can be considered as counter-productive for some individuals. For example, traditional masculine ideology was discussed in Theme 2 as problematic due to how it limits opportunity for social support for the men's mental health issues, however theme 1.1 'It's dog eat dog' suggested that a hegemonic masculine identity enhanced social status and acted as a protective mechanism in a community where aggression and violence is commonplace. With a lack of understanding about mental health concerns, the potential for being attacked via a drop in survival defences, and feelings of shame being initiated as a result of deviating from the social norm it is understandable why 'speak out' campaigns are often not taken up by this population. Individually aimed targets encouraging men to speak out about mental health issues can result in a response that could worsen their experience.

Masculine ideologies and gender role strain

Within theme 2 the participants discussed perceived social norms and ideological views of masculinity, mental illness and the intersection of the two. Ideological masculine assumptions are generated by cultural belief systems about the masculine identity which are organised at both the individual and social constructed level, which then become internalised (Pleck, 1995) The findings spoke to this process and the participants described how both trans generationally, and socially they have received messages about what it means to be a man. The findings are consistent with much of the literature around the psychology of men that outlines how common it is for boys to be taught from an early age that there will be negative consequences for deviating from masculine role norms (Reigeluth and Addis, 2016). Theme 2 'We're not fucking cavemen anymore' illustrates what the participants feel they are 'allowed/not allowed' to do in relation to having mental health problems such as, 'not being

allowed to have problems, cry or have feelings' which speaks to an awareness of an ideological masculinity.

In the intersection of ideological masculinity and limited economic power, financial pressures falling upon the 'man of the house' manifest into an insurmountable challenge for men in the Valleys and have significant psychological and emotional consequences. Indeed, psychological or emotional distress can occur for the individual who is influenced by a masculine identity that conceptualises the man as the breadwinner, and finds themselves in a position of economic austerity, unemployment or low-income work (O'Donnell and Richardson, 2018; Wiley and Platt et al. 2012). However, the findings illustrate that when masculinity and mental health concerns intersect in the Valleys, it is met with antipathy in the community. The participants described how others in their community take an individualistic view of men's mental health problems conceptualising suffering as a personal failure and viewing the individual as 'weak'. This image lies in opposition to the masculine ideology depicting the man as 'strong and invulnerable' that was identified. The participants explored and discussed their experiences and thoughts around being measured against these standards, which were discussed as both an external process, being judged and criticised by others, and an internal process, sometimes in resulting in self judgement and criticism or conflictual ideas about masculinity and mental health.

This internal process can be understood as an enactment of gender role strain (Pleck, 1981), which suggests that gender roles are developed from socially learned stereotypes and norms that are often unrealistic or contradictory. Later work by Pleck (1995) highlights masculine ideologies as fundamental mediators in the experience of gender role strain. Findings within Theme 2 demonstrate that the men in this study feel impacted by impossible expectations of emotional behaviour such as, not being allowed to have feelings or cry. Plecks theory acknowledges that emotional and psychological distress can occur when individuals violate the standards and norms set out in societies, thus creating a vicious cycle of emotional and psychological distress such as described by the participants in this research. Gender roles have been widely acknowledged to be socially constructed, a notion that has become a prominent perspective in the psychology of men (Levant and Richmand, 2016). Gender role conflict, a component of gender role strain was also attended to within the findings. Many of the

participants described conflictual feelings about opening up and sharing their mental health experience.

Whilst women were thought to have a natural ability able to speak about their problems, conflicting ideas also emerged in which the participants questioned whether this is reflective of a culture that offers women a better opportunity to manage their mental wellbeing. Many of the men disclosed that they would easily and preferably communicate their emotional difficulties to women. Therefore, the lack of discourse around men's mental health for men can be thought of as more of an external issue, which is reflective of the notion that men have less potential and fewer opportunities to communicate their mental health concerns to a non-judgemental listener. The findings suggest that for the experiences of the men in this study ideological masculine powers are enacted not only in the cultural norms within the communities, but also by systematic organisations such as the police and social services that are more compassionate to women.

Limitations

As social factors and political factors were found to be significantly impactful in the development and maintenance of psychological and emotional distress, further research into the experiences of women in the Valleys could offer a wider understanding for this experience to ascertain whether these are linked to the intersection of masculinity alone. The use of IPA in this study also presents certain limitations. It can be argued that due to the double hermeneutic of the methodology, which involves the researchers sense making of the participants material, the analysis offers just one interpretation born out of the researcher's subjectivity. It is possible that a different researcher may have uncovered new meanings from the data.

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