AN INVESTIGATION OF THE RELATIONSHIP BETWEEN SELF-STIGMA AND ATTITUDES TOWARD ONLINE AND IN-PERSON MENTAL HEALTH INTERVENTIONS

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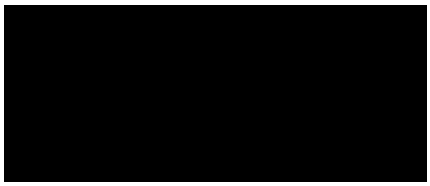
I, Johanna Marie Kenrick, affirm that all work presented in this thesis is my own, and wherever information has been derived from other sources, this has been indicated within the thesis.



ABSTRACT

Counselling psychology is currently witnessing a surge of technology-based therapies, such as computer-administered Cognitive Behavioural Therapy. In addition to claims of cost-effectiveness and increased geographical reach, many have expressed hope that these e-therapies will be more accessible to those for whom self-stigma is a barrier to treatment. This research used q-methodology to survey the attitudes of twenty UK men between the ages of 18 and 26 who have never previously sought psychology therapies. Participants were given Vogel's Self-Stigma of Seeking Help Scale and asked to complete a q-sort from a set of statements pulled from relevant research. Two factors were extracted from the High SSOSH group, and one factor was extracted from the low SSOSH group. The group was then analysed as a whole, and two factors were extracted from the complete group. Several themes regarding self-stigma and views on the traditional face-to-face versus computerized therapy were identified.

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DECLARATION

PREFACE

> *"You see, we cannot draw lines and compartments and refuse to budge beyond them. Sometimes you have to use your failures as stepping-stones to success. You have to maintain a fine balance between hope and despair.'*
>
> *He paused, considering what he had just said. 'Yes', he repeated. 'In the end, it's all a question of balance."*
>
> — Rohinton Mistry, *A Fine Balance*

On some things, everyone seems to agree. Waitlists are too long, services are over-taxed, funding is too low, more training is needed. Those clients who "successfully" navigate referral forms and triage screenings may find themselves sitting across from me, in a brightly lit and nondescript room as I run through the newly introduced questionnaire now required by the trust.

Deeply personal questions embed themselves within impersonal bureaucratic forms, asking users to rank indefinable concepts from one to five.

I know this is likely to read as a criticism, but I don't mean it as such. It is an observation. Mental health services (and, to a greater extent, the medical field writ large) desires to create an environment that is welcoming and supportive to all. The NHS is, in many ways, a triumph in the human endeavour to support and protect the communities we all share, and there can be no doubt that it is full of passionate and caring individuals. People don't embark upon nursing or midwifery or psychology courses for the glamour and heady pay checks, after all.

Nonetheless, our deepest held values are not in-and-of-themselves enough to create the supportive atmosphere we desire. And in our efforts to be inclusive, we will invariably have to make compromises, many of which we might not even realise we are making.

This lengthy document includes a thesis and a case study [redacted for publication], each attempting to demonstrate my capacity to work as a competent counselling psychologist. We are asked to create a unifying statement, knitting together themes from these disparate works. On a demographic level, there is not be an obvious umbrella; while my research focuses on young men and those who eschew traditional modes of talk therapy, my case study focuses on a woman who has actively pursued support and adopted many psychologically minded ways of talking and thinking through her difficulties.

To me, however, a unifying quality is clear, one that extends far beyond these two works toward nearly any piece of research or individual work: a theme of service providers understanding and responding to client needs.

I have spent three years with my current service, starting as a trainee during the COVID-19 lockdown. The waitlists were oceanic in their breadth. Service users who had previously been discharged with marked improvements were back, their symptoms flaring up after redundancies and financial difficulties, new users who'd never considered themselves "the therapy type" were calling, buckling under the stress of cohabitating with abusive family members and fear of a deadly virus. In trying to accommodate so many clients, we invariably made compromises. In addition, we ourselves are often compromised: over-tired, feeling unwell, dealing with the same anxieties our clients maybe navigating.

Even to the more philosophically minded among us, ethics can feel like a stale thing, more appropriate between dusty book covers than in a real-life setting. Small things, like forgetting to return a client call, garbling an unfamiliar name or putting off process notes, don't feel like ethical questions at all. And indeed, I have been guilty of these offenses on busy weeks. But I would argue that ethical dilemmas masquerade themselves in banality every day. It is easy for us to distance ourselves from the dramatic ethical violations that populate headlines, but harder to separate from a system that can wear people down slowly. That, in its attempts to be inclusive to everyone, often sacrifices warmth and personality.

There is also the question of knowing our own limits. I vividly recall a client I worked with during training, who struggled with compulsive behaviours. After discussion with my supervisor and

thoughtful research, we put together a plan for exposure and response prevention therapy. I was feeling optimistic. My client assured me that he was feeling optimistic. We embarked together on the treatment path, and for several weeks, things seemed to be progressing well. Almost too well. Practically textbook. Until one session when I asked a small question that unravelled the truth: while he had dropped some of the compulsive behaviours, those had been replaced by new ones; actions and rituals related to the very ERP therapy that was meant to make him 'better'. I am grateful and impressed by that client's honesty, but clients don't always feel so prepared to be free with us, and if we hadn't had the amount of time that we did, I may have never learned that my attempts at exposure therapy had the opposite effect. Ultimately, he was referred onward to a specialist service, when a more thorough assessment with very specific questions revealed his OCD was much more severe than he was letting on.

While that is one of my more memorable examples, it is not the only client where the scope of the difficulties only revealed themselves after we had started treatment. There was a client who explained during assessment that her parents dislike her boyfriend because he was black, only to finally reveal, a mere week before our sessions were due to end, that they also disliked him because he beat her and locked her out of her home. There was the client who consistently scored a 0 on the PHQ-9 and GAD-7 forms our service diligently administered. She steadfastly refused to admit that she was holding anything back, but occasionally reminded me that, as kind as she thought I was, I was part of a system, and systems were corruptible. Those scores could go to social services, they could go to the police, they could otherwise be used against someone.

It is telling that despite her mistrust, she still sought out therapy and spent her time in the session rooms mulling over problems with me in the passive voice, as though she was thinking through problems on behalf of a friend.

On one hand, when I have allowed myself to relax in the therapy room and stray too far from evidence-based practice, it stymies progress. This relaxed approach often makes the 'work' more pleasant and I do wonder that it sometimes builds personal connection, but it also strips the work from 'the work', meaning that clients are essentially just venting with no direction or structure. My sense is that many clients crave a time and space to do this, but also at their core

they know it's not what they most need. On the other hand? Following theory too rigidly seems to cause people to turn off or tune out. They either disengage or they show up as 'good students', ready to get a gold star for their therapy. Creative solutions, such as allowing a client to write a musical theatre number to help mentalise about their parent's perspective or creating a collage of 'healthy' images can be crucial to maintaining connection and meeting clients where they are at, rather than forcing them into a therapeutic box.

I am 100% more clinician than researcher, I'm interested in the person in front of me and what I can do in the here-and-now. But I understand and believe that research is crucial for allowing us a broader perspective, for checking our biases and assumptions, for forcing us to grow.

I believe all research should be informed by the needs of the client group, and endeavour help us improve our practice at what is often a Sisyphean task, but a beautiful one, that I feel privileged to attempt.

AN INVESTIGATION OF THE RELATIONSHIP BETWEEN SELF-STIGMA AND ATTITUDES TOWARD ONLINE AND IN-PERSON MENTAL HEALTH INTERVENTIONS

PIERCING TOGETHER RESEARCH ON GENDER, INTERNALISED STIGMA

AND ATTITUDES TOWARDS TRADITIONAL VERSUS E-THERAPIES

1.0 LITERATURE REVIEW

1.1 INTRODUCTION AND ADDRESSING THE RELEVANCE TO COUNSELLING PSYCHOLOGY

Counselling psychology is currently witnessing a surge of enthusiasm for technology-based therapies, including computer-administered Cognitive Behavioural Therapy and other virtually administered therapeutic programmes, such as Silvercloud. In addition to claims of cost-effectiveness and increased geographical reach, many have expressed hope that these e-therapies will be more accessible to those for whom self-stigma is a barrier to treatment (O'Kearney, Gibson, Christensen & Griffiths, 2006; Papadatou-Pastou, Goozee, Payne, Barrable & Tzotzoli, 2017; Sanchez-Ortiz, House, Munro, Treasure, Startup, Williams & Schmidt, 2011). This review aims to explore whether such hopes are justified, with a particular eye toward young men, a high-risk group unlikely to engage in help-seeking.

For the purposes of this research, barriers to help-seeking can be loosely conceptualised in three distinct categories: practical barriers (e.g.: cost, scheduling), external social barriers (e.g.: provider attitudes, social stigma) and internal barriers (e.g.: self-stigma, willingness to change). Computer-based therapeutic interventions are undoubtedly useful in helping to ameliorate practical barriers, but it remains unclear how or if they can support users navigating external and internal barriers. Self-stigma is repeatedly cited in the literature as one of the major barriers to help-seeking.

TABLE 1: BARRIERS TO HELP-SEEKING, EXAMPLES

Practical Barriers	External Social Barriers	Internal Barriers
Time / Scheduling	Attitudes of friends/family	Self-stigma
Financial issues	Providers attitudes and training	Willingness to change
Local availability	Lack of awareness	Locus of change
Waitlists	Cultural norms	Distrust in services
Language		Judgement of Therapists

The body of the literature review will be in three parts, the first examining men's help-seeking in mental health and the second reviewing qualitative and quantitative explorations of self-stigma in men as a barrier to help-seeking. The last portion will evaluate qualitative and quantitative research on attitudes towards e-therapies and alternatives to traditional face-to-face therapies for youth. Throughout, this review posits that further research is needed to understand if young men will view e-therapies as a viable route to mental health care and if pursuing alternative, computer-based treatment is less likely than face-to-face talk therapy to violate self-stigma.

In Western countries, young men are among the one of the highest risks for death by suicide (Office for National Statistics, 2017; World Health Organization, 2014), and among the least likely to engage in help-seeking behaviour when faced with mental health difficulties (O'Kearney et al., 2005; Fisher et al, 2021). They are significantly less likely to pursue treatment than women of their same cohort (Chandra & Minkovitz, 2006; Pederson & Vogel, 2007), and of those who do seek treatment, they are more likely than their female counterparts to only present when symptoms are at a severe level (Fisher et al, 2021). In addition to suicide, researchers have raised concerns about self-medication through drugs and alcohol (Frazier, Richards, Mooney, Hofmann, Beidel, Palmieri & Bonner, 2016), with qualitative research indicating that men may often see these as a culturally sanctioned alternative to therapy or social support (Lynch, Long, & Moorhead, 2018).

The transition into adulthood marks a period of significant change. This cohort is especially vulnerable to financial, familial and educational life stressors (Frazier et al., 2016). This is an age during which many mental health issues, such as substance use disorder, depression and anxiety, are likely to develop, (Olifee, Orgodniczuk, Bottorff, Johnson & Hoyak, 2012) suggesting it is a period during which early intervention is key, and also a period during which external social barriers may more heavily impact help-seeking and therefore alternative routes to mental health support may be useful.

Several researchers (Keohane & Richardson, 2018; River, 2018) have criticised the existing literature on men's help-seeking, claiming it often implies that men are 'the problem' when it comes to gaps in care, allowing professional services to side-step the difficult but possibly actionable solutions of examining their

own treatment offerings. These arguments posit that there is a paucity of research into men's treatment values and how counselling psychology could tailor resources to meet those needs. Additionally, these arguments highlight how some internal barriers to help-seeking (such as self-stigma or distrust in services) could and should be proactively addressed by services, rather than hand-waved away.

The ethos of counselling psychology dictates that practitioners seek to understand and meet the needs of diverse client groups, and to develop alternative or non-traditional courses of action in response to contextual factors (British Psychological Society, 2009). This clearly indicates the need of counselling psychology to proactively grapple with providing services for hard-to-reach clients, including thinking of strategic ways that services can address not only practical barriers, but also external social barriers and internal barriers.

Reviews of cCBT and e-therapy programmes have determined that digital tools offer the potential to significantly improve mental health services and the quality of life for clients and their caregivers (Tal & Torous, 2017). Narrowly tailored cCBT programmes (for example, specific to LGBTQ youth) have been endorsed by target populations as helpful (Lucassen et al, 2015) and qualitative research on experiences of cCBT clients found users expressed interest in tailored programmes (Mackie, Dunn, MacLean, Testa, Heisel & Hatcher, 2018; Sanchez-Ortiz et al., 2011). This offers hope that, with a better understanding of the values and needs of young men, counselling psychology has the potential to offer new or unique solutions.

Given the previously stated directive for counselling psychology to proactively meet the needs of all client groups, coupled with research indicating that target populations can find e-therapies appealing, I believe the scope of this literature review is relevant to counselling psychology.

1.2 YOUNG MEN AND HELP-SEEKING IN MENTAL HEALTH

Several researchers have proposed conceptualising health care as being divided into the informal/popular sector and the formal/professional sector (Whitley, 2021). The former group includes advice from friends, online forums, physical exercise, twelve-step programs, alternative therapies and many cultural practices, such as religion. The latter represents the formal academic and medical systems. All individuals in a social group invariably engage with the first sector. However, there are marked gender differences in terms of engagement with the professional sector.

Numerous studies in a variety of locales have consistently found that men are less likely to use formal mental health services than their female peers (Whitely, 2021). Interestingly, this gendered pattern is consistent across medical specialties and not unique to mental health (Galdas et al, 2005; Yousaf et al., 2015). That consistency in gender difference for engagement with formal/professional health services lends credence to the argument that men's lack of engagement is not only due to practical barriers, but external social barriers and internal barriers, such as manifestations of masculinity. However, the difference in help-seeking appears to be more pronounced in mental health services than in other health sectors (Pattyn et al, 2015), suggesting these barriers may be even more pronounced where men are seeking mental health support. This research takes the position that it is incumbent on caregiving professionals to critically examine offerings and attempt to close service gaps, regardless of how culturally ingrained a particular gap might be.

1.2.1 WHY MIGHT MEN BE USING MENTAL HEALTH SERVICES LESS?

It is difficult to explore gender differences in mental health demographics without also exploring what is meant by 'gender'. A full articulation of gender theory and what it means to be a man would require extensive discussion and is significantly beyond the scope of this paper. For the purposes of this review, gender is being viewed through a more constructivist lens, aligning with Courtenay's view (2000) that gender is a construct created through cultural meanings that shift and vary over time and place. Additionally, this perspective considers that gender needn't necessarily be conceptualized as a binary with feminine and masculine at opposing poles but allows multiple femininities and masculinities that are embedded within our cultural understanding, even if we are not always consciously able to identify these (Cleary, 2005). As such, if participants in a study self-identified as male, their experiences are considered applicable to this research and their definitions of masculinity are considered legitimate, even where they may differ.

One prevalent explanation for the gender gap attributes it to masculine ideals, with a belief on 'toughing it out', grit, and a resistance to being vulnerable (Whitely, 2021). Masculine norm adherence appears to be linked to self-stigma and self-disclosure risk, which is an individual's sense of the consequences for disclosing personal information to another (Vogel et al., 2011; Vogel et al., 2017). These manifestations of masculinity are manifested in both internal barrier (such as self-stigma) and external social barriers (such as social stigma).

Gender differences in diagnoses of mental conditions have been frequently reported, for example with women being diagnosed with depression at roughly twice the rate of men (Addis & Hoffman, 2017). Whether these rates reflect the true instance in the population has been questioned due to several factors, such as biased diagnostic tools. For example, research has shown that studies comparing anxiety symptom presentation in men and women have found that women report more intense anxiety symptoms such as "feeling on edge" and shortness of breath, but actually, both genders were comparable in overall anxiety symptoms (Wilhelm et al., 2002). Similarly, research has shown that women with symptoms of problematic eating were much more likely than men to perceive a need for treatment and to be diagnosed (Strother et al. 2011) even if symptoms were at a comparable level. Gallaher (2021) identified several points of likely gender bias in a clinical eating disorder risk assessment questionnaire used by professionals. Measurement bias that missed clinically significant symptoms for men has also been found in questionnaires for depression (van Beek, 201). The possibility of biased tools changing the way that people understand their difficulties and therefore understand their options for treatment can be considered a practical barrier to mental health.

Additionally, studies (Berger et al., 2013) have found that men are more likely to agree with or score highly on depression inventories when labels such as "hassles in living" or "stress" are used instead of depression; this further legitimizes the doubts about whether some of the gender disparities found in depression diagnoses are due to men's resistance to identify with depression (Addis & Mahalik, 2003; Addis & Hoffman, 2017), which further suggests the presence of masculine ideals as an internal barrier. Service providers may also wish to consider that men's apparent rejection of these diagnostic labels may be a manifestation of self-stigma, which will be discussed in greater detail further on.

1.2.2 QUALITATIVE EXPLORATIONS OF MEN AND MENTAL HEALTH HELP-SEEKING

An exploration of men's help-seeking behaviour and mental service use was conducted using narrative-biographical interviews (Staiger et al., 2020). Twelve men were recruited within healthcare settings, in line with the criteria of being between the ages of 18 and 64 and diagnosed or self-identified as having depression without any identified co-morbidities. Narrative-biographical interviews were conducted in which interviewees were allowed as much time as needed to talk through their experience of depression, help-seeking and service use. Afterwards, a semi-structured interview guide was used by researchers to further elicit participants' thoughts on topics such as illness theories, social consequences and personal

coping strategies. Lastly, participants were asked to reflect on whether and how masculine norms may have influenced their help-seeking decisions.

Qualitative content analysis was used to interpret the interview transcripts by defining potential categories, creating codes and then collating the codes into themes. Interviews were coded independently by three different researchers so that coding could be compared, and discordant coding could be reflected upon. This methodology is not dissimilar to the thematic analysis that drove the collection of materials for the q-sort, discussed later in the methodology section.

Most participants identified masculine norms as being influential in their views of depression and decisions around help-seeking. These norms manifested in both external social barriers and internal barriers. In particular, they reported trying to solve or wait out their mental health symptoms for a period of time before seeking support. They also reported low rates of disclosure to friends or family. Men's roles as "stable" and "breadwinner" were frequently brought up, with career concerns being a major factor in avoiding help-seeking as they feared being seen as unemployable due to their mental illness. Many of these fears are pragmatic and how much these dangers are real or just perceived will likely vary significantly based on the specific cultural environment the participant is in, but it is important to note that these fears are not completely unfounded, as there is a history of men being rejected from work opportunities due to their perceived mental health difficulties, although how likely these negative outcomes would be is beyond the scope of this paper.

One practical barrier was identified: with regards to the theme of mental health services and help-seeking, several men reported that their problems were minimised or dismissed by GPs and other mental-health gatekeepers, which delayed help-seeking. In contrast, those who reported positive and validating experiences with their GPS and service gatekeepers felt encouraged toward help-seeking. This result is encouraging for those who believe that mental services can better support men by improving accessibility and removing obstacles to care. The lack of gatekeeping is often touted as one of the main benefits of e-therapies, since many allow users to sign up without ever having to speak to anyone. On the other hand, a positive experience with a gatekeeper appears to bolster motivation for users, suggesting that further training and support for those gatekeeping services, such as GPs or mental health triage teams, is a possible solution.

The qualitative analysis also found that of those participants who had experienced inpatient support or group-therapy, the peer support and validation from other service users was described as a positive influence.

This study underlines many barriers that have been identified in previous research such as self-stigma, masculine norms and service gatekeeping (Addis & Hoffman, 2017). However, there were a number of limitations. Crucially, this study only recruited men who had sought help for depression and completed an intervention, which is likely to be a more motivated group, with less self-stigma than those who have never sought support. As with most qualitative research, the study had a small sample size and cannot be used to draw population-level conclusions. Specifically, in regard to this paper's relevance to the current lit review, this study didn't limit participants by age, and several participants were middle-aged, leaving questions about how applicable these findings are towards youth.

Noting that young men transitioning into adulthood are one of the highest risk groups for suicide, Rassmussen, Hjelmeland and Dieserud (2018) conducted a study using a sometimes-controversial approach called the psychological autopsy, one of the primary methods for studying death by suicide among populations that have not presented to mental health services prior to their deaths (Isometsä, 2001) The authors identified a gap wherein very few psychological autopsies looked specifically at barriers to help-seeking and examined ten suicides carried out by young men between 18 and 30 years of age. Notably, this study identified only internal barriers, although this may be in part due to the nature of the research methodology.

Sixty-one interviews were conducted with surviving parents, siblings, friends and ex-partners, and six suicide notes were collected. These were analysed with interpretative phenomenological analysis. None of the ten men in the study had any record of mental illness or previous help-seeking. Three major factors were identified and articulated by researchers: (a) total defeat; (b) no room for weakness; and (c) fear of a mental disorder. At least two of these factors can be clearly linked to self-stigma and internalised masculine norms. The first of these being: (b) no room for weakness. Interviews clearly showed themes such as needing to achieve high performance at work and external success that was dependent on making few mistakes and not showing vulnerabilities. This brought up the question of whether suicide seemed like a more reasonable option than facing vulnerabilities. However, whether the difficulty is admitting vulnerabilities to oneself or to one's community is not something this study can address. A common thread amongst all the young men was their death by suicide shortly after they were in a position where they would be forced to disclose or publicly face weaknesses (such as the loss of a job or

an inability to go to university) to their fathers. This raises questions about the father-son relationship and how masculine norms manifest in this dynamic. In addition, this links to ideas suggested in the past by Cleary (2005) that one aspect of masculine performance means "death rather than disclosure" when it comes to mental health difficulties. Although Cleary's research is from the early 2000s, this theme continues to surface in contemporary qualitative research looking at men and their relationship to their own mental health (River, 2018).

The third major barrier identified was: (c) fear of mental disorder, which unequivocally relates to themes of self-stigma. For at least half the men, interviews suggested there was reason to suspect that the deceased person feared being seen as mentally ill. Several of them raised questions about whether the deceased person believed that strong negative emotions or loss of control over emotions would immediately result in rejection from others. Fear of rejection for showing 'unacceptable' emotions was a common theme, as well as fear of the emotion 'tipping over' and the person 'losing control' and being unable to manage any of their feelings going forward. These fears seem to echo cultural myths around mental health, lack of normalisation of difficulties and lack of nuance in how mental health struggles are understood. Quite a few of the interviewees also reported that the deceased person turned towards self-help or personal research to better manage their symptoms. The preference for self-help appears to align with masculine norms around self-sufficiency, and allows the men to confront their problems without disclosure or facing any diagnostic labels. Crucially for proponents of e-therapies, these can be packaged as self-help and thus allow users to engage with mental health strategies without necessarily having to perceive themselves as needing external support.

Overall, the researchers describe "a weakened capacity to tolerate [any] failure", coupled with an inability to reveal their perceived weaknesses or pursue support which may have left these young men with the feeling that suicide was the only tolerable avenue. These findings are consistent with numerous other studies that look at self-stigma and internalised masculine norms as a major barrier to help-seeking (Addis & Hoffman, 2017). Of course, with any psychological autopsy, numerous limitations are present, chiefly among them being that the actual persons of interest are unable to contribute. It is also important to note that psychological autopsies are not standardised and there are not systemic guidelines in place. It is difficult therefore to examine the reliability or validity of these studies. However, explicitly laying out how the qualitative data was collected and analysed, as well as interviewing a relatively high number of informants around each person can be considered best practice (Hjelmeland et al, 2012) and was used in this case.

Despite their imperfections, it can be argued that there is a place for this style of research. Counselling psychology cannot dismiss the needs or perspectives of these men simply because they did not present themselves to services in life. If counselling psychology is to meet the stated ethos of being client-driven, research that engages with the impossible but invaluable question of looking at those who never present to services despite high levels of distress must be considered.

In a qualitative exploration of help-seeking amongst suicidal men, River (2018) took life histories from eighteen men who had engaged in nonfatal suicide. These participants were gathered through a variety of methods including local advertising in papers and recruitment through local clinics and community services. Taking life histories allows a researcher to build upon ideas rather than testing a hypothesis. With this approach, it is crucial that the researcher be thorough in self-examination otherwise their own biases and personal ideas may influence the way that histories are drawn out from interview subjects.

As with some of the other studies examined, this research looked at men between the ages of 23 and 66, so it is difficult to elicit themes directly related to age or life stage. All interview transcripts were analysed through the lens of four spheres from gender theory as outlined by Connell (1987): power, production, symbolic and cathexis. Crucially, no one distinct pattern of help-seeking was prominent within the histories. Instead, three different patterns emerged.

One was of men who were avoiding health services: a clear theme of rigid adherence to masculine norms emerged within this group, a commonly identified internal barrier. The second pattern was of men who felt they had "nothing to lose" and actively sought mental health support. The last group and majority (*N=9, 50%*) was a pattern of help-seeking triggered through unsolicited encounters with mental health services. Within this group, there was a clear theme of wanting to avoid being labelled by mental health professionals, particularly with regards to their distress being framed in terms of a mental illness. This could be a manifestation of either an internal barrier (self-image) or an external social barrier (fear of judgement). This adds weight to the previously raised hypothesis of whether men are more likely to reject diagnostic labels. The tone of initial encounters with mental health services was crucial; a positive first interaction often led to further help-seeking, while a negative first interaction led to withdrawal. Again, this echoes previously discussed findings and underscores the importance of the service gatekeepers.

One positive aspect of River's (2018) exploration is the attempt to gather men from the community, including men who have not engaged in mental health services, a group that is almost certainly under-

represented in research. Additionally, the author was clear about her ideas on gender theory and how that may influence her interpretation of the interviews. On the other hand, the results frequently relied on percentages (e.g., noting that 50% of men indicated a particular theme in their interviews) and the discussion used comparatively few quotes from the interviews, even though they were likely rich with different themes and direct quotes would allow readers to more firmly understand the study's epistemologies. Unfortunately, that renders it difficult from the results and methodology section to ascertain exactly how this content was analysed.

With relation to this literature review, River's study was examined due to the theme of the original encounter with mental health services, as this ties in with questions regarding how e-therapies can be utilized to help draw in possible clients who may not have sought help elsewhere. In addition, River (2018) consistently emphasised that there was not one clear pattern across the board, making it difficult to theorize about an "ideal" mental health service for men. This further supports ideas about the importance of a variety of services and avenues for support.

1.2.3 QUANTITATIVE EXPLORATIONS

One 2020 exploration of men's perspectives on barriers to mental health services surveyed 778 men who self-reported a mental health concern (Seidler et al, 2020). Of these, 65% (n=513) wanted treatment and 35% (n=265) did not want treatment. The three most cited barriers were believing that feeling sad and down is common (80%), not knowing what to look for in a practitioner (80%) and the feeling of needing to solve one's problems independently (73%). Additionally, over two-thirds of respondents endorsed the statement: "It's hard for me to admit that I need professional help." This statement is in-line with elements of the internal barrier of self-stimga of seeking help as identified by Vogel (2017).

Men who were not interested in receiving treatment were more likely to endorse attitudinal barriers, such as "I need to solve my own problems," potentially suggesting an increased adherence in masculine norms by those who reject treatment. The authors noted that the only practical barrier more fully endorsed by men who rejected treatment was "I would not know how to find a counsellor." While this may relate to the themes of service gatekeeping, it is indirect and suggests that, for this group, the barriers are more attitudinal than practical.

A 2015 meta-analysis reviewed 41 qualitative and quantitative studies in order to extract themes about delays in medication and psychological help-seeking among men (Yousaf et al, 2015). This paper

approached the questions from a health psychologist perspective and looked at research on men who delayed help-seeking for physiological difficulties and papers that dealt with psychological difficulties. Most research silos mental and physical health-seeking into distinct categories, probably due to the focused and specific nature of research, but perhaps making it harder to see patterns that might appear across the board. Researchers have raised questions about whether the medicalization of mental health is part of the barrier that triggers self-stigma or is otherwise unappealing to men (River, 2018) this also brings up connections to Whitley's (2021) conceptualization of formal versus informal types of care, and prompts questions about whether the formalisation of mental health care is part of what activates self-stigma in men, especially given the medicalized language around difficulties.

Exclusion criteria included theoretical papers, scale developments, papers that looked at help-seeking habits but not factors or barriers that reduced help-seeking, papers that looked at specific sub-populations of men (e.g. drug users or homeless individuals) and papers that did not analyse data from men separately. Papers were then rated for quality using a standardized assessment which identifies 14 quality criteria for quantitative papers (such as: study national, study design, sample size) and ten quality criteria for qualitative (such as: extent of detail in data analysis, connection of topic to existing theory). Papers were analysed on this standard independently by two different reviewers, with all differences in score being discussed and reflected upon.

Forty-one papers were chosen for review. Each of these operationalised help-seeking as pursing treatment or advice from a relevant health-care professional. None of the papers looked at informal approaches to mental health care. Fifteen studies looked directly at help-seeking factors in specific relation to mental health care, and ten looked at specific diseases (e.g., prostate cancer). Seven major internal barriers and external social barriers were identified from the meta-analysis:

- restricted emotional expression
- need for independence and control
- gender role conflict; embarrassment
- anxiety, fear and distress
- men not seeing themselves as susceptible to health concerns
- lack of knowledge about symptoms, treatment and services

Practical barriers and contextual factors were also identified. These included:

- poor communication with health professionals
- lack of time to monitor one's health and arrange for medical appointments
- cost of medical services
- demographic factors, such as low educational status, young age and never-married status.

The four barriers that were most consistently and empirically supported by multiple methodologies were: (1) embarrassment/anxiety/distress/fear related to using health-care services; (2) need for emotional control/guarded vulnerability; (3) viewing symptoms as minor and insignificant, and (4) poor communication/rapport with health professionals.

Several of these barriers can be connected to cultural ideas around masculinity and self-stigma For example, embarrassment related to using health-care services may be linked to the 'self-sufficiency' masculine ideal (Vogel et al, 2017). Viewing symptoms as minor and insignificant, for example, can be connected to the previously discussed pattern of how men score higher on measures for depression and anxiety when they avoid medicalised language. While this perspective may speak to a lack of education around mental health ideas, it may also indicate a desire on the part of men to not see themselves as "mentally ill" and to avoid conceptualising their difficulties as serious or outside the norm.

Another piece of research examining barriers was a web-based survey of over 12,000 students in eight different countries (Ebert et al, 2018). This found that less than 25% of students reported that they would definitely seek treatment if they had an emotional problem. The most commonly reported (56.4%) reason for not seeking professional support included a preference to handle the problem independently, a theme that lines up with the previously reviewed qualitative research that identified masculine ideals of self-reliance. While the study did not distinguish between female and male respondents this result could be interpreted as in alignment with research that suggests independent problem solving is an important part of the masculine identity. Consistent with the findings of the Seidler et al. (2020) meta-analysis, Ebert (et al, 2018) found that attitudinal barriers were more highly endorsed than structural barriers, supporting the idea that masculine ideals and self-stigma are major factors in young men not seeing mental health support. This underscores the need for counselling psychology to create alternative avenues for treatment with flexible entry points, and perhaps incorporating aspects of self-help.

1.3 UNDERSTANDING SELF-STIGMA AND ITS RELATIONSHIP TO HELP-SEEKING

Some research has suggested the possibility of tools and interventions which can increase help-seeking intentions despite the presence of high self-stigma (Brenner et al, 2020). These promising finds offer hope that counselling psychology can develop pathways that will allow services to reach underserved populations.

Brenner et al. (2020) submit that experiential avoidance may be a moderating factor in the relationship between self-stigma and help-seeking; essentially positing that interventions which limit the amount of self-stigma "triggers'' will be more successful than interventions that force clients to immediately or regularly confront their self-stigma.

Experiential avoidance can be broadly defined as a desire to avoid unpleasant triggers (such as thoughts, feelings, settings, physical activities) even if the avoidance prolongs an unpleasant or undesired state (Hayes, Strosahl & Wilson, 1999). In terms of its relevance to this literature review, experiential avoidance might manifest as wishing to avoid cues that force service users to engage with having to self-identify as 'mentally ill' or 'needing help'.

If experiential avoidance is a significant moderating factor, it introduces the possibility that cCBT and e-therapies would be a promising avenues for counselling psychology, since computer-based support can help users bypass cues such as administrative staff, clinical settings, or even having to directly ask someone for help. The scheduling flexibility (users can typically sign up for e-therapies online, at any time) also means that the resource is available at moments when a user is more likely to feel comfortable, rather than having to sign up during a time/setting where they might be aware of their self-image, such as during the workday.

1.3.1 WHAT IS SELF-STIGMA AND HOW DOES IT DIFFER FROM SOCIAL STIGMA?

In order to consider how self-stigma might be a barrier to services, it is necessary to define and explore the idea.

Self-stigma is typically conceptualised as negative schemas that form resulting from existing stereotypes prominent in one's culture (Corrigan & Calabrese, 2005). Rather than manifesting outwards, however, these stereotypes are turned inward, causing individuals to turn the critical voices towards themselves and their own self-image. Crucially, this makes self-stigma an internal barrier to help-seeking, rather than an external social barrier or practical barrier. These internal barriers are, by their nature, much more

difficult for researchers and practioners to see and address, as they are often not measurable by conventional means, especially if they go unstated.

Research consistently shows a strong relationship between social stigma and self-stigma, adding weight to the hypothesis that these internalised stereotypes is likely to be the result of a broader social conversation (Whitely, 2021). This suggests that one of the best long-term approaches to combat the negative impact of self-stigma is to work on shifting the cultural ideas. Whilst counselling psychology is not able to actionably change any internalised self-stigma, an argument can be made that it can consider how its offerings might inadvertently reinforce self-stigma, for example using language such as 'patient' rather than 'client' or 'service user'. This research also links a commonly cited internal barriers with external social barriers, suggesting that a thoughtful approach to addressing external social barriers may, over time, help to address internal barriers.

Service providers, therefore, have a responsibility to be mindful of external social barriers to help-seeking when considering what options are made available to users, how those service pathways operate, the language around the offerings and how those factors might influence the broader perception of mental health and mental health help-seeking. For example, requiring sign-ups to be via the phone might be discouraging, requiring people to fill out medicalized forms or self-identify with diagnoses might be cues for self-stigma, even the layout of the therapy room can invoke culturally ingrained ideas about Freudian analysis or mental institutions. For example, a study looking at declined engagement in a mental health intervention found that participating in the diagnostic interview was a deterrent for roughly 9% of the 81 participants surveyed (Hoek, Aarts, Schuurmans & Cuijpers, 2012). While that may seem like a comparatively small percentage, it is worth considering whether this is a group that suffers more highly from internalised stigma and therefore might be highly distressed by their symptoms.

In an examination of self-stigma versus mental health stigma, Tucker (et al, 2013) refers to previous work on the negative impact receiving the label "mental patient" can have on individuals (Link, 1987). They note a large body of evidence indicating that users avoid mental health services in order to circumvent the self-stigma of mental illness, but there is also reason to suggest that the self-stigma of seeking help may be operating independently of mental illness stigma. That is, the self-stigma of seeking help can be conceptualised as a separate phenomenon, not merely a facet of mental illness stigma.

This again highlights how that multiple approaches may need to be taken in order to address barriers on all three levels (practical, external social and internal) rather than a single-pronged approach. Mental

illness stigma might require interventions such as normalising symptoms or providing practical methods to cope with discrimination, while help-seeking self-stigma might be addressed through normalizing help-seeking, re-branding treatment seeking as self-care, normalizing therapy and challenging myths about treatment (Tucker et al, 2013).

1.3.2 QUANTITATIVE EXPLORATIONS

Wallin and others (2014) examined the relationship between self-stigma and a preference for online therapies. A primary sample consisted of undergraduate students in Sweden (N = 267). Over 75% of this group was female and most participants (97.8%) reported daily internet use. Their second sample was of patients recruited from three primary care clinics based in Sweden (N = 195). This group was a more even gender breakdown (56.9% female) and most participants also reported daily internet use. Of note is that the first sample had a mean age of 24.5 years while the mean age in the second group was 45.3 years. Several established scales were used to measure current psychological distress, mental health self-stigma and help-seeking stigma. Subsequently, treatment preferences were measured using forced choice items.

Findings showed that participants were 11.19 times more likely to choose online treatment over treatment face-to-face if seeking help for a problem they perceived as stigmatised compared to mental health problems in general, suggesting a heavy impact from the external social barriers of judgement and social stigma. As researchers expected, higher levels of help-seeking self-stigma predicted an increased preference for online treatment relative to face to face. This was true even though participants of the study also reported lower expectations for the helpfulness of online treatment, suggesting that participants are valuing the avoidance of self-stigma triggers more than the efficacy of the treatment.

1.4 THE POSSIBLE IMPACT OF SELF-STIGMA ON HELP-SEEKING

One interesting conceptualisation of self-stigma has been put forth by Crocker and others (1989). This is the idea that self-stigma may be the opposite of what could be termed ‘empowerment’. A number of studies have identified that a significant percentage of members in certain culturally stigmatised groups show higher self-esteem than is typical for majority (Corrigan & Calabrese, 2005).

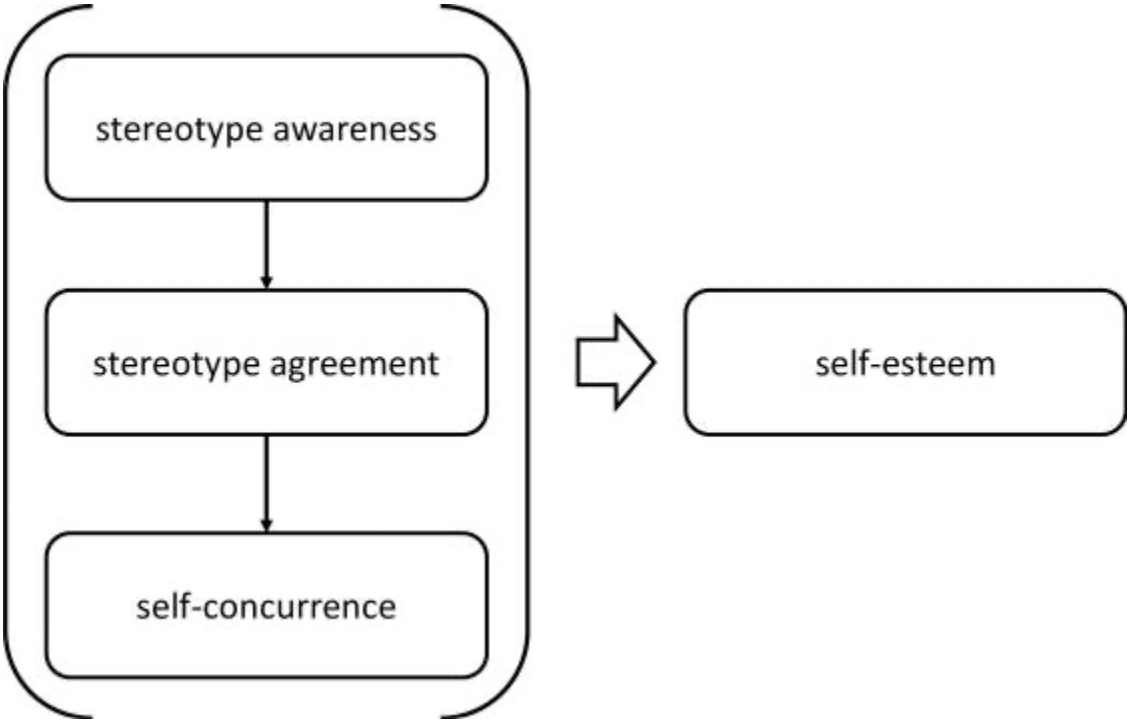
Corrigan and Calabrese (2005) have proposed self-stigma and personal empowerment as being on the same continuum, with persons on one end feeling unable to change and preoccupied with negative self-image. On the other end are persons who report feeling energised by the public stigma to foster change

and personal independence. Essentially, some group members assume the negative cultural stereotypes as part of their own self-image, whereas others are able to reject these stereotypes and are instead invigorated by defying these negative labels.

If the self-stigma group feels powerless and 'trapped' by their internalised barrier of the cultural stereotypes, one can make the *a priori* assumption that this group will be less likely to take decisive action such as researching and scheduling an appointment with a mental health professional. They may also be less likely to engage in services even if they have made contact. On the other hand, the empowered group may feel motivated to use services, and may conceptualise their service usage as a source of pride and power rather than of shame or defeat.

Corrigan (2011) has proposed a "progressive model of self-stigma" [*Figure 1*]. This is a conceptual model which suggests three proximal stages through which social stigma becomes internalised as self-stigma, where it can have a greater impact on self-esteem and a negative relationship to help-seeking. The succeeding stages are awareness of stereotypes or perception of public stigma, followed by personal agreement (implicit or explicit) and lastly self-concurrence. In the self-concurrence stage, the individual internalises these stereotypes and integrates them into their self-image.

FIGURE 1: CORRIGAN'S (2011) PROGRESSIVE MODEL OF SELF-STIGMA



Stereotypes tend to be related to long-existing narratives within cultural dialogues. The conceptualisation of self-stigma as being synthesised and integrated from cultural narratives suggests that there is an opportunity for new forms of treatment to not trigger internalised stereotypes in a way that traditional forms of help-seeking do. For example, while most famous early psychotherapists and psychologists were men (Freud, Jung, Piaget, Skinner), many of the publicised patients were women, such as Anna O or Sybil. Thus, while the traditional setting of a couch and psychoanalysis may cue ideas around femininity and 'being mad', alternative setting might not provoke the same cultural associations. Notably, uptake of new technologies and computer programmes tends to be associated with male users and may have different cultural associations.

1.4.2 SELF-STIGMA AND YOUNG MEN

Research has also indicated that self-compassion can have a buffering effect on the relationship between masculine norm adherence (or the intensity to which a man feels he must align with traditional masculine ideals) and self-stigma (Vogel et al., 2017) which indicates that interventions which have a self-compassion element may be able to mitigate some attrition factors. Importantly, however, these interventions still necessitate the initial engagement with services, perhaps the biggest hurdle.

1.5 COUNSELLING PSYCHOLOGY AND ADDRESSING SELF-STIGMA AS A BARRIER TO HELP-SEEKING

Previous research has suggested that marketing materials specifically targeting men are not better received than materials meant for the general population (Vogel et al, 2017). Although this study had limitations with regards to its geographical scope and focused exclusively on university students, its results suggest that marketing campaigns alone are unlikely to have the needed impact. Vogel (2017) proposed that one issue with such campaigns is that in their attempts to employ masculine norms to increase help-seeking (e.g.: "seeking help requires bravery and strength") they may inadvertently reinforce these norms or trigger reminders of self-stigma / demand avoidance; highlighting how difficult it can be to address internal barriers to help-seeking. It is possible that in using these positive terms, the marketing is activating a sense of dissonance. Previous research on corrective marketing campaigns have found that there may be a 'backfire effect' when culturally established ideas are challenged through the campaign, in that discussing these ideas may inadvertently reinforce the idea that there is a worthy

debate, although whether the 'backfire effect' is significant enough to refrain from marketing is contested.

1.5.1 CONSIDERING CCBT AS A POSSIBLE AID TO SELF-STIGMA

There is reason to believe that non-traditional methods of introducing mental health care, such as through physical activity (Bottorff, et al. 2021) or gaming may be less threatening to self-stigma than the traditional one-on-one talk therapy format, which suggests that it may be a better option for men for whom internal barriers are a significant factor that may lead them to otherwise put off or avoid mental health support entirely. Non-traditional options such as e-therapies have a low barrier to entry and can be used with minimal contact to others, which may decrease the likelihood of triggering self-stigma. Even if these approaches are not sufficient, they may serve as an accessible entry point which allows users to adjust to the idea of more traditional methods of support.

1.6 THE DAWN OF CCBT AND ONLINE THERAPIES

1.6.1 BACKGROUND ON THESE TREATMENTS AND WHAT IS CURRENTLY AVAILABLE?

Expense and accessibility are known issues when it comes to mental health treatment, in the UK and abroad. The invention and expansion of technology has led to a boom in therapy-oriented technologies and software, ranging from online Skype sessions to virtual reality simulations for exposure therapy, to video games with CBT prompts.

For the purposes of this exploration, we are considering software-based self-help therapy programmes such as Silvercloud. These programmes are typically completed in units whenever the user decides to engage in them, so the pace at which users progress can vary considerably. Although there may be a clinician to assess or check-in periodically, they tend to be largely client-driven programmes.

1.6.2 WHAT IS THE CURRENT STATUS OF RESEARCH ON CCBT/E-THERAPIES?

A 2017 meta-analysis looking at quantitative and qualitative research studies from 2007 to 2017 found relatively high levels of acceptance from clients to cCBT programmes, however they also noted a number of methodological issues in the existing body of research, including ambiguity of terms being measured

(such as terms like acceptance, satisfaction or usability being used interchangeably) as well as ambiguity on the causes of attrition from the studies (Rost et al, 2017).

QUALITATIVE EXPLORATIONS

One 2018 study (Perera-Delcourt, R. & Sharkey, G., 2018) used thematic analysis to explore patient experiences of cCBT within an urban IAPT service. Using semi-structured interviews, researchers spoke to ten patients and identified six primary themes: being offered cCBT, how cCBT compares to self-help, the patient's state of mind, their relationship with the supporter, preferring to talk, and cCBT's value as treatment.

The interviews elicited a general sense of feeling 'fobbed off' by the NHS for the offer of cCBT over more traditional face-to-face therapy. A majority of the participants reported feelings as though the cCBT programme offered information that was already known to them and that the interventions were not meaningfully tailored or applicable to their lives. However, it's worth considering that these factors suggest participants who already feel a degree of familiarity and knowledge with mental health, and this was a group that had proactively sought out mental health support, perhaps with the expectation of traditional one-to-one talk therapy. Thus, the group studied may differ from users who have high levels of self-stigma Participants stressed that being highly motivated was necessary for successful completion of the programme. This specific factor is concerning considering questions around avoiding 'triggers' of self-stigma. Even if e-therapies may be more accessible in terms of initial signing-up, the prolonged need for self-motivation may run up against self-stigma; this is an important question to consider.

Most participants had positives to note about their experience with cCBT. Several described it as a helpful first step, expressing that it helped them manage time on a waiting list or with building momentum towards further treatment-seeking. The relative discreteness of cCBT was also included as a positive. Both of these are aspects of the cCBT program that may indicate a good entry point for users with high self-stigma.

An older qualitative exploration of cCBT user experience (Gerhards et al, 2010) used semi-structured interviews with a specific goal of better understanding client adherence and attrition. A number of themes were elicited through the interviews. Negative themes included difficulty translating the cCBT materials to their own lives or feeling like suggested 'homework' was not applicable to them. For example, one participant pointed out that the suggestion to "go and find friends" didn't feel applicable to

him. Another major theme was professional support as something that users felt would benefit them, both to add a personalised element and/or to provide motivation. Notably, nearly all the non-completers indicated a desire for human support. While cCBT may be a more accessible avenue for mental health, it is worth questioning whether it will have an overall positive impact on self-stigma, especially if the programming elicits feelings that the content is not targeted or inadvertently reinforces negative self-image.

Despite the identified drawbacks, a number of positives were also mentioned. For example, several completers indicated that they enjoyed being able to 'pick and choose' what aspects of the programme they were interested in and that it allowed for tailoring. Other positive themes were the privacy and flexibility of computer-based treatment.

QUANTITATIVE EXPLORATIONS

Systematic reviews of e-therapy programmes have found that they can have a modest but significant impact on symptoms but note that there is a lack of research on non-student populations (Deady et al., 2017). Looking at 200 individuals with a diagnosis of depression, Forand (et al., 2017) identified one of the best predictors of successful engagement with cCBT as moderate or 'good' prognosis prior to starting, suggesting that cCBT may not be an ideal intervention for those with more severe symptoms.

There is a sizable block of studies that has looked at college students and their responsiveness to online therapies. A Finnish RCT trialled a guided-online-ACT programme and found that it was effective relative to the waitlist condition, with improvements being retained at a 12-month follow-up (Räsänen et al, 2016), however this programme did include some face-to-face support rather than being purely self-guided.

A quantitative exploration of attitudes towards e-therapy for eating disorder treatment found a positive relationship between high scores on Vogel's Self-Stigma of Help-Seeking Scale and preference for e-therapy; a one-point increase in the SPHS score was associated with a 1.5 increase in the odds of preferring e-therapy to face-to-face therapy, although they did not find a relationship between gender and e-therapy preference (Linardon et al, 2020). The study authors proposed that being able to engage in therapy at a private time and setting likely appeals to users who are high in self-stigma.

In a 2013 meta-analysis of cCBT for adult depression, fourteen trials were reviewed; although most showed a short-term reduction in depression, the effect at long-term follow-up was not significant. In addition, all studies noted high attrition rates in real world settings and that many studies which identified 'successful' treatment through cCBT also included structural incentives to complete the courses (So et al., 2013).

AREAS FOR FURTHER EXPLORATION

Despite the explosion of research into cCBT, relatively little is known about which elements of the treatment are most effective in producing change (Forand, 2017) and what attracts users, aside from cost and ease of access. It is important to consider that many of the successful RTCs have been completed in research settings where users were checked in on and their progress monitored. Attrition remains a significant issue with cCBT relative to traditional talk therapy (Lewis et al., 2020). Additionally, most of the studies listed have recruited either from universities or from existing service users. As such, more research needs to be done to better understand users who do not proactively engage with research and mental health services.

1.6.3 CCBT AS LESS-LIKELY TO VIOLATE SELF-STIGMA AROUND HELP-SEEKING?

A variety of hypotheses have been posited to explain the gender gap in help-seeking, such as gender socialisation through messages from peers and adults (Chandra & Minkovitz, 2006), and poor mental health literacy (Guilliver, Griffiths & Christensen, 2010). These are wide-ranging social issues, which would be difficult for any single e-therapy programme to address. Thus, while these issues may be touched upon for contextual purposes, the primary focus of this review will remain on internalised or self-stigma, which will be shown to have been repeatedly correlated with a negative attitude to help-seeking.

Vogel, Heimerdinger-Edwards, Hammer & Hubbard (2011) surveyed a broad sample of men (n = 4,773), aiming to address diversity gaps in the existing literature. Using structural equation modelling, they examined the cross-cultural relevance of a medical help-seeking model. This was done with an especial focus on connections between conformity to masculine norms, self-stigma and attitudes towards counselling. This appears to be the first analysis to examine invariance of the medical help-seeking model across different racial and ethnic backgrounds, as well as sexual orientations. Findings complement the existing literature on the relationship between stigma and help-seeking (Judd, Jackson, Komiti, Murray &

Fraser, 2006), indicating that self-stigma is a predictor of negative help-seeking attitudes and users with high levels of self-stigma are significantly less likely to seek help, across racial and ethnic backgrounds.

Several limitations should be noted. Relevant to the purposes of this literature review, the average age was well into adulthood, and age was not thoroughly examined as a variable. In addition, the sample was not limited to men who were experiencing current psychological issues. Different factors may be at work for those who are actively experiencing distress versus those who are not, however past research (Vogel, Wade & Hackler, 2007) has suggested that the decision-making progress for help-seeking is often consistent during and after periods of distress, it is unclear how significant this limitation is.

Clement, Schauman, Graham, Maggioni, Evans-Lacko, Bezborodovs, Morgan, Rusch, Brown and Thornicoft (2015) embarked on one of the first comprehensive reviews to examine the impact of mental health-related stigma on help-seeking. Their synthesis of quantitative studies found stigma had a moderate but consistent detrimental impact on help-seeking. Using thematic analysis, qualitative studies were reviewed, identifying five themes and 43 sub-themes. These included dissonance between preferred self/social identity and mental illness stereotypes/beliefs, consistent with previous findings examining men's attitudes towards mental health care (Lynch et al., 2016). Relevant to the purpose of this paper, the five groups that were identified as disproportionately impacted by stigma included both males and youth (Clement, et al., 2015).

The significant majority of the studies reviewed were undertaken within Western and high-income countries, limiting their generalisability. While it is important to note this context, this was an intentional choice as the perspective of this paper is firmly embedded within a UK psychology ethos and is thus focused on literature that is most likely to reflect the reality of young men within the UK. Of the studies reviewed, 46% did focus exclusively on youth, but none looked explicitly at men, and women were generally over-represented in the samplings, a theme also common in the cCBT literature.

Responding to calls for further research aimed at addressing barriers, Wahto and Swift (2016) designed questionnaires with a view to understanding whether different labelling of treatment providers and treatment settings could result in lower violations of stigma. The average age of participants in this study was 25.97. Consistent with past research, self-stigma and social stigma were found to be significant predictors of negative help-seeking attitudes. The results showed that self-stigma uniquely explained 11% of variance in participants' attitudes, while social stigma was found to uniquely explain 5%. This suggests that internal barriers may be more significant than external factors.

However, changing labels for treatment providers or treatment areas (e.g. psychologist vs. counsellor, or health clinic vs. counselling centre) did not impact measures of self-stigma or indicated likelihood of help-seeking. These results are consistent with research which has found that switching labels does not result in more positive help-seeking attitudes in men (McKelley & Rochlen, 2010). However, they are contrary to studies which have found attitude differences in response to alternative treatment options (Blazina & Marks, 2001; Lynch et al., 2016). These ambiguous results indicate that further investigation is necessary.

Lastly, there is one study that directly measured how self-stigma ratings were impacted by the use of a cCBT programme. Hypothesising that self-guided programmes may better align with expressed values of male youth, such as autonomy and self-reliance, O'Kearney, Gibson, Christensen & Griffiths, (2005) examined 78 adolescent boys as they completed MoodGYM, a self-paced cCBT programme. In order to measure stigmatic attitudes, O'Kearney et al., (2005) used nine items from the personal attitudes subscale of the Depression Stigma Scale, with modified scoring. The study did not find significant results between boys who completed the program and boys who did not, suggesting the programme did not impact levels of self-stigma.

However, the modification of the scoring on their measurements rendered it difficult to compare their results to other research. In addition, a number of participants did not complete all the modules. Lastly, while the questions of the study were uniquely in line with the perspective of this paper, which is why it was reviewed, the study is now over a decade old, meaning e-therapies technology and development has changed significantly since then. Contemporary research examining self-stigma and cCBT is lacking, despite the rapid development and promotion of further cCBT offerings.

1.6.4 UNDERSTANDING ATTITUDES TOWARD CCBT AS AN ALTERNATIVE TO IN-PERSON THERAPIES

Several studies have found that alternatives to the traditional face-to-face therapy model may be more accessible to young men (Blazina & Marks, 2001; McArdle, McGale & Gaffney, 2012; Robertson & Fitzgerald, 1992). In addition, younger people may be more interested in self-guided interventions (Rickwood & Bradford, 2012). In a qualitative review of cCBT for patients suffering from bulimia, a female user expressed feeling more engaged as computers are neither judgmental nor gossipy (Sanchez-Ortiz et al., 2011). This research also found that 72% participants who were willing to sign up for a cCBT

programme had not previously sought any form of therapy (Sanchez-Ortiz et al., 2011), suggesting that cCBT may help people overcome barriers that are in play for in-person treatment.

There are many studies demonstrating the effectiveness of cCBT as comparable to in-person therapies (Davies, Morriss and Glazebrook, 2014; Mullin, Dear, Karin, Wootton, Staples, Johnston, Gandy, Fogliati and Titov, 2015) although as previously noted, issues with attrition are also well-documented in real world settings (Day, McGrath & Wojtowitcz, 2013). Nonetheless, these results offer hope that e-therapies might be effective with clients who would otherwise forgo treatment. The question here is whether e-therapy programmes are less likely to engender feelings of self-stigma. Relatively few studies have directly examined this, however there is a growing body of research on attitudes towards e-therapy, some of which include self-stigma in their lens.

In a closer examination of youth perceptions of online therapies, Sweeney, Donovan, March and Forbes (2016) identified that young people valued the benefits of stigma reduction. Of those surveyed, 72% indicated they would choose an online therapy in the event of a mental health problem, with a third indicating they would select online therapies over face-to-face support. However, actual usage numbers were much lower, with only 3.7% indicating that they had ever used such a therapy, despite the majority of participants reporting existing or past mental health challenges. Consistent with expectations, female students reported themselves more likely to consider online therapies (Sweeney et al., 2016). In addition, Sweeney et al., (2016) found that participants with less stigmatised mental health attitudes demonstrated a more positive attitude towards online therapies, highlighting the fact that stigmatisation will affect usage of mental health resources, even with cCBT.

The majority of participants in the Sweeney et al., (2016) investigation were female, with less than 30% of the participants being male. In addition, Sweeney et al., (2016) recruited participants via Facebook which may have led to a disproportionate representation of users who are comfortable with expressing themselves online. On the other hand, this represents a departure from surveying current service users or university students, both groups that are heavily covered in the literature and who may not represent the perspectives of users that are unlikely to engage with traditional mental health services. The authors recommended further research to better understand the mediating relationship between attitudes and uptake.

Ellis, Collin, Hurley, Davenport, Burns and Hickie (2013) employed mixed methods to explore young men's attitudes as they related to mental health and technology, with an aim to find implications for future

development. An online survey was administered over a period of three months to participants recruited from Facebook. Participants were also encouraged to help recruit their friends. Users surveyed were between 16 and 24. Overall, a total of 486 men completed the online survey. Following this, 118 young men in this same age group were recruited to 17 different focus groups. These were gathered through advertisements in a selection of youth-serving organisations via flyers. Survey data was analysed via simple linear regression, while focus group data was analysed thematically using two separate researchers for coding.

Perhaps surprisingly, given other researcher's findings that men are less emotionally open among peers (Lynch et al., 2016), more than half the respondents reported discussing their problems online, and that talking online helped. Age was a significant predictor, with young men being more likely to have done this. It is possible that the anonymity allowed by some message boards and online forums helps users to feel more comfortable revealing their personal struggles.

Across all 17 focus groups, the term 'mental health' was associated with stigma and negative connotations. Stigma and self-denial were raised in the interviews, suggesting that men would have difficulty coming to terms with their own experience of mental health challenges. However, also across all focus groups, participants voiced a willingness to use the Internet as a source of support.

Given recruitment via Facebook, the survey portion of the study likely represents students who are already heavily engaged in online interactions, limiting its generalisability.

Addressing gaps in the research for young people outside of a predominately white setting, Fleming and Merry (2012) used interviews and focus groups to survey providers of youth services, the majority based in high deprivation communities. Youth service providers are at the frontlines for finding and responding to troubling symptoms in vulnerable populations. In addition, these service workers, in educational or sports-based settings, will encounter individuals who have not sought out mental health care.

A general inductive approach was used to comb through interview transcripts and code themes. A common theme was the expressed concern that mental health services weren't developed for 'our' kids. These concerns highlighted that mental health treatment was viewed as designed for youth from wealthier backgrounds. Nonetheless, most participants indicated tentatively positive responses to e-therapy programmes after viewing the software developed by researchers.

Several participants suggested these programmes might be especially useful for boys, who they indicated were more enthused about technology and less likely to talk about what is going on in their lives. The most frequently expressed advantage to e-therapy was the potential ability of the online programme to be a 'gateway' to additional help. A few providers indicated that e-therapy has distinct advantages over service providers, including privacy and control for the user. Overall, youth service providers were cautiously optimistic about the use of e-therapy for their clients (Fleming & Merry, 2012). Although researchers did not directly solicit information regarding stigma, the positive aspects identified suggest that youth workers view e-therapy as a promising development for getting young men to engage. It is reasonable to assume that youth service providers are picking up on negative self-image among their charges and thus accounted for this factor in their responses.

A notable limitation is the interviewers were involved in the development of the cCBT programme, which interviewees were aware of, possibly inducing bias in their answers.

Using an online questionnaire designed around themes identified in the literature, Horgan & Sweeney (2010) surveyed 922 students from a university in Ireland. As with other pieces of research, this sample was primarily female (62.4%, n = 552). Of the 867 participants who responded to questions about using the internet for mental health services, 30.8% indicated that they have used the internet to access mental health information, with 8.2% using it once a week or more, suggesting that a significant population of students is willing to regularly engage with mental health online. Of those students who reported accessing the internet for mental health information, the primary reason given was depression. A majority of respondents (68%) indicated that they would use the Internet for mental health support if necessary.

Of particular relevance to this review is the 20.6% of respondents who indicated a preference for Internet support over face-to-face interventions. Several ideas were identified to explain this preference, including themes around privacy, accessibility, integrity and believing that they would be less judged in an online atmosphere than in person. In addition, some participants suggested they would be more inclined to open-up on the Internet and that it would be easier to express themselves.

A limitation is that the questionnaire used by the researchers was self-designed and not tested for validity. The authors reiterated the need for further study exploring how youth view and interact with mental health support online.

1.7 CASE FOR FURTHER RESEARCH

While the body of literature on the gender gap in help-seeking is broad, it often relies on correlational data, and cannot indicate causal links. Thus, there have been calls for experimental designs, such as the manipulation of self-stigma through different modalities of therapy (Vogel et al., 2011) to round out the research. While O'Kearney, et al., (2005) explored this, their research is now well over a decade old, and deserves revisiting, particularly given the fast-paced evolution of digital therapies (Tal & Torous, 2017). In their synthesis of qualitative and quantitative literature, Clement et al., (2015) identified sub-themes in the qualitative data not explored in the quantitative studies, which suggests the value of qualitative data for providing a more nuanced picture of these multifaceted processes and raising thoughtful questions. The authors also identified a need for further research examining the relationship between stigma and help-seeking by youth. While a few studies have looked how different labelling or treatment alternatives impact self-stigma, these have conflicting results and employed different methodologies (Blazina & Marks, 2001; Lynch et al., 2016; McKelley & Rochlen, 2010; Wahto & Swift; 2016) making it difficult to draw conclusions. More research is needed to see whether e-therapy programmes lessen violations of self-stigma.

Currently, there is extensive research on possibilities offered by e-therapy, with many randomised controlled trials validating its efficacy (Tal & Torous, 2017). Less work has been done examining client attitudes toward e-therapies. Of the existing papers, many rely on specifically designed questionnaires, making it hard to synthesise results across studies. In addition, females appear to be disproportionately represented in many of the papers, perhaps because many of these studies are likely to recruit participants from psychology courses, which may be likely to include a majority of women. Several studies also recruited directly from Facebook, where they may be more likely to find youth already comfortable with expressing themselves online. Future investigations should consider recruitment outside of online forums and psychology courses.

This review posits a need for mixed method exploration of how self-stigma in young men is impacted by the completion of a e-therapy programme.

1.8 SEARCH PROTOCOL

Gathering literature started with a preliminary search using the following terms: cCBT, computerised, digital therapy, online therapy, university students. This search was used to gather initial studies for

understanding the impact of cCBT on a young cohort. In addition a search was made for: stigma, masculinity, help-seeking, young men. Additional search terms were identified via themes in the literature. Article bibliographies were compared to identify frequently cited authors. Databases were accessed via City, University of London.

While financial constraints and wait-times were frequently identified in the literature as barriers to treatment seeking, even in the United Kingdom where NHS services are available to users, this literature review and the remainder of this paper does not focus on these factors. This is not because these are unimportant or insignificant issues, but as these structural issues merit in-depth consideration in order to do them justice, a close examination of them is beyond the scope of this review. It is important to bear in mind that vulnerable groups are by far the most likely to be impacted by structural barriers, even if other accessibility factors (such as therapist training or marketing language) are addressed.

2.0 METHODOLOGY

2.1 INTRODUCTION AND RESEARCH QUESTION

This paper probes the topic of young men's self-stigma around seeking mental health support and their subjective viewpoints on e-therapy versus traditional one-to-one talk therapy. The following chapter will undertake an overview how of these questions were developed and with what rationale they were pursued. It will start with an examination of the researcher's epistemological stance and personal reflexivity, followed by a rationale for the choice of q-methodology and a detailed review of the procedural steps. Because q-methodology is not always well understood, the paper will approach this methodology with the assumption that readers may be unfamiliar.

The consideration of self-stigma and whether e-therapy was a viable route to addressing self-stigma concerns was an idea that germinated as a response to seeing extensive marketing materials from for-profit e-therapy companies in the real word. While the offerings of these companies often perform well in structured trials, even in comparison to traditional one-on-one therapy (Twomey et al., 2017), the marketing generally eschews sharing facts around e-therapies high attrition in real world settings (Morrison & Doherty, 2014). Despite high hopes that these e-therapies will be a new avenue for users that may not seek traditional therapies, much of the actual administration tends to target participants who would otherwise pursue traditional avenues of mental health support.

While the promises of e-therapies are invigorating and exciting – accessibility and affordability, especially for those who may face the most structural barriers to access – it remains unclear whether these platforms are really attracting and supporting clients who would not otherwise seek or receive help.

Another question was regarding populations who are resistant to seeking therapy. A lot of research has been attempted on groups that rarely seek treatment and there are a myriad of contributing factors, such as cultural familiarity, systemic barriers and stigma (Barry et al, 2019). This research is particularly interested in that last point, especially self-stigma, which is a difficult barrier for mental health services to address, as the solutions are less obvious and those with self-stigma may not always present themselves, or be frank about their self-doubts when they do.

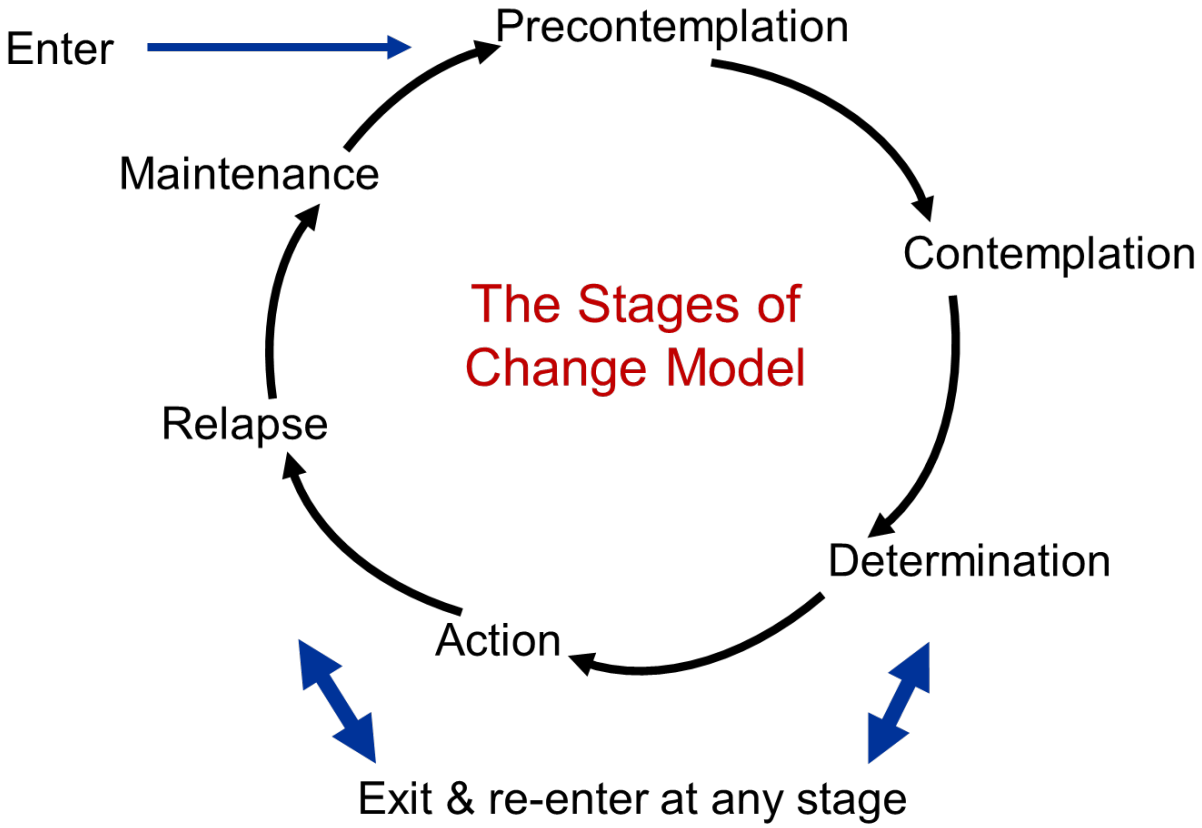
Marketing e-therapies often posit that these alternatives might be less threatening and more comfortable to individuals who have self-stigma or other reasons to decline traditional face-to-face therapies. This is

also an idea that is frequently raised in the academic literature looking at e-therapies. However, these questions remain unanswered. For the context of this research, the group resistant to seeking help is young men between the ages of 18 and 26, who are considerably less likely than their female peers to seek mental health support (Barry et al, 2019). This group was chosen both due to need, as men are more likely to die by suicide than their female counterparts, and also for pragmatic reasons, as it is a large group that is easily accessed.

The question of whether e-therapies attract those who might otherwise be resistant to treatment also connected to the Transtheoretical Model or the Stages of Change Model, developed by Prochaska and DiClemente in the late 1970s [*see figure 2*]. Although this model was developed around seeking support for addiction, it provides an interesting framework to view change-based programs in general, including therapy. It seemed possible that if e-therapy programmes might be perceived as more accessible to groups with high self-stigma, as the low barrier to entry might allow a transition from the 'contemplation' and 'preparation' stages to the 'action' stage with comparative ease, while traditional face-to-face treatment might thwart progress through these stages through treatment gatekeepers or long wait times. In thinking through the research methodology, there was an aim to include discussion of the possible perceived barriers to traditional mental health treatment as well as possible barriers to e-therapies, in part to think through how a service user might not be "lost" during the preparation stage.

One of the focuses of the q-set, therefore, is looking at elements of traditional therapy that might be discouraging to uncertain users, such as the scrutiny of the therapist, the possibility of someone seeing them attending treatment, or having to sign up through conversations with medical gatekeepers.

FIGURE 2: STAGES OF CHANGE MODEL



(Prochaska and DiClemente, 1984)

2.3 ONTOLOGICAL AND EPISTEMOLOGICAL STANCE

This section of the paper will examine the philosophical stance in more depth, with the aim of allowing readers to understand what assumptions are driving the judgment calls made throughout the paper.

Epistemology is a branch of philosophy dedicated to making explicit our ideas about what knowledge is and how (or even if) it can be acquired (Nagal, 2014). Ontology is the branch of philosophy examining existence, becoming and reality. Put bluntly, ontology refers to what *is* and epistemology refers to what is *knowable* and how it can become knowable. An understanding of reality inherently rests upon epistemological and ontological assumptions; they are the invisible compasses that orient one's thoughts on the world.

More often than not, one's epistemological and ontological assumptions are so interwoven into a sense of reality that it is incredibly difficult to identify these beliefs (Willig, 2012). Indeed, they are often not recognised as beliefs as all. However, a rigorous examination of epistemological stance is critical for well-developed research, especially when examining an intangible concept. Clarifying the philosophical stance allows the researcher and the readers to understand exactly where 'due north' lays; in essence it provides a map of possibilities. In exploring this stance, this section of the paper will assume a more personal tone in elaborating on the researcher's own beliefs and ideas.

My stated position is that of critical realism and pragmatism. Critical realism means assuming a stratified approach to ontology, making a distinction between the empirical (i.e.: observations and data), the actual (i.e.: experiences) and the real (i.e.: underlying mechanisms and structures that generate/influence events). These distinctions, as put forth by Bhaskar (1975) allow an epistemological approach based on what domains (or interaction between domains) one hopes to explore, acknowledging that methods of gathering knowledge or data will be different depending on which domain we are examining.

Critical realists acknowledge that a positivist epistemology is often justified for examining the empirical domain, while remaining critical of the indiscriminate transposition of positivism onto social sciences, as the approach ignores the constructionism inherent in our social worlds and the influence of the research on the subject. Indeed, for psychological research to obtain the internal validity necessary for a positivist approach, it risks sacrificing so much in external validity that the research tells us nothing relevant, or worse, actually threatens to distort our collective knowledge by deflecting attention toward phenomena only observable in unnatural situations and obscuring social-cultural and political factors (Yardley & Bishop, 2017). Any pursual of popular psychology coverage will make obvious the strong temptation to generalise the results of highly structured research onto real world settings that are unlikely to produce similar results.

This critique relates back to some of the material covered in the literature review, as much of the e-therapies research has been conducted in academic or paid settings that offer structure and incentives to participants while real life e-therapy usage doesn't have these conditions. The fact that these quantitative studies were conducted within these artificial frameworks means we must question how applicable the results are to the real-world usage these apps are ostensibly developed for. Of course, the research here is no exception to that, and it is important to bear in mind that there are significant limitations on what we can know and that the results are offered up as fodder for clinical discussion rather than objective fact.

My argument is that there exists an inherent challenge in psychology given the acknowledged connection between our physical state and our mind state, and the need for psychological practitioners' client advocacy within a largely medicalized system. This is where a pragmatist philosophy becomes valuable. William James (1906) argues that many ontological debates are functionally linguistic disagreements, with arguments that differ in theory but ultimately either position, if true, wouldn't change practical results. James asserts that beliefs are relevant only in how these beliefs become our 'rules for action'. In less formal verbiage, James's ideas bring to mind a pithy phrase sometimes heard in statistics courses: "stats are when you don't know for sure, but doing nothing isn't an option."

Essentially this argument is that often the aim of inquiry is not truth for truth's sake, but to forge a path toward a better real-world experience.

Evaluations of inquiry should not be independent of, but rather informed by, the type of knowledge being sought (Yardley & Bishop, 2017) and what real life outcomes are hoped for. This relates to the overarching ethos of counselling psychology, which suggests that research should be driven not by academic curiosity or prestige for its own sake but for the needs of clients and to improve the client experience.

Thus, even within social sciences, it may be appropriate to use positivist tools to examine the empirical domain, so long as we do not claim knowledge about underlying mechanisms based on this data. An exclusively survey-based inquiry may have allowed for more generalisations, but considerable nuance would be lost, and it disallows questioning an interaction between the empirical and actual (or experiential) domains, as outlined by Bhaskar (1975). Additionally, a pragmatic perspective would point out that considerable survey data has already been gathered, and it benefits us to expand our scope rather than collect additional data that overlaps with what has already been found.

A more constructivist approach can create rich narratives around the actual/experiential domain, but this raises other issues. Firstly, there already exist a number of qualitative explorations of men's experiences of therapy. Secondly, the population in question is one that has already been identified as part of a group unlikely to engage proactively with psychologists, so a less intimate research approach may be more acceptable. Lastly, insufficient effort has been made to explore connections between qualitative and quantitative analysis of men's subjective views on therapies.

Additionally, our question should be driven by real-world values. Counselling psychology has a client-driven ethos. We are duty-bound to seek understanding of clients' needs and how to best serve them (BPS, 2009). Reiterating the points made early in my introduction: men are consistently less likely to seek professional mental health support (O'Kearney et al., 2006) and more likely to die by suicide than women of all ages (Office for National Statistics, 2017; World Health Organization 2014). I assert that it is patently unacceptable to dismiss this as the status quo, and it is similarly unacceptable to hand-wave away the gender discrepancy as laying at the feet of the underserved population for crime of not presenting themselves to mental health services.

Several researchers (Keohane & Richardson, 2017; River, 2018) have echoed these criticisms on the existing work on men's help-seeking for implying that the gender care gap problem belongs to the clients rather than services and arguing that there is a paucity of research on men's treatment values and how mental health services can meet these. There is a continued question in the research as to whether different labels and treatment options will be more acceptable to users with high self-stigma, with different research approaches and formats finding conflicting results (Wahto & Swift, 2016; Lynch et al., 2016). This raises the question of whether we can create meaningful external pathways to mental health care if users are barred by 'internal' barriers. The possible interplay between these external and internal barriers is one of the central questions at the heart of this research.

2.4 PERSONAL REFLEXIVITY

My ability to reflect on my own epistemological position is limited, as so many of these assumptions are underpinning beliefs that we may not be consciously aware of choosing. Willig (2012) offers several questions we can use to clarify our stance: what kind of knowledge do I aim to produce? What do I believe exists? What is the relationship between myself and the knowledge I aim to generate?

I aim to produce knowledge about subjective views on mental health offerings. While I believe there is likely an objective 'truth' about how most young men view the mental health offerings available to them, I believe I am fundamentally limited in my ability to gather this knowledge or to verify it.

Like many counselling psychologists, I hold the subjective experience as hugely important, even independent of 'objective' truth. My work is primarily clinical, not research-based, and the goal of clinical work is not to generate objective data about large populations or theorize about the nature of mind in the abstract. Instead, we seek first to compassionately support the client, often through seeing and validating their subjective experience. Rather than grapple with clients about 'how accurate' their beliefs are, I consider what impact those beliefs have on them, their experience of the world and choices they feel are available to them. Even should two people have the same 'objective' reality, their experiences could nonetheless be incredibly unique and not easily compared (Dhillon, 2018). In addition to the practical and epistemological concerns about survey research, this personal belief influences my choice towards Q-methodology. Holding subjective experience in esteem somewhat devalues the sort of knowledge I could expect to generate from a survey-type instrument.

However, I found that many of the more oft-used methods of qualitative inquiry didn't seem to suit my questions. While I wanted to better understand subjective opinions on mental health options, I wasn't interested in generating new material.

I also found myself thinking about the place counselling psychology holds in research. I feel that, in its haste to establish itself as a legitimate area for scientific inquiry, clinical and research psychology has often been too eager to operationalize complex and multi-layered processes into artificial measures. Much of the research in psychology has come under fire for practices like moving goalposts and for not being replicable, or for making assumptions about real world behaviour based on laboratory settings where participants are unlikely to act naturally. Much of the research being criticised has taken a traditional positivist approach. One aspect of Q-methodology that I found especially exciting was that it challenges the often-underlying assumption that statistically based research is necessarily objectivist or beyond subjectivity; as I will discuss further in the analysis chapter, the factor analysis used in Q involves multiple decision points which involve subjective judgement and will influence the data.

However well-documented the problems with positivist psychological research, qualitative research is often dismissed entirely, especially in broader policy discussions. It strikes me that there is value in being able to speak thoughtfully to statistical reasoning and questions and that counselling psychology (where

candidates are overwhelmingly likely to choose a qualitative research project) would benefit from having some voices outside the traditional qualitative paradigm. I'm also interested in how different methods of inquiry can help us triangulate ideas about a phenomenon. One of my experiences within clinical settings has been meeting with clients who are clearly not used to or are fundamentally uncomfortable in a mental health care setting. Often it is unclear to them how much agency they can use within the setting. I wonder if an open-ended style of inquiry might be too overwhelming for the participant group that I'm interested in. Offering a clear structure for them to operate within could be holding and help us capture viewpoints that may not come to participants in a more organic way.

Reflexivity historically has received more focus in purely qualitative research (Ryan & Golden, 2006). Nonetheless, as any research project is heavily influenced by its creator, a reflexive statement is imperative to demonstrate an awareness as to how their own person might influence the research. This is in keeping with the critical portion of critical realism.

Oftentimes researchers are driven in their motivation by a personal connection with the source material or the population. However, this researcher believes that we must also make an effort to look beyond our personal experiences. This is especially salient given the heavy tread towards women in counselling and clinical psychology, meaning that there is increasingly a disproportionate amount of female service providers relative to men (Liddon et al., 2018). The ethical mandate of the profession makes clear that practitioners and researchers are duty-bound to understand how to best serve the population (BPS, 2009) regardless of their similarity to our own selves. It is ever important that we take up research interests even if we are not personally connected to the specific population at hand, otherwise counselling psychology risks limiting its focus to a service user population that reflects its own face.

In addition to the selection of the research topic, the researcher must be alive to other ways in which they might impact the results. For example, during recruitment it will be clear through names the gender of the researcher and supervisor, who both identify as women, unlike the target population. The names also suggest the perspectives of white and ethnically European researchers. It is possible this knowledge will impact how people respond and engage, and similarly possible that these demographic qualities will impact what questions I think to ask, how I chose to analyse the results and what papers I choose to consult.

Analysis is another important area where it is possible for researchers to influence results, particularly given the variety of options available to analyse Q data (Watts & Stenner, 2012). As such, the researcher

should be highly reflective throughout the analytical process, documenting thoroughly so that any limitations can be easily spotted and brought to light for discussion and review.

2.5 Q-METHODOLOGY: A BRIEF OVERVIEW

Introduced in 1938 by William Stephenson, q-methodology was a response to Stephenson's concern about the turn towards objectivism in psychology. Stephenson was concerned that the increasing reliance on quantitative methods was giving experts a false confidence especially regarding nuanced subjects that did not lend themselves to this methodology. Typically, the purpose of q-methodology is to understand different 'subsets or groupings of subjective opinions that appear within a population (McKeown & Thomas, 2013). Thus, q-methodologies' foundations align with the critical realist belief that positivism is too blunt an instrument for research on subjective opinions.

Briefly, in order to conduct a q-methodology study, researchers identify a question and first pull together a rich quantity of information that could answer this question. The information could be in a variety of forms (pictures, music, text) although text is most often used. This amalgamation of information and opinions is called the 'concourse'. Researchers then comb through this information to create a 'representative sample' of the possible answers – q-statements. Stephenson recommends that q-statements be gathered from varied standpoints so that participants can compile them to truly express their views (Coogan & Herrington, 2011). Typically, this will amount to about 16-32 pieces. This condensed sampling of answers is called the 'q-set'.

Groups of participants are often called the p-set. As with other forms of research, participants are selected thoughtfully based on the research question. Participants are shown the q-set and asked to arrange the items in a normalized pattern that they think best represents their own answer to the question. Researchers then use factor analysis to examine the results and identify any common groupings of opinion.

Crucially, q-methodology *forces* participants to rank every answer relative to the other in a normalised fashion. Unlike a more open-ended methodology such as IPA, participants are only able to work within the q-set they've been offered. This means that participants is likely putting together a viewpoint that does not perfectly represent their unique perspective. Thus, as with a more traditional quantitative methodology, such as a survey, a q-set necessarily distorts views by leaving out or over-representing certain viewpoints in the provided materials. This can be both a strength and limitation, depending on the

purposes of the research. On one hand, it cannot accurately capture an individual viewpoint, nor can it generate new material.

On the other hand, limiting potential responses to certain selected statements allows the researcher to effectively 'invite' participants into an ongoing conversation within the literature, exploring their views and rankings on data that has already been collected, rather than generating new material. In a way I am more hoping to engage in a dialogue with the existing research than with the population and use the results of the study to reflect on existing research.

2.5.1 EPISTEMOLOGICAL AND ONTOLOGICAL ASSUMPTIONS OF Q-METHODOLOGY

Firstly, it can be clarifying to review what q-methodology *does not* claim to do. Q-methodology does not claim to know the mind of the majority of people within a group. That is to say, it is not a survey and is not attempting to understand what percentage of people in a cohort think X or Y.

Instead, it is attempting to understand what sort of viewpoints might exist on a given topic. In this regard, q-methodology assumes that subjective opinions are not likely to lay along a binary spectrum, but instead are dynamic and three-dimensional.

Q-methodology also does not claim to know the opinion of a specific participant. For example, it does not solicit much in the way of first-hand accounts or original viewpoints. Instead, it assumes that people will be able to express themselves (to an extent, albeit a limited extent) through the viewpoints of others. This can be a weakness of q-methodology, but it can also be a strength, depending on what question it is answering. For example, within the context of political opinions, or within the context of my research question – the methodology is interested in how people align themselves with already stated viewpoints, or viewpoints that are available to them, rather than generating new content.

Rather than trying to understand how an individual creates meaning around self-stigma, or e-therapies, I'm interested in how people align to already established viewpoints within the literature. Part of the reason for this interest is because my individual participants are unlikely to have a voice in these ongoing dialogues. With mental health development, as with politics, people are (in some ways) limited to choosing between established and powerful points-of-view, whether or not those line up neatly with their own perspectives. It can be valuable to see different ways they are ranked and aligned, especially because popular discourse will often reduce complex subjects to a binary.

2.5.2 RATIONALE FOR ADOPTING Q-METHODOLOGY

As discussed in the literature review, there are already a plethora of survey-based research studies looking at young men and their relationship toward mental health support. On a purely pragmatic note, given my own resources, I would not be able to meaningfully contribute to this area. Thus, I ruled out a purely qualitative approach early on.

A variety of qualitative approaches are available to use from a critical-realist perspective, such as Discourse Analysis, Narrative Analysis, Grounded Theory and IPA. Why pivot towards a rarely used methodology such as q-methodology with these other tools available?

Discourse analysis considers first the subjective use of language, considering how stories are told and language is used to help construct an individual's experience of reality (Willig, 2001).

I have identified myself as taking a stance of critical realism and pragmatism. While the epistemological positioning of q-methodology is not immediately obvious, I believe it can work well within this paradigm. Although q-methodology typically uses statistical analysis[1], it is not a purely quantitative approach and has been described as mixed methods, qualitative, or 'qualiquantological' (Watts & Stenner, 2012). Within a q-framework, statistics is not a tool for generalization to the larger population, a method of prediction (Brown, 1980) nor an attempt to objectively measure 'attitudes' of individual participants (Watts & Stenner, 2017). This lack of claim to objectivity excludes it from positivism.

However, like many positivist forms of research, q-methodology is not naturalist. Thus, I cannot assert that the q-sorts are a direct representation of the participants' real-world expression of their viewpoints. As with survey research, the artifice of q-methodology design allows researchers a route for direct comparison of phenomena that could not otherwise have a one-to-one comparison. Crucially, however, q-methodology does not claim to be an objective *measure* of anything. The meaning of statement rankings is not predetermined but emerges through the analysis (Watts & Stenner, 2017), unlike with psychometrics and other positivist tools.

Mixed methods explorations have historically suffered from the oft-critiqued strategy of using the qualitative methods in a 'supporting' role. In our haste to obtain knowledge, researchers may be tempted

[1] *Some Q methodology studies are completed with only one participant and thus do not use any statistical analysis to compare participants. These are more obviously qualitative studies.*

to use tacked-on qualitative data to support their own interpretations of the quant findings. Coupled with a cultural bias toward positivism, this creates an inconsistent valuing of qualitative data: holding it up as supporting it viewed as consistent with the quantitative findings and discounting it as unscientific if it contradicts (Yardley & Bishop, 2017).

Within health psychology, q-methodology has been successfully deployed to identify areas of misunderstanding between practitioners and patients, for example examining different ways of conceptualizing the symptoms of IBS (Watts & Stenner, 2017). In this same way, I was curious to see if I could find areas of commonality or conflict between the literature around online therapies and possible end users. The purpose of this analysis then, is neither to make generalizations about a population nor to look at individual meaning-making, but to invite possible end-users' subjectivity into an existing academic discourse.

2.6 PROCEDURE

2.6.1 RESEARCH QUESTION

Curt (1994) advises that Q-methodology research questions should be focused on representations of a subject matter, understandings of it or conduct in relation to it. This is key because Q-methodology is only able to draw on existing subjective viewpoints of a subject, not generate new material. Although the drawbacks of this are obvious, as previously discussed, one of the benefits of inviting subjects to rank existing viewpoints is that it allows us to take different perspectives on a dialogue.

It is the last of Curt's categories that is relevant: understanding perspectives on conduct in relation to a subject matter. Conduct questions look for how a specific group is responding to a subject matter. These questions elicit perspectives on policy and response to social issues, a common topic for Q-methodology (Watts & Stenner, 2005).

The research question will drive the structure of the q-set provided, and therefore needs to be clarified prior to creating the q-set and selecting participants. It is important that the research question be simple and understandable to the population being surveyed. In this case, the guiding question is: "*Which of these statements best describe factors that would influence your choice if you were asked to decide between a computer-based therapy program versus traditional face-to-face therapy?"*

There is an ongoing conversation within the literature regarding the advantages and disadvantages of online versus traditional one-to-one psychological treatment (Beatty & Binnion, 2016). The aim of this study was to invite a relevant group to participate in this largely academic conversation. Q-methodology allows participants to reflect on relevant viewpoints currently being articulated within the research, rather than generating new material.

In addition to the research question driving the q-sort, this research will also explore if different factors emerge from participants who score highly on the Self-Stigma of Seeking Help questionnaire versus those who score less on self-stigma, in an effort to better explore the idea of self-stigma as outlined in the literature review.

2.6.2 OUTLINE OF STEPS

This outline briefly reviews every step that will be taken during this research project, with the aim of providing a clear window into how results were obtained, thus allowing for critical analysis of the results by the researcher and others.

CONCOURSE & Q-SET DEVELOPMENT

Participants in a q-Methodology study will be offered a selection of 'items' (usually written statements, but these could potentially be images or other media) which they are then asked to arrange in a normative pattern, usually ranking from "Most Disagree" to "Highly Agree". The selection of items offered to participants is dubbed the q-Set and it should provide a representative selection of opinions for the participants to choose from. In a sense, the selection of a q-set works similarly to the selection of participants for an R study: that is, the items provided should be representative of the domain it aims to investigate, just as the participants in an r-study should be representative of the group being investigated (Watts & Stenner, 2005).

A robust understanding of the academic literature surrounding a particular topic allows themes and controversies to emerge; this is a sound base for gathering information for the q-set (Watts & Stenner, 2005). Also valuable is to pay attention to the phrasing of the statements. Participants should be responding to the underlying meaning of a statement, rather than clumsy or clever wording. Double-barrelled statements, or those containing qualifications, should be avoided as it cannot be later ascertained which portion of the statement a participant is responding to (Watts & Stenner, 2005).

The ‘Concourse’ describes all the materials gathered and reviewed for the purposes of creating a representative sample of subjective opinions for the q-set that participants will view. Obviously, there are far more views on a topic than can be practically shown to participants, so narrowing down what items will be on the q-set is a key portion of the research. Gathering the statements for the q-set often takes longer than the actual data gathering (Watts & Stenner, 2005).

There are no specific rules for designing a q-set. It can be designed purely on theoretical grounds, from naturally occurring conditions or simply to suit the requirements of a research question (Stephenson, 1952). This stance is both freeing and frustratingly vague. Stephenson said little in his writing about the process and ethology of designing q-sets (Watts & Stenner, 2005), leaving other researchers to fill in the gaps subsequently. This is a major criticism of q-methodology, since the collection of material leaves a lot of area for the researcher to influence the study’s ability to respond to the question at hand. Vitally, documenting the creation of the q-set is integral to justifying and explaining the results.

Because the goal of this research was to invite possible end-users into a conversation taking place within the academic literature, statements were pulled from research papers on young men in therapy and online therapies. Statements were chosen by pulling views identified in recent research on men’s views of therapeutic interventions. Both qualitative data (interviews and focus groups) and quantitative data (from surveys) was considered. A total of 232 statements were considered from 74 articles. The process of reviewing the materials and selecting the statements is highly individual and reflective of the researcher’s viewpoint. As such, it can be considered part of the analysis (Watts & Stenner, 2005) and will be reviewed in greater detail within that section.

The final q-set was uploaded to Qualtrics, an online tool designed to help researchers distribute surveys to participants online. Qualtrics was selected due to availability, cost, high reviews, as well as its compliance with GDPR and privacy standards. Qualtrics is not specifically developed for use with q-methodology and thus completing the ranking with this tool can take a little longer than tools used specifically for q-methodology. We should consider that the sort of participants who are comfortable completing a survey like this online are not a randomly selected group but will likely be participants who are more tech-savvy and have access to a tablet or laptop. Several other online tools were rejected due to overly complex processes required on the participant side, however there were also several other tools that would be adequate for any replication.

Unfortunately, given the complexity of many issues, a q-set can never be said to be fully complete, even with piloting and years of research. It is important throughout the process to be aware of what was excluded. Watts and Stenner (2005) observe that q-set takes advantage of the fundamental human need to describe meaning and adhere structure to beliefs and opinion. This suggests that even though a researcher could not create the 'perfect' q-set, the methodology remains workable because participants will nonetheless be active in drawing meaning from what is available.

RECRUITMENT

Participants were recruited primarily online. A link was given for distribution and shared via Reddit. Participants were offered the chance to share a link to the study with any friends who further qualified. Selection criteria was simple, looking specifically for men between the ages of 18 and 26 who live in the United Kingdom. This age range was selected in light of the existing literature on young men that focuses on ages 16 to 26 and the lower cap placed at 18 for pragmatic reasons.

With any online research, there is the risk of dishonesty from participants (Lane, Armin & Gordon, 2015). Often, researchers can engage in a sort of post-collection pruning of data, removing any results that seem incredibly unlikely or out-of-sync with the expected population, although this practice raises its own ethical questions (Lane et al., 2015). However, q-methodology has been selected in part due to its flexibility for users, and this researcher believes such pruning would be contrary to the spirit of the methodology. Subsequent factor analysis should hopefully lessen the impact of any dishonest participants, although the possibility must be acknowledged as a limitation.

Q-methodology is traditionally administered in person, however online administration was opted for both due to practical concerns (especially given COVID precautions) and due to the fact that the research was looking at therapies being administered online. While this had some advantages and was necessary due to lockdown restrictions, we must also consider that some aspects were lost due to the lack of facetime with participants.

STUDY

Participants were asked to complete Vogal's Self-Stigma of Seeking Help Questionnaire to operationalise self-stigma around seeking professional mental health. Bhaskar, as cited by Price and Martin (2018), maintains that critical realism does not necessarily place models of the world as entirely 'in the mind' - a

facet of this positioning is that the phenomena examined in this study is held to exist independent of my investigation. However, it is also transformed by the investigation; we cannot necessarily obtain a clear picture of it.

The SSOSH scale has been shown to have cross-cultural reliability, face validity and criterion validity (Vogel et al, 2013). While I cannot assert that it is objectively measuring self-stigma activation in the face of psychological help-seeking (or that such a measurement would be possible), the internal validity suggests that it is capturing *something* real related to our shared conceptions of self-stigma. Given our professional mandate to advocate for clients within a systematic context, finding reliable methods of transforming conceptual beliefs into quantifiable data is important. Within the context of this research, SSOSH questionnaire results are not held to have predetermined meaning but must be interpreted alongside the identified factors.

After the completion of the SSOSH, participants were directed to a pre-sort. The pre-sort asked that participants arrange statements according to the categories of "least agree," "neutral," and "most agree". Following this, participants were served the statements relevant to the category they selected and asked to split out the "least agree" and the "most agree" with further granularity.

In addition, taking a cue from previous research (House et al., 2018) participants will also have access to an open-ended question asking if they believe anything is missing from the q-set. This question is within the critical realist and pragmatist viewpoint of q-methodology and acknowledges the method's main limitation (namely, that the q-set developed will always be subjective and can never be perfect). Although these answers are not meant to provide a main portion of analysis, if a significant number of participants respond, it opens up the research to further scrutiny and suggests avenues for further exploration. In this event, the answers will be coded and incorporated as an additional section into the analysis. This would also affect how heavily we can weigh the results of the q-sorts.

ANALYSIS

The analysis portion of s-methodology involves what Stephenson (1935) dubbed an 'inverted factor analysis'. Thus, it is the different tests which become the study sample rather than the participant group. That is to say, the variables are no longer test results, but are instead the various participants (Watts & Stenner, 2005). This analysis method allows researchers to identify items in the q-sort that are statistically significant in their endorsement by participants. Comparing the placement of items, it is then possible to

identify statements which are representative of a viewpoint held by the group, often dubbed 'factor-defining statements'.

As with other aspects of q-methodology, the question of how to begin analysis should start with the expectations and aims of the researcher. This is because inverted factor analysis does not have a single, universally acceptable approach (Watts & Stenner, 2012). The factor analysis could be designed so as to produce a large number of different factors, or a more limited number of results. So, the sensitivity of the analysis must be calibrated and justified based on the aims of the research.

Factor extraction begins with the correlation matrix, which is created through the intercorrelation of each q-sort completed by participants (Watts & Stenner, 2012). To say that two q-sorts are highly intercorrelated is to indicate that the participants have arranged the q-set into very similar configurations. The amount of high intercorrelation within the q-sorts will provide a window into how many 'viewpoints' might be found within the results. Generally speaking, the more q-sorts, the higher the variability of the correlation matrix (Watts & Stenner, 2012). The goal of the factor analysis should be to shed light on the relationship between the q-sorts in the group; where there are shared meanings, we have identified factors.

There are other statistical methods that can be used to explore the results of a q-sort, notably a tool described as principal component analysis (PCA). However, Watts and Stenner (2012) note that the PCA employs an objectivist viewpoint -- providing one 'right' answer, which is epistemologically at odds with the qualitative stance of this research.

In order to check if the chosen method for analysis is providing a reasonably accurate portrait of the results, a parallel analysis can be employed. In the simplest terms, this process allows the researcher to see how many eigenvalues would be expected if each participant had completed the q-sort perfectly randomly (Watts & Stenner, 2012). An eigenvalue (or EV) in this context refers to the sum of the squared loadings (that is, a number representing the placement of a statement) of all the q-sorts of that factor. EVs are able to be used to derive communality of a particular statement (with higher values representing more broadly endorsed statements) (Watts & Stenner, 2012). Comparing the randomly generated EVs from the parallel analysis with the ones derived from the correlation matrix allows the researcher to determine which factor-defining statements might be surfacing as significant due to chance. Including this data within the analysis portion of the research also allows readers to consider the researcher's reflexivity in their chosen method of analysis. Factors that do not at least match the 95th percentile of the

EV identified parallel analysis should be excluded from the results. Factors that do match (or exceed) this number have a less than 5% chance of being due to chance (Watts & Stenner, 2012).

2.6 REVIEW OF ETHICAL IMPLICATIONS

Any piece of research carries with it ethical implications, especially when participants are directly involved. There are no manipulated variables in this research, which eliminates many potential ethical complications. Nonetheless, standards (British Psychological Society, 2014) dictate that researchers remain cognisant of any possible ethical implications for their participants and the broader population. In regard to this research, that means an awareness that any questioning carries the possibility of distress (Willig, 2013). This is particularly relevant as this research is aimed at a population group that may not be likely to access services.

Thus, participants were explicitly told of this possibility prior to their engagement and debriefed with information about nationwide resources for support. In addition, participants were reminded that their participation is voluntary, and they are able to click out at any time without any follow-up from the researcher.

Privacy concerns are paramount whenever research is conducted online. All data was collected within GDPR guidelines, and anonymised with ID codes in place of names, per BPS suggested guidelines (British Psychological Society, 2017). All data was be stored on a secure server and only accessible via two-factor authentication by the researcher.

2.7 REVIEW OF LIMITATIONS

Several limitations to this research have already been raised; this is a further review of these issues. It is important to understand that, like all research projects, this investigation is limited in its scope. First, it should be restated that q-methodology is primarily a qualitative methodology, intended to elicit subjective views of a topic from a particular group (Watts & Stenner, 2007). Crucially, it cannot prove a hypothesis or be used to make generalizations about a group (Watts & Stenner, 2005). This research can only be understood as a jumping off point for generating questions and discussion, rather than offering any definitive answers. It is also important to recall that any q-study approaches with the assumption that the participant will not hold all statements to be meaningful and relevant to the topic at hand. If participants view the q-set as irrelevant or inadequate to the question, this will limit the findings

significantly. In this regard, an open-ended question soliciting for feedback on the q-set will hopefully draw out any concerns. Although ideally this question will not produce enough material to be useful in analysis, if a statistically significant number of participants indicate feedback for the q-set, these results will be coded and included within the analysis as they may reflect a serious limitation in regard to the q-set's ability to allow participants to adequately demonstrate their viewpoint.

Q-methodology does not allow a researcher to make broad statements regarding a group, however this limitation has been oft-responded to within the surrounding literature. Several researchers have noted that q-methodology never claims to make broad statements and that to critique q-methodology for not generalizing is akin to criticising surveys because they are unable to predict individual behaviour (Brown, 1981). This researcher believes that q-methodology will fit in nicely with existing research on groups of hundreds of young men, which have demonstrated a lack of engagement with mental health services. These analyses are often broad and taken with an objectivist stance (Lynch et al., 2018) and thus the literature would benefit from more intensive research. Complementing the previous survey research, much of the qualitative work has had more of an exploratory bend, allowing for open-ended elucidation of themes and ideas from male participants. This research aims to place a brick in bridging the gap, instead trying to identify if existing views on the topic provide the freedom for young men to endorse a view.

The self-stigma scale used was developed by Vogel. A major limitation was that this scale was developed by surveying 583 college students, the majority of whom were of white European background and nearly all of whom were psychology students. Thus, this scale hinges on the implicit assumption that questions of self-stigma relevant to this group will also be applicable to larger groups. However, it should be noted that this scale has been studied for cross-cultural validity and has generally found to be valid across nationalities (Vogel, Strass, Heath, Al-Damarki, Baptista & Zlati, 2017; Topkaya, Vogel & Brenner, 2017). It should be noted, however, that one of the creators of the scale was involved in the research validating its use across national groups, which raises questions regarding reflexivity. When using any psychological scale, we should be aware of the difficulty of operationalizing a complex internal experience. We can't be sure that this scale is measuring self-stigma in exactly the way that we intend, or that users are interpreting the questions in exactly the way that the researchers have intended them.

As previously noted, any study conducted online raises additional concerns regarding limitations. There is an established practice of using online recruitment to research social attitudes and online interventions, particularly to avoid the WEIRD (western, educated industrialised, rich and democratic) phenomenon

(Lane et al., 2015; Ellis, Collin, Hurley, Davenport, Burns and Hickie, 2013). Although online research can broaden the potential participants, it introduces some sampling bias, as those who respond to online recruitment may represent users with above-average confidence online. Any recruitment strategy, however, is likely to introduce some sampling bias (Gosling et al., 2010), and this cannot be reasonably avoided. Participant fraud is also a possible issue, although it is of greater concern with studies that offer financial incentives (Kramer et al., 2014). A low-risk way of ensuring no participant fraud can be to ensure that IP addresses are only able to provide one unique response (Kramer et al., 2014).

3.0 RESULTS

3.1 RESULTS INTRODUCTION

This chapter will review the process of analysis that was undertaken and briefly review the factors. The discussion section will explore these factors and their implications more in-depth. Throughout this analysis, we must bear first in mind that q-methodology is not able or interested in estimating the prevalence or distribution of a perspective among a population, but is instead uncovering the plurality of different perspectives, even if they may be minority ones.

Although it relies on statistics, q-methodology is fundamentally a qualitative methodology. Therefore, any analysis needs to be approached with a thoughtful strategy. In this case, my approach involved looking at scores on Vogel's Self-Stigma of Seeking Help (SSOSH) scale. I was curious to compare the factors that came out of the high SSOSH scores versus the low SSOSH scores. I also wanted to run analysis on the entire group, not for one-to-one comparative purposes, but to see any other viewpoints that might emerge and to feel confident that the data was thoroughly explored.

As reviewed in the methodology section, the approach is a form of exploratory factor analysis, which is essentially a statistical method of searching for the structure that underlines the variables in a dataset; these structures can be called factors. As datasets often include a rich variety of variables, there are many ways to 'slice up' the data. Factor analysis is a means of data reduction that seeks to explain as much of the study variance as possible. It does so by looking at commonalities across participants q-sets.

3.2 ANALYZING THE SSOSH RESPONSES

As outlined previously, self-stigma has long been established as a barrier to seeking mental health support and one of the previously stated aims of this research is to reflect upon if or how this barrier might be ameliorated using computer or phone based mental health interventions, such as Silvercloud.

The method this paper uses to explore self-stigma is the Self-Stigma of Seeking Help scale (SSOSH) (Vogel et al., 2006). PsycINFO indicates the SSOSH has been administered in over 150 studies and 12 countries worldwide (e.g.: Vogel, Armstrong et al., 2013; Vogel et al., 2017). Although the SSOSH has received psychometric support (Vogel et al., 2006), the field would benefit from developing revised and ultra-brief versions of the SSOSH through examining individual item functioning.

3.2.1 SLICING THE DATA

Overall, twenty total Q-sorts were completed. Of these, seven fell into the High SSOSH group and five into the low SSOSH group, with another eight not scoring high or low on the SSOSH. Three factor analyses were run: one on the high-scoring SSOSH group, one on the low-scoring SSOSH group, and one for the entire group.

Note that the 'mid-SSOSH' group was not analysed separately from the whole; this is due to the stated aims of this project, which is specifically to look at how people with low or high SSOSH consider different options for therapy. In keeping with recommendations on best practices for Q methodology, more experienced researchers were consulted on how to best divide up the P set (Watts & Stenner, 2005). It was recommended that the mid-group be left out of the analysis and the factors instead focus on those who scored high and low on SSOSH, as the mid-group, while the largest, responded to the SSOSH survey in such a way that it isn't possible to understand if or how self-stigma is impacting their therapy choices.

Two factors were identified within the High SSOSH group, one factor was found in the low SSOSH group, and two factors were further pulled out of the group entire.

The analysis was run via Ken-Q, an online platform that allows the data to stay on the server, so it is compliant with GDPR and general privacy guidelines.

Questions were only shown to respondents who self-identified as being between the ages of 18 and 26, residing in the United Kingdom, male, and who hadn't previously sought out mental health support. A total of 81 participants indicated their consent and were shown the questionnaire. Unfortunately, due to a technical issue, a number of these were not shown the proper questionnaire and could not complete

the sort, so 21 sorts had to be discarded. Another 40 terminated their questionnaires prematurely, a known issue with online recruitment and surveying.

Respondents were grouped based on their SSOSH score. Participants who scored between a 0 and a 25 were placed in the "low" SSOSH group and participants with a score of 30 or above were placed into the "high" SSOSH group. Five participants had low scores and seven participants were in the high-scoring group, a remaining twelve did not fall into either high or low SSOSH camps.

3.2.2 P-SET

Participants were targeted via Reddit. Respondents ranged between 18 and 26 years of age, with the average age being 23. Analysis was conducted via Ken-Q Analysis, a desktop web application. Once the application is loaded there is no further communication with the server, so all matrix calculations, factor rotations and file downloads are processed in the browser, meaning that the data never leaves the web browser and is secure.

Watts and Stenner (2005) recommend extracting one factor for roughly every seven participants. This general rule of thumb is broadly accepted within the Q-methodology community, and based on how much information is needed to generate a factor that accounts for variability within the data and was used as a preliminary guide to help identify how many factors could be neatly extracted from the data. As this research includes a p-set of 20, that suggests we would expect to extract roughly two to three factors.

Running the data first results in a correlation matrix, then it results in an unrotated factor matrix *[figure 4 in appendix]*. This unrotated factor matrix can give suggestions as to how many factors might be reasonably extracted from the data, if viewed through the lens of three guiding principles outlined by Watts and Stenner (2005).

The first guiding principle to consider is the idea that each factor should have an Eigenvalue (EV) greater than 1.00. The power of the EV indicates a factor's statistical strength and explanatory power. If the value is less than 1.00, it indicates that the factor accounts for less study variance than a single Q-sort. The guideline of keeping factors with an EV of 1.00 or greater is often referred to as the *Kaiser-Guttman* criterion (Watts & Stenner, 2005) and is widely accepted as the standard. A drawback as outlined by

Brown (1980) among others is that the *Kaiser-Guttman* criterion can lead to solutions that have an overly large number of factors, however this is unlikely to impact small p-sets such as the one in this study (Watts & Stenner, 2005).

A further principle is that at least two significant q-sorts should be loaded onto each factor. If this is not the case, it suggests that the factor is not meaningfully related to the q-sorts. Additionally, this allows us to compare how "significantly" related a q-sort is to a factor. For example, we might see that some q-sorts are significantly related to multiple factors and explore that overlap. Significance levels can be assessed through a check of the factor loadings that result in the unrotated factor matrix, and calculated using the following equation from Brown (1980):

$$= 2.58 \times (1 \div \sqrt{\text{number of items in the q-set}})$$

Therefore, to the purposes of this paper:

$$= 2.58 \times (1 \div \sqrt{28})$$

$$= 2.58 \times (1 \div 5.2915)$$

$$= 2.58 \times 0.1889$$

$$= 0.4875 \textit{ rounded up to } \mp 0.49$$

This result means that a q-sort with a loading of ∓ 0.49 or greater is meaningfully related to the factor.

Lastly, Watts and Stenner (2005) suggest Humphrey's Rule should be considered. This rule states that a factor may be considered significant when the total of the two highest loadings for that factor exceeds twice the standard error.

When analysis was run on the entirety of the q-set, two unrotated factors qualified based on the above criteria, which prompted me to run the analysis again looking for this number of factors.

One of the benefits of Q methodology is that it offers us the flexibility to slice up the data in multiple ways.

The next step, as outlined by Watts and Stenner (2005) and Brown (1993) would be to carry out a varimax rotation of the factors. Varimax rotation is an attempt to clarify the relationship between factors and is used as standard with Q-sort analysis.

3.2.3 CORRELATION MATRIX

A first step in this interpretation is the correlation matrix, a table that shows how each Q-sort is intercorrelated with every and any other individual Q-sort. These scores are on a scale ranging from -1.00 to +1.00. A large positive score indicates a strong positive relationship between two Q-sorts, indicating that they are similar, whereas a low score indicates an inverse relationship. Relationships such as this are often sought in traditional quantitative approaches to psychological research, using by-variable factor analysis and *r*-methodology. Unlike this approach, which aims to look at the relationship between traits and outcomes, or the relationship between two traits, Q methodology inverts the traditional approach by comparing individuals what Watts & Stenner (2005) call "by-person" factor analysis, as opposed to "by-variable" factor analysis. The variable, therefore, in a Q methodology study, is the individual completing the set.

The correlation matrix for the low-SSOSH group indicates that several of these sorts are not highly related to each other. None of the sorts are negatively related to each other, indicating that the sorts are either unrelated or tend towards being similar. As there are only five sorts in the low-SSOSH group, we can expect to only extract about one factor, given the general guides previously discussed.

The correlation matrix was calculated using forced q-sorts and a single factor was extracted for the four sorts using varimax rotation. Two factors loaded on to the q-sort.

Given the results, a further analysis was conducted looking for factors that better explained the study variance. Only two of three unrotated factors met the criteria established by Watts and Stenner (2005), specifically the Eigenvalue over one and at least two q-sorts loading significantly onto the factor. Due to this the analysis was re-run with only two factors and varimax rotation was applied.

A cursory glance of the correlation matrix for all respondents showed that sorts from the High SSOSH group and the low SSOSH group were often inversely correlated.

Participants who scored over a 30 or above on the SSOSH scale were grouped into a 'high SSOSH category'. Nine of the p-set fell into this group. An initial factor analysis showed that two unrotated

factors met the three criteria outlined by Watts and Stenner (2005), with a third unrotated factor showing an EV of above 1.00 but with only one factor loading with a significance level above ∓0.49. As such, only two factors were kept for rotation.

3.3 INTERPRETATION OF FACTORS

This portion will offer a brief overview of the factors that emerged from the Q-sorts as well as some of the individual writings that participants included when asked an open-ended reflection question. These will be further expounded upon in the discussion section.

A total of five factors were extracted from the data, one from the Low SSOSH group, two from the High SSOSH group and two from the group entire. A summary of the factors is displayed via the below table and individual factors are further elaborated on throughout the results section.

TABLE 1: FACTOR ARRAYS

Item Number	Wording	Factor 1 Low SSOSH	Factor 1 High SSOSH	Factor 2 High SSOSH	Factor 1 All	Factor 2 All
1	If I were struggling, I would be more comfortable completing an online therapy course than sharing my feelings with a stranger.	0	0	-2	-2	0
2	I would feel more comfortable with an online mental health programme, because it can be used discreetly when and wherever is best for me.	1	0	-1	-1	1
3	It's easier to share personal stuff with a computer programme because you don't have to face someone.	-1	-2	-1	-3	0
4	I could open up to a sympathetic professional sitting across from me.	1	3	-1	3	1
5	A therapist could share some of their own experiences, which would make me feel better about my struggles.	0	2	0	1	0
6	An online therapy programme is better because you can use it without people knowing.	0	0	-1	0	0

7	I think one-to-one therapy with a professional would be better to draw me out of my shell.	1	3	-2	3	2
8	Receiving the undivided focus of a professional would make me feel on the spot.	2	2	-1	0	3
9	An online mental health intervention would lack the depth of in-person communication and feel superficial.	0	1	3	2	0
10	A personal therapist would judge me.	-2	1	0	0	-2
11	I worry what my community would think if I was seen going into a mental health clinic.	-3	1	-3	-2	-1
12	I would find it easier to enrol in an online health intervention than a traditional one, since I could sign up without having to speak to anyone.	-1	1	1	0	0
13	I would appreciate having the expert opinion of a mental health professional who knew me personally.	3	0	2	1	1

14	I wouldn't know what to expect or what to do in a therapy session.	1	0	2	0	2
15	I don't think a therapist would understand me or my problems.	-3	0	1	0	-3
16	I'm sceptical about meeting with a therapist, because they might have psychological problems themselves.	-2	0	1	0	-1
17	If I saw a therapist, I worry they wouldn't like me.	0	-1	1	-1	-3
18	It would be helpful to have a warm relationship with a therapist who cares about you.	3	1	0	1	1
19	An in-person therapist would be constantly assessing and judging you.	0	-1	0	-1	-1
20	I would prefer in-person therapy because I'd feel safer with a time and space specifically dedicated to mental health.	2	0	1	2	0
21	It would be uncomfortable to complete a mental health programme on the same	0	-1	0	0	-1

	computer/mobile that I use for the rest of my life.					
22	I would feel isolated and lonely completing a computerized therapy programme.	1	-1	0	1	0
23	Online therapy programmes are best for people who are already comfortable talking about their mental health.	0	-1	0	-1	0
24	Traditional in-person therapy is designed for people who are already comfortable talking about their mental health.	-1	0	0	0	-2
25	I would worry about the data an online mental health programme would collect on me.	-1	-3	0	0	-1
26	If I used an online mental health programme, I worry that someone could find it on my phone or computer.	0	-3	0	-1	0
27	I would be more likely to share my problems if I could do it in writing instead of face-to-face.	-1	-2	-3	-3	1

28	I would feel better if a professional let me know my experiences were normal	0	0	3	1	3

COMPLETE GROUP

To observe broader viewpoints for the whole group, factor analysis was run on all 20 of the completed Q sorts. To get a sense of how many factors could be extracted, the initial run was for seven factors. Of these, only five had an Eigenvalue above 1, so the factor analysis was re-run with the aim of extracting five factors. Of those five, only two explained more than ten percent of the variance, so the analysis was re-run to extract two factors. This result is in line with the general 'rule of thumb' outlined by Watts and Stenner (2005) that we should expect roughly one factor for every seven participants

TABLE 2: UNROTATED FACTOR MATRIX FOR COMPLETE SSOSH GROUP

Unrotated Factor Matrix for Complete SSOSH Group

Participant	Factor 1	Factor 2
Low1	0.6389	-0.0039
Low2	0.4979	-0.1293
Low3	0.555	0.3513
Low4	0.5001	-0.6055
Low5	0.5435	-0.3219
Mid1	-0.2588	0.4135
Mid2	-0.0986	0.4252
Mid3	0.5827	0.2319
Mid4	0.1068	0.0458
Mid5	-0.2376	0.2373
Mid6	0.6721	-0.1694
Mid7	0.7444	0.1676
Mid8	0.3534	0.7123
Mid9	0.2887	0.1423
Mid10	0.2716	-0.0244
Mid11	0.3447	0.4471
High1	-0.5665	0.2407
High2	-0.2844	-0.2597
High3	-0.0722	0.2028
High4	0.4933	0.4481

Eigenvalues	4.0507	2.2266
% Explained Variance	20	11

STATISTICAL SUMMARY OF FACTOR 1 FOR THE COMPLETE GROUP

Seven participants loaded significantly onto Factor 1 for the Complete Group. The eigenvalue for the factor was 4.05 and it explained 18% of the total variance. The factor correlation between this factor and the second factor kept for rotation was 0.309, suggesting that the two views are not highly similar.

VIEWPOINT

A computer-based mental health programme does not feel like a good option to me, especially relative to more traditional one-on-one therapy. I would certainly not feel more comfortable sharing personal stuff or completing an online therapy course (1, -2) (3, -3).

It doesn't make a difference to me that an online therapy course can be used on my own timetable (2, -1) or that you can use it discretely (6, 0). I also understand that online mental health programmes aren't designed for people who are already good at talking about mental health (23, -1). The issue is that the intervention would lack depth and feel superficial (9, +2). Private enrolment is not a draw for me personally (12, 0) and while I don't have privacy concerns with a computer-based mental health programme (21, 0) (25,0) (26, -1), I would feel isolated working on my difficulties alone on a computer (22, +1). I would not be likely to share my problems in writing (27, -3).

And I think it would be easy for me to open-up to a sympathetic professional (4, +3) especially if they shared some of their own self in the room (5, +1) and normalised my experiences (28, +1). That would be the best thing to draw me out of my shell (7, +3). I wouldn't feel anxious being the centre of focus (8, 0) or worried about judgement (10, 0) and I am definitely not going to worry about people seeing me heading in for appointments (11, -2).

The expert opinion of a professional would be invaluable (13, +1) and I don't have any major doubt about therapists as individuals (15, 0) (16, 0) or worry about them liking me or judging me (17, -1) (19, -1). A warm relationship with a professional would be helpful (18, +1) and the dedicated time/space would make me more comfortable sharing (20, +2).

This factor had themes around valuing the depth of the therapeutic relationship, trust in professionals and valuing traditional one-to-one therapy over computerized options. These views were echoed in the expanded statements from participants: "*They're trained to be non-judgmental, and it's not like I'm an asshole or anything, I'm sure they've seen it all before*" and "*I believe that someone who shows interest in*

my mental health and my issues/challenges and life becomes an easier person to communicate well with which allows me to open up quicker and to more depth. I think people clearly react better to those who appear sympathetic and because they appear sympathetic people would (and I would) likely speak from my point of view and understanding of events and my situation rather than a purely neutral or matter of fact one. I would think breaking down one's understanding of events and personal viewpoint is important to the process after all."

However, issues around access and feeling let down by services were also brought up by participants in their written responses: "*I would have like to seen a mention of how difficult getting actual one on one therapy is*" and "*Therapy doesn't help for people with actual problems, the majority of therapy is trash like CBT that only attempts to change thought patterns rather than addressing the actual problems. A one fit all size solution that is designed to get as many patients through as quickly as possible."*

Highly endorsed statements included:

- *I could open up to a sympathetic professional sitting across from me* (z-score: 2.26)
- *I think one-to-one therapy with a professional would be better to draw me out of my shell* (z-score: 2.15)
- *An online mental health intervention would lack the depth of in-person communication and feel superficial* (z-score: 1.67)

Poorly endorsed statements included:

- *If I were struggling, I would be more comfortable completing an online therapy course than sharing my feelings with a stranger* (z-score: -1.274)
- *It's easier to share personal stuff with a computer because you don't have to face someone* (z-score: -1.685)
- *I would be more likely to share my problems if I could do it in writing instead of face-to-face* (z-score: -1.72).

STATISTICAL SUMMARY OF FACTOR 2 FOR THE COMPLETE GROUP

Four participants loaded significantly onto Factor 2 for the complete group. The Eigenvaluge for the factor was 2.22 and it explained 11% of the total variance.

VIEWPOINT

If I were struggling, I would feel no more comfortable with an online therapy course than I would sharing my feelings with a professional (1, 0). The advantage of an online mental health programme is that it can be used on my own time (2, +1). It's not necessarily easier to share stuff with a computer programme (3, 0), in fact I think I could talk more readily to a person sitting across from me (4, +1) (27, +1). Especially as I am sure they would like me fine (17, -3) and wouldn't be judgmental (19, -1). I'm sure a professional would understand me and my problems (15, -3) so I would value their expert opinion (13, +1). I don't need a therapist to share anything personal about themselves with me (5, 0) but a warm relationship would be helpful (18, +1) and I would really value if they normalised my experiences (28, +3).

My one concern is that I wouldn't know what to do or expect from the therapy session (14, +2) but I think that traditional one-to-one therapy is better for those are new to talking about their mental health (24, -2).

I'm relatively indifferent to the increased privacy of online mental health programmes (9, 0) (26, 0), the fear of isolation (22,0) or ease of enrolment (12, 0), but I actually worry about the discomfort of completing a mental health programme on the same computer/mobile that I use for social and work (21, -1). The one advantage I can see is that I would find it easier to write out my problems then say them out loud to another person (27,+1).

Factor 2 for the Complete Group had themes of ambivalence, which is consistent with assumptions that might be made for a SSOSH group. While themes around normalization and valuing the therapeutic relationship were highly endorsed, so too were themes around nervousness and feeling unsure what to do in a therapeutic setting.

This ambivalence is echoed in some of the writings that participants put in response to the follow-up questions: "*I have anxiety and paranoia about weather people like me, and seeing a therapist on a regular basis and having them get to know me would make this worry worse. I don't feel like i could explain myself or that it would feel real if the therapy was done online, and being in a safe space and in a space dedicated to mental health would make me feel less out of place.*"

There appears to be a clear theme of wanting connection and support but feeling unable to obtain it in a safe or sustainable manner.

Highly endorsed statements included:

- *Receiving the undivided focus of a professional would make me feel on the spot* (z-score: 1.68)
- *I think one-to-one therapy with a professional would be better to draw me out of my shell* (z-score: 1.45)
- *I would feel better if a professional let me know my experiences were normal* (z-score: 1.45)

Poorly endorsed statements included:

- *I don't think a therapist would understand me or my problems* (z-score: -2.224)
- *A personal therapist would judge me* (z-score: -1.485)
- *If I saw a therapist, I worry they wouldn't like me* (z-score: -1.48)

LOW SSOSH GROUP

Five Q-sorts were grouped into the Low SSOSH Group. When the data was run through the Ken-Q software, only one factor was found that had an Eigenvalue of over 1.00 and therefore only one was kept for analysis.

TABLE 3: UNROTATED FACTOR MATRIX

Unrotated Factor Matrix for Low SSOSH Group

Participant	Factor 1
Low1	0.5963
Low2	0.4825
Low3	0.5687
Low4	0.4422
Low5	0.8331

Eigenvalues	1.8015
% Explained Variance	36

STATISTICAL SUMMARY OF FACTOR 1 FOR THE LOW SSOSH GROUP

The factor extracted from the Low SSOSH group had an eigenvalue of 1.8 and explained 36% of the variance. Three sorts loaded onto the factor. The viewpoint is spliced together from the various statements using the method described by Watts and Stenner (2005) wherein the ranked statements are knitted together based on the ratings within the factor to create a cohesive whole. It goes without saying that the tone of these viewpoints is necessarily going to reflect the perspective of the researcher. A plus of amalgamating the statements is that it allows the factor to come alive as a subjective viewpoint on a nuanced topic, humanizing the perspective.

VIEWPOINT

I believe there is value in receiving the opinion of someone who holds trained expertise (13, +3) and in establishing a warm relationship with your service provider (18, +3). Sure, being the focus of someone's attention can be nerve-wracking (8, +2), but one-to-one talking would be a good way to draw me out (7, +1). I trust that a professionals wouldn't judge me (10, -2), so I wouldn't need to worry about whether the therapist likes me (17, 0). And I'm sure they themselves are in good mental place to offer judgement (19, 0; 16, -2). After all, it's their job to understand the client (15, -3).

I don't think it would be helpful for a therapist to share their own experiences (5, 0) or otherwise try to normalize difficult experiences (28, 0), and admittedly, it could be hard to know what to expect from a traditional therapy session (14, +1).

But overall, I believe it's possible to open-up to a sympathetic professional (4, +1) and that it is preferable to have a specific time and place dedicated to your mental health (20, +2).

While an online therapy course isn't necessarily any more comfortable for me than speaking with a trained professional (1, 0) and I think would be bit awkward to share personal things with a computer (3, +1), it is helpful that you can use the programme discreetly and on your own timetable (2, +1). It doesn't matter if anyone knows you're using an online program (6, 0).

An online course doesn't necessarily feel superficial to me (10, -2) and I don't have any major concerns about privacy (21, 0; 25 -1; 25, -1) but also there is no reason to worry about what your community would think seeing you at a mental health clinic (11, -3), nor is the private sign-up process a draw (12, -1). While I mostly have neutral thoughts on computerized mental health programmes, I do feel that there are two major drawbacks: completing one while you're struggling could make someone feel lonely and isolated (22, +1) and people are more likely to share their problems face-to-face rather than in writing (27, -1).

This factor had themes of valuing expertise and a therapeutic relationship. Sorts that endorsed the factor indicated low-levels of social stigma, which corresponds with the low SSOSH scores that distinguish this p-set. When offered a chance to reflect on the Q-sort, participants in this group made comments that echoed these themes, such as: "*I trust the science, so I trust the people who study the science. People who know me personally as well are more likely to have a more wholistic and full appreciation of my mind and the causes which go to my behaviour.*" There were also themes of not being worried about social stigma: "*I think that attempting to receive help for mental health problems is not frowned upon in my community and if people did frown upon it I couldn't care*."

The low SSOSH group also included reflections on their concerns about online mental health offerings: "*If you're already comfortable with addressing your emotions you are probably are aware of them and are starting to already change them. If anything, the people who need most help are the ones who cannot talk about their mental health as they are the ones at highest risk to neglect it*."

A highly critical statement came from a member of the group who loaded significantly onto the factor but also expanded in his personal statement to write on themes of gender and acceptance within the mental

health community: *"This research seems to be incorrectly predicated on the fact that EVERY male doesn't want to seek mental health support. This is seemingly because of the opinions of women informing you about the male experience. I think you should listen to what men have to say and not TELL them they are embarrassed to go to mental health support. Most men don't go because OF THE TREATMENT THEY GET. Do you know how horrible it is to go into mental health support (a profession dominated by women) and be talked to like crap about your experiences because it's a woman on the other side???"* This criticism resonates significantly with academic critiques discussed in the literature review, which assert that counselling psychologists must be thoughtful to make sure that the gender care gap isn't being solely attributed to male behaviours. Indeed, this statement seems to assert that self-stigma is unlikely to be the major barrier, but rather lack of training on the part of the clinicians. This critical statement will be further examined in the discussion section of this paper.

This was the only factor which negatively endorsed statement 12: "I would find it easier to enrol in an online health intervention than a traditional one, since I could sign up without having to speak to anyone." It merits considering whether the low self-stigma of seeking help group considers the personal touchpoints in a service pathway to be a positive.

Highly endorsed statements in this factor included:

- *It would be helpful to have a warm relationship with a therapist who cares about you.* (z-score: 1.854)
- *I would appreciate having the expert opinion of a mental health professional who knew me personally.* (z-score: 1.723)
- *I would prefer in-person therapy because I'd feel safer with a time and space specifically dedicated to my mental health.* (z-score: 1.245)

Poorly endorsed statements in this factor included:

- *I don't think a therapist would understand me or my problems. (*z-score: -1.413)
- *I'm skeptical about meeting with a therapist because they might have psychological problems themselves.* (z-score: -1.105)
- *I worry what my community would think if I was seen going into a mental health clinic.* (z-score: -1.235)

HIGH-SSOSH GROUP

All participants who scored above a 31 on the SSOSH scale were considered to fall into the high self-stigma of seeking help groups and a separate factor analysis was completed looking at this cohort independently of the larger group. There was a total of seven participants in this group although not all participants loaded significantly onto the identified factors, with three not loading significantly onto any factor. This group was run through Ken-Q Analysis to see how many factors could be extracted that met Watts and Stenner's (2005) best practices as outlined above.

Two factors were extracted with Eigenvalues of over 1.00 and three factors were found with an explained variance of higher than 10%. Both Factor 1 and Factor 3 (from the unrotated factor matrix) were kept for rotation.

TABLE 4: UNROTATED FACTOR MATRIX FOR HIGH SSOSH GROUP

Unrotated Factor Matrix for High SSOSH Group

Participant	Factor 1	Factor 2	Factor 3
High1	-0.4066	0.5734	0.1563
High2	-0.3738	0.4816	-0.2985
High3	-0.0478	0.0987	0.7419
High4	0.6668	-0.0251	0.4059
High5	0.1556	0.3372	0.414
High6	0.7776	0.3509	-0.2561
High7	0.3188	0.4243	-0.1936
Eigenvalues	1.4826	0.988	1.1032
% Explained Variance	21	14	16

STATISTICAL SUMMARY OF FACTOR 1 FOR THE HIGH SSOSH GROUP

Two participants loaded significantly onto Factor 1. The eigenvalue for the factor was 1.48 and it explained 21% of the total variance. The factor correlation between this factor and the second factor kept for rotation was -0.058, suggesting that the two views are not similar.

VIEWPOINT

I wouldn't necessarily be more comfortable completing an online course than speaking with a professional (1, 0) and the fact that it can be used discreetly on my own time doesn't sway me (2, 0) (6, 0). This is because it's not any easier to share personal details with a computer programme; in fact, it is easier to share things face to face (3, -2). Plus, online programs will lack depth and would feel superficial (9, +1). I also think I would struggle to share my problems in writing (27 -2), although this is not due to the privacy or data concerns with an online programme (25, -3) (26, -3). On the other hand, you could sign up without talking to anyone, which is admittedly a benefit (12, +1).

If I were to use such a programme, it would be fine to use the same computer I use for the rest of my tasks (21, -1) and it wouldn't make me feel lonely (22, -1). I don't think therapy programmes are only for people who are already comfortable dealing with mental health issues (23, -1) but traditional therapy might be more geared to people who are already comfortable talking about their mental health (24, 0).

Regarding one-to-one talk therapy, I don't think having a specific or dedicated place for mental health would much difference (20, 0) nor do I think a professional helping me normalize my experiences would have an impact (28, 0). The expert opinion of a professional doesn't necessarily influence me one way or another (13, 0) and I'm not sure if a therapist would understand my difficulties (15, 0).

But I'm sure I could open-up to a kind professional (4, +3) and I think a warm relationship with a therapist would be helpful (18, +1), especially if they shared some of their own experiences (5, +2). While one-on-one therapy would be better for getting me to talk (7, +3), the focus and attention would make me ill-at-ease (8, +2). This is because I worry about being judged (10, +1) (19, -1) and what people would think if they saw me (11, +1). That said, I'm not worried if the therapist would like me or not (17, -1).

This factor had themes of opening-up and receiving attention, as well as bonding with the therapist as an individual, for example endorsing statements that value therapist self-disclosure and warm therapeutic relationships, but not endorsing statements on normalizing symptoms. This factor also endorsed worries about judgement from the therapist, suggesting that the users in this group very much value the clinical

bond they would have with the service provider. Notably, however, there is a bit of ambivalence around whether either e-therapy or in-person therapy would be better.

Participants who loaded onto this factor were less concerned with issues around privacy, which might be surprising given that they were part of the high SSOSH group.

When offered a chance to reflect on the Q-sort, participants in this group made comments that echoed these themes, such as: "*Writing for me always takes a considerate amount of effort in order to convey emotion. I don't think words can highlight experiences that are so nuanced and personal to me.*" This group also looked down on the idea of a computer programme, both in the Q-sort and in their writing: "*Using a computer program is exactly that, no human touch, no emotion, just words on a screen*."

However, two participants in this group also suggested that non-therapists might be better equipped to offer this support rather than clinicians: "*I do think therapy can help but only with people who know who you are and are intensely familiar with how you think and perceive the world. Unloading problems to a friend who is always there makes me feel more comfortable to discuss issues with. That may be possible in a therapy session but as a side note, I do think a close friend is preferable but a substitute to that would of course be a mental health professional. And being told that what you're experiencing is normal is some of the best things that anyone can say to me,"* and "*I'm very religious, most people can't wrap their head around that, I doubt a therapist would be any better*."

These statements align with the ambivalence towards formalised treatments that came up in this factor and raises questions about whether this factor represents a viewpoint that might prefer the informal mental health support as discussed in the literature review.

Factor 1 High SSOSH group was the only factor to neutrally rank statement 2: "I would feel more comfortable with an online mental health programme, because it can be used discreetly when and wherever is best for me", and the only factor to positively endorse statement 11: "I worry what my community would think if I was seen going into a mental health clinic." That this worry was endorsed from a group that ranks highly in self-stigma of seeking help supports hypotheses around the link between social and self-stigma.

Perhaps also in line with the high scores for self-stigma of seeking help, this group was the only one to not positively endorse statement 13: "I would appreciate having the expert opinion of a mental health professional who knew me personally."

This was also the only group to negatively endorse statement 22: "I would feel isolated and lonely completing a computerised therapy programme," suggesting that for participants who loaded onto this factor, computerised programmes may not trigger self-stigma in the way that going into a clinic might, for example. This does raise questions about the distinction between self-stigma and social stigma.

Participants who loaded onto this factor seemed to be open to e-therapies and relatively uninterested in traditional therapy. They did not appear interested in normalisation, and while they did positively endorse some statements on the therapeutic relationship, they also indicated that they would feel judged.

Highly endorsed statements for this factor included:

- *I think one-to-one therapy with a professional would be better to draw me out of my shell* (z-score: 2.164)
- *I could open up to a sympathetic professional sitting across from me* (z-score: 1.639)
- *A therapist could share some of their own experiences, which would make me feel better about my struggles* (z-score: 1.312)
- *Receiving the undivided focus of a professional would make me feel on the spot* (z-score: 1.312).

Poorly endorsed statements included:

- *I would worry about the data an online mental health programme would collect on me* (z-score: -1.77)
- *It's easier to share personal stuff with a computer programme because you don't have to face someone* (z-score: -1.443)
- *If I used an online mental health programme, I worry that someone could find it on my phone or computer* (z-score: -1.77).

STATISTICAL SUMMARY OF FACTOR 2 FOR THE HIGH SSOSH GROUP

Two participants loaded significantly onto Factor 2. The eigenvalue for the factor was 1.1 and it explained 16% of the total variance.

VIEWPOINT

I would not feel comfortable completing an online therapy course if I were struggling, even if the alternative was sharing my thoughts with a stranger (1, -2). The fact that an online course can be used discreetly is not enough to put me at ease (2, -1) (3, -1) or make it a decent alternative to traditional therapy (6, -1). It's not necessarily that it would feel isolating (22, 0) but that online mental health intervention would feel shallow and superficial (9, +3) and I cannot imagine sharing my problems in writing; I'd rather tell a stranger (27, -3).

The only advantage is that it would be easier to enroll in a mental health treatment if I didn't have to talk to anyone (12, +1) and I have no major privacy concerns (21, 0) (25, 0) (26, 0).

Traditional therapy would not be a setting I could open-up in (7, -2). I don't think I could open-up to a professional (4, -1) and them sharing their own experiences would not make me feel any different (5, 0). The problem isn't necessarily that receiving the undivided focus of a professional would make me feel on the spot (8, -1) or even that I worry what my community would think if they saw me going to the mental health center (11, -3).

I feel divided about the value of a warm therapeutic relationship (18, 0). On one hand, I would appreciate the expert opinion of a professional (13, +2), but I also struggle to imagine how they would understand someone like me (14, +1) and I worry they wouldn't like me (17, +1) or that they would have problems themselves (16, +1). On top of all that, I wouldn't know how to act or what to expect in a session (14, +2), although I can see the value of having a dedicated time and space for the work (20, +1).

The one major value I can see is that it would make me feel better if someone with expertise let me know my experiences were normal (28, +3).

This group had themes of normalization, valuing in-person connection, as well as themes of uncertainty and scepticism. Some of the individual responses in this group captured some levels of scepticism and perhaps anger towards mental health professionals: "*I don't care what the therapists thinks of me, they are there to do a job. Just like how I don't care what a waiter thinks of me. Undivided focus of a professional is required to examine what is wrong*."

Highly endorsed statements included:

- *I would feel better if a professional let me know my experiences were normal* (z-score: 2.267)

- *An online mental health intervention would lack the depth of in-person communication and feel superficial* (z-score: 1.765)
- *I wouldn't know what to expect or do in a therapy session* (z-score: 1.09).

Poorly endorsed statements included:

- *I think one-to-one therapy with a professional would be better to draw me out of my shell* (z-score: -1.507)
- *I worry what my community would think if I was seen going into a mental health clinic* (z-score: -1.511)
- *I would be more likely to share my problems if I could do it in writing instead of face-to-face* (z-score: -2.267).

4.0 DISCUSSION CHAPTER

This chapter will review the findings of the research in the context of the Literature Review and with an eye towards any implications for practice. As previously outline, the guiding question as shown to participants was: "*Which of these statements best describe factors that would influence your choice if you were asked to decide between a computer-based therapy program versus traditional face-to-face therapy?"*

4.1 SUMMARY OF RESULTS

During this research, twenty q-sorts were collected from male participants in the UK between the ages of 18 and 26. This data was sliced and analysed two ways. In the first condition, the seven participants who scored above a 30 on the SSOSH scale were grouped, as well as the five participants who scored 20 or below on the SSOSH scale.

Two factors were extracted from the High SSOSH group, and one factor was extracted from the low SSOSH group. The group was then analysed as a whole, and two factors were extracted from the complete group. The following section will expand up on these factors and discuss possible implications of what was found.

It cannot go unnoticed that this study did identify more users who ranked high on self-stigma of seeking help relative to users who ranked low. This is consistent with previous findings that users who identify as men are likely to struggle in this area.

4.2 DEVELOPING THE Q-SET

The q-set was developed through analysing research examining men's relationship with therapy and users' relationships with e-therapies. Both qualitative data (interviews and focus groups) and quantitative data (from surveys) were considered and over two hundred statements pulled considered from 74 articles for review. The idea was that potential service users could be 'invited' into a dialogue happening within the research by including ideas that were being raised in academic papers. Language was simplified and personalised in order to make the q-set more readable and also in order to control for the different language used in the academic papers.

FIGURE 3: SECTION OF CONCOURSE DEVELOPMENT

Source	Quote	Coding	Concourse Draft
Osma et al., 2019 — No. 2	The patients in our study offered the following arguments in favor of individual therapy: the ease of expression, intimacy/privacy, and personalized attention.	theraputic relationship positives of in-person th... qualitative barriers to online therapy	Completing therapy with a professional therapist helps you express yourself and you can get personalized attention.
Roesler, C., 2017 — No. 1	Information technology leads to a general loss of depth, quality and essence in thinking and feeling of individuals; digital media in general produce superficiality.	barriers to online therapy skepticism	I feel that online communication lacks the depth of in-person communication; digital programs can feel superficial and distant.
Schroder et al., 2017 — No. 1	The discrepant attitudes towards Internet interventions in individuals with depression symptoms versus psychotherapists in the present study could be explained, in part, by a central feature of most Internet interventions, less fear of stigmatization due to anonymity (represented by APOI-ABE), which many psychotherapists appraise rather negatively (i.e., lack of personal contact) but depressed individuals tend to appraise rather positively.	stigma Barriers to in-person the... positives of online therapy	Someone with depression will feel more comfortable completing an online therapy course than sharing their feelings with a stranger.

Statements were coded for themes in order to ensure that a variety of topics were covered. Sixteen themes were explicitly identified, including things such as: scepticism of therapy, stigma, therapeutic relationship, privacy concerns. Several themes were then deliberately excluded: these included themes around pragmatic barriers such as finances, waitlist lengths or travel times. While these are real systemic

barriers that are more likely to disproportionately impact vulnerable groups, practical limitations such as survey length meant that some factors had to be left out.

4.3 DISCUSSION OF FACTORS IN RELATION TO THE RESEARCH QUESTION

A number of themes came out in the course of the factor analysis, as well as some statements that were especially likely to be highly or negatively endorsed.

For example, the only factor that emerged from the group that scored low on Vogel's Self-Stigma of Seeking Help scale, negatively endorsed statement 12: "I would find it easier to enrol in an online health intervention than a traditional one, since I could sign up without having to speak to anyone." In contrast, both of the groups which emerged from the high-scoring group positively endorsed that statement, suggesting that they both value the ability to engage in a service pathway without having to speak to administrators.

Statement 3: "It's easier to share personal stuff with a computer programme because you don't have to face someone," was negatively endorsed across the board, with the exception of Factor 2 from the Complete Group, which neither positively nor negatively endorsed it.

This statement was extracted from a 2016 qualitative paper, which used thematic analysis to analyse interviews with 63 youth who completed a variety of therapy programmes. One of these was an online-based programme which allowed texting, and a theme that emerged in some interviews was a preference for being able to type out issues rather than having to speak directly to an individual. This seemed like a way for users to engage in a treatment option while minimising experiential avoidance, which is in large part why it was included in the study.

Nearly all the groups (apart from Factor 1 High SSOSH, which ranked it neutral) positively endorsed statement 13: "I would appreciate having the expert opinion of a mental health professional who knew me personally." This was true even if the group otherwise positively rated worries such as "If I saw a therapist, I worry they wouldn't like me" (statement 17) or "I'm skeptical about meeting with a therapist, because they might have psychological problems themselves" (statement 16). This positive or neutral ranking across the board is unusual relative to the other statements. There is no especial reason to believe that self-stigma and valuing expertise would necessarily be linked. This statement has themes of

valuing expertise and learning, as well as valuing being 'seen' and understood, since it clearly indicts a personal relationship.

Both of the factors extracted from the High SSOSH group positively endorsed statement 12: "I would find it easier to enrol in an online health intervention than a traditional one, since I could sign up without having to speak to anyone." This clearly underscores concerns raised in the literature review that service gatekeepers are a deterrent to users who rank high in self-stigma.

No factors positively endorsed the data security and online-privacy related statements. These were statement 25 "I would worry about the data an online mental health programme would collect on me" and statement 25 "If used an online mental health programme, I worry that someone could find it on my phone or computer." At least for this cohort, data privacy is not a major concern for users when considering e-therapies.

FACTOR 1 FOR THE COMPLETE GROUP

RECAP

Highly endorsed statements included:

- *I could open up to a sympathetic professional sitting across from me* (z-score: 2.26)
- *I think one-to-one therapy with a professional would be better to draw me out of my shell* (z-score: 2.15)
- *An online mental health intervention would lack the depth of in-person communication and feel superficial* (z-score: 1.67)

Poorly endorsed statements included:

- *If I were struggling, I would be more comfortable completing an online therapy course than sharing my feelings with a stranger* (z-score: -1.274)

- *It's easier to share personal stuff with a computer because you don't have to face someone* (z-score: -1.685)
- *I would be more likely to share my problems if I could do it in writing instead of face-to-face* (z-score: -1.72).

DISCUSSION

Two of the themes that additionally emerged from the open-ended questions about what might be absent from the q-set focused on practical barriers: "*I would have like to seen a mention of how difficult getting actual one on one therapy is*" and "*Therapy doesn't help for people with actual problems, the majority of therapy is trash like CBT that only attempts to change thought patterns rather than addressing the actual problems. A one fit all size solution that is designed to get as many patients through as quickly as possible."*

The idea of a 'one-size-fits-all' solution is a common critique of e-therapies, and of highly operationalised therapies such as CBT. There is room for debate in this area, however. While clients may not like the feeling of being 'fobbed off', as some users complained when they were given cCBT instead of talk therapy (Perera-Delcourt, R. & Sharkey, G., 2018), and while therapists tend to rate the therapeutic alliance as an important agent for change, research consistently suggests that it a less important factor in change than both parties might believe (Waller & Turner, 2016). Indeed, this explains why e-therapy programmes often perform comparably to traditional talk therapy when attrition is controlled for. It is important to question whether the client *liking* or *enjoying* the treatment and the alliance is necessary or even helpful in order for the treatment to be effective.

It is worth considering whether the therapeutic alliance might function similarly to the 'gatekeepers' and 'informal resources' discussed previously in the literature review and discussion, wherein the social connection can have a bolstering impact on motivation, or a dampening effect on willingness to engage, but is unlikely to be neutral. Rather, the therapeutic alliance is perhaps most important as a source of motivation and accountability, while the change itself comes from the client's own engagement and practice. Research on therapist effectiveness has also proposed questioning a correlation versus causation question when it comes to examining therapeutic alliance, as multiple studies have shown that early symptom change can drive improvements in the therapeutic alliance (Waller & Turner, 2016).

The other statement clearly indicates a level of distrust with the motives of services ("*designed to get as many patients through as quickly as possible")* and raises a valuable ethical critique of talk therapy as focusing on "*thought patterns rather than real problems"*, which is designed to challenge individual thinking patterns and emotional processing rather than practical change. Many of the papers examining masculinity have identified that men often value practical problem-solving and tangible results (Wasylkiw & Clairo, 2016). Service providers are also increasingly speaking out about the need for social change and looking at mental health issues through a politically contextualised lens, so as not to pathologize normal emotional distress in response to real-world problems (Ahsan, 2022). In their eagerness to help, therapists should be cautious about not invaliding people's real-world experiences or suggesting that it is possible fix emotional distress that if it is a normal response to difficult circumstances. These critiques challenge the medicalisation of mental illness, pointing out that a culture of medicalization may lead to clients as perceiving their emotional distress as an internal or unavoidable problem and may shift the language away from collective responsibility towards personal responsibility. This is especially interesting when considering that a number of studies have identified the masculine ideals around personal responsibly to lead to isolation and be detrimental to help seeking (Seidler et al, 2020). It is therefore worth considering if men have been disproportionally impacted by the medical language surrounding mental health care. Given that men are less likely than women to seek treatment for physiological aliments as well (even if the gap is not as large) it suggests that individual struggles are conceptualised by men as something they should first deal with independently.

The theme of distrust of services is also an important one to consider. There is reason to believe that some men may decline or turn away from treatment because of concerns about the honesty of clinicians or fears of being labelled and having that label used against them (Moritz et al, 2013).

FACTOR 2 FOR THE COMPLETE GROUP

RECAP

Highly endorsed statements included:

- *Receiving the undivided focus of a professional would make me feel on the spot* (z-score: 1.68)
- *I think one-to-one therapy with a professional would be better to draw me out of my shell (*z-score: 1.45)

- *I would feel better if a professional let me know my experiences were normal* (z-score: 1.45)

Poorly endorsed statements included:

- *I don't think a therapist would understand me or my problems* (z-score: -2.224)
- *A personal therapist would judge me* (z-score: -1.485)
- *If I saw a therapist, I worry they wouldn't like me* (z-score: -1.48)

DISCUSSION

This group indicated that it would be advantageous to be able to complete an online programme on their own time schedule; this may relate to themes of self-control and independence that have come up in previous research on men and their relationship to mental health support. Flexiblity is also a perk that is likely to appeal to marginalized groups such as X And Y.

This raises the question of how to navigate a possible client's desire for supportive connection when they don't know how to reach out and ask for it.

It's not necessarily easier to share stuff with a computer programme (3, 0), in fact I think I could talk more readily to a person sitting across from me (4, +1) (27, +1). Especially as I am sure they would like me fine (17, -3) and wouldn't be judgmental (19, -1). I'm sure a professional would understand me and my problems (15, -3) so I would value their expert opinion (13, +1). I don't need a therapist to share anything personal about themselves with me (5, 0) but a warm relationship would be helpful (18, +1) and I would really value if they normalised my experiences (28, +3).

My one concern is that I wouldn't know what to do or expect from the therapy session (14, +2) but I think that traditional one-to-one therapy is better for those are new to talking about their mental health (24, -2).

I'm relatively indifferent to the increased privacy of online mental health programmes (9, 0) (26, 0), the fear of isolation (22,0) or ease of enrolment (12, 0), but I actually worry about the discomfort of

completing a mental health programme on the same computer/mobile that I use for social and work (21, -1). The one advantage I can see is that I would find it easier to write out my problems then say them out loud to another person (27,+1).

Factor 2 for the Complete Group had themes of ambivalence, which is consistent with assumptions that might be made for mid-SSOSH group. While themes around normalization and valuing the therapeutic relationship were highly endorsed, so too were themes around nervousness and feeling unsure what to do in a therapeutic setting.

This ambivalence is echoed in some of the writings that participants put in response to the follow-up questions: "*I have anxiety and paranoia about weather people like me, and seeing a therapist on a regular basis and having them get to know me would make this worry worse. I don't feel like i could explain myself or that it would feel real if the therapy was done online, and being in a safe space and in a space dedicated to mental health would make me feel less out of place.*"

FACTOR 1 LOW SSOSH GROUP

RECAP

Factor 1 from the low SSOSH group is outlined in its entirety in the results section. Below is a brief overview of the prominent features of this factor, as well as a more thorough discussion of how the themes relate back to the topic of this paper.

Highly endorsed statements in this factor included:

- *It would be helpful to have a warm relationship with a therapist who cares about you.* (z-score: 1.854)
- *I would appreciate having the expert opinion of a mental health professional who knew me personally.* (z-score: 1.723)

- *I would prefer in-person therapy because I'd feel safer with a time and space specifically dedicated to my mental health.* (z-score: 1.245)

Poorly endorsed statements in this factor included:

- *I don't think a therapist would understand me or my problems. (*z-score: -1.413)
- *I'm skeptical about meeting with a therapist because they might have psychological problems themselves.* (z-score: -1.105)
- *I worry what my community would think if I was seen going into a mental health clinic.* (z-score: -1.235)

DISCUSSION

One of the participants who loaded on this factor left a highly critical suggestion in response to a question about missing element from the q-set. They suggested that men don't go to therapy due to the treatment they receive and that women are typically the service providers and don't listen to the male experience. The purpose of post-sort interviews or questionnaires in a Q study is typically to elucidate greater detail about why subject participants placed statements in a particular order, to better understand what the subject make of the question and the statements, and to understand if the subjects felt it was possible to capture their viewpoint through the provided q-set. While these interviews are often conducted in-person, this entire q-sort was completed online, both due to practical concerns regarding the then-active COVID-19 lockdown and because the study was specifically targeting young men who are unlikely to be recruited through more traditional means.

> *"This research seems to be incorrectly predicated on the fact that EVERY male doesn't want to seek mental health support. This is seemingly because of the opinions of women informing you about the male experience. I think you should listen to what men have to say and not TELL them they are embarrassed to go to mental health support. Most men don't go because OF THE TREATMENT THEY GET. Do you know how horrible it is to go into mental health support (a profession dominated by women) and be talked to like crap about your experiences because it's a woman on the other side???"*

This critical statement brings up lots of questions and highlights how it can be incredibly valuable to be in the room with participants. On the other hand, this researcher questions whether such frank and possibly confrontational language would have been used if the respondent was sitting face to face with a female researcher, where they may have felt social pressures to be accommodating or polite. This quote heavily indicates themes of therapy as not able to meet men's needs, perhaps with the suggestion that therapy is more for women (both the women receiving and the women performing) conceptualizing the issue not as men having a reluctance to seek help but rather that the 'product' available is not designed for men or their needs.

Much ink has been spilled over discussions and debates about how psychologies "founding fathers" and most famous clinical practitioners are predominantly men – however comparatively less attention has been paid to the fact that most of the famous initial clients have been women.

Study by Seidler (et al., 2021) identified three themes, notably including the theme of men as "being ill-equipped for therapy", for example one female therapist describing men as:
"not psychologically minded".

Of the therapists who participated in the study, over 70% were female.

One clear theme from this statement is the disparities in gender within mental health professionals (Brown, 2017). D It is difficult to consider this discrepancy without also raising further questions: does the gender of the mental health professional impact how treatment is delivered? Does the gender of the mental health professional impact how the treatment is perceived? Does the gender of mental health providers impact how self-stigma might be triggered during the therapeutic process? Does the gender of mental health professionals' impact who seeks treatment and how users engage with treatment?

Over the last few decades there has been increased awareness of a growing gender discrepancy in practicing mental health professionals, with women significantly outnumbering men in clinical psychology (Fowler et al., 2018), counselling psychology and counselling (Johnson et al., 2020; Brown, 2017).

Unfortunately, there is relatively little empirical data on men's preferences for therapist gender although an online survey of Australian men found that the majority had no preference and preferences for male versus female therapists were roughly equal. Crucially, however, non-heterosexual and more masculine-identifying men were more likely to prefer a male therapist (Seidler et al., 2022). The study also asked questions to ascertain information about the reason for the preference, and used a validated scale called

the Traditional Masculinity Femininity Scale (TMF) to assess how much participants identified with masculinity. This theme was further explored by asking participants to rate the extent to which attending therapy felt like a violation of masculine norms. Crucially, amongst men with a preference for therapist gender, satisfaction with therapy was higher when the clients were able to see a therapist who matched their preference. Men also reported less feelings of emasculation from attending therapy when they were able to see a therapist who matched their gender preference.

A major issue along these lines is described by Seider (et al., 2022) – page 175

> "One potential implication of men's gender preference match involves the degree to which a man feels that attending therapy violates masculine norms (i.e. feeling emasculated); as is commonly reported in research examining men's experiences in therapy (Rabinowitz & Cochran, 2008; Rice, Telford, Richwood, & Parker, 2018; Seidler, Rice, Oliffe, Fogarty & Dhillon, 2018). A man being treated by a therapist who does not match his preferred gender may only serve to reinforce feelings of discomfort and a common sentiment "this isn't for me," which could act as an ongoing barrier to treatment satisfaction and engagement (Seidler, 2018b)."

While gender preference may not be something expressed by most men, several studies have found that a significant minority report preferring a male clinician. We should remain aware of the possibility that this group may be reflecting a sense of wanting belonging amongst other men or men who are already sceptical about their ability to "fit in" to therapy.

> "Given the female-dominated nature of many therapy professions, the preference among more masculine-identifying men for male therapists could reflect attempts to masculinize the therapy environment by preferring to engage with a male, thereby also reducing any sense that they 'don't belong' there." (Seidler et al., 2022, pg. 184)

It appears that many studies which examine preferences for therapist gender have looked at relatively small sample sizes from non-clinical college populations (Seidler et al., 2022). In fact, these studies have largely been done on what is often 'playfully' described as WEIRD populations; that is: Western, Educated, Industrialised, Rich, Democratic, with a serious over-representation of university-educated students as opposed to those of working-class background. There is a wealth of accumulated evidence to

suggest that these populations are not as representative as researchers hope and, in fact, researchers often over-estimate how representative these populations are of the general (Pitesa & Gelfand, 2022).

The study's authors suggest that their finding show evidence that one of the mechanisms underpinning male therapist preference is the extent to which attending therapy evokes feelings of emasculation.

The suggestion of therapists not understanding also raises questions about how engagement with services might be impacted if a treatment provider is unhelpful or evokes negative feelings. This theme will be explored further in the next factor.

The open-ended questions also elicited themes around a preference for informal therapy (Whitley, 2021), something that will be discussed further at a later section of this review.

FACTOR 1 HIGH SSOSH GROUP

RECAP

Here we will include a brief review of the first factor extracted from the High SSOSH group, followed by a more thorough discussion of unique themes elicited from the factor.

Highly endorsed statements for this factor included:

- *I think one-to-one therapy with a professional would be better to draw me out of my shell* (z-score: 2.164)
- *I could open up to a sympathetic professional sitting across from me* (z-score: 1.639)
- *A therapist could share some of their own experiences, which would make me feel better about my struggles* (z-score: 1.312)
- *Receiving the undivided focus of a professional would make me feel on the spot* (z-score: 1.312).

Poorly endorsed statements included:

- *I would worry about the data an online mental health programme would collect on me* (z-score: -1.77)

- *It's easier to share personal stuff with a computer programme because you don't have to face someone* (z-score: -1.443)
- *If I used an online mental health programme, I worry that someone could find it on my phone or computer* (z-score: -1.77).

DISCUSSION

Several of these highly endorsed statements suggest that these participants place a lot of value on the uniqueness and intimacy of the therapeutic relationship. However, there is also a statement indicating the feeling of being 'on the spot'. This merits further reflection. Being 'on the spot' tends to indicate feelings of being scrutinized or judged. On the other hand, it also implies that the client is being witnessed by the therapist. Participants who loaded onto this factor seem to be very aware of the 'human' elements of mental health services, both the positives of a warm relationship and the negatives of rejection. Notably, this group also ranked the lack of gatekeeping for e-therapies as a significant draw. The emphasis on positives and negatives of human interaction during the service use links back to findings on service gatekeeping, wherein positive interactions can bolster motivation while negative interactions can turn off users (Staiger et al., 2020).

A 2022 meta-analysis examining how young people interacted with informal sources of help while accessing and engaging with mental health services, using thematic analysis to review 32 studies (Lynch, Moorhead, Long & Hawethorne-Steele, 2022) identified two key themes: informal helpers as supportive intermediaries and informal helpers as obstructive forces. This further echoes the gatekeeping dichotomy in Staiger's (2020) work: interpersonal engagement along the route to treatment appears to either be a positive or negative force for help-seeking, never a neutral. When informal sources of help functioned in a supportive capacity, they often served to help users overcome practical barriers, as well as helping to reassure users of their place within the community despite needing additional support. Interestingly, one of the agents of obstruction from informal support identified was lack of help with practical barriers, suggesting that if services are able to help bridge some of these practical barriers, perhaps through flexibly by administering online treatment, that one avenue of obstruction could be lessened (Lynch et al, 2022). The value of informal helpers as a support toward change may also be considered a possible factor in the gender gap, as there is considerable sociological evidence to suggest that men have smaller social networks then women, and their social contacts are often weaker (Scourfield & Evans, 2015).

The importance of interpersonal interaction along the service pathway is an important reminder that even highly operationalised forms of mental health care, such as CBT, will nonetheless rely on competent and emotionally responsive administrators (Hofmann & Reinecke, 2010).

The comments from Factor 1 Low SSOSH group indicate criticisms about female therapists not listening to the male perspective and not being able to validate or respond to their male clients. Similarly, Factor 1 High SSOSH group indicates themes 'being judged or on the spot'. This raises questions about the client-therapist relationship and how that impact or interplay with gender and self-stigma. Will bad interactions with a therapist turn a possibly tentative help-seeker away from pursuing further treatment? What is the cost of a rupture in the therapeutic relationship? There seems to be a rich body of discussion on what and how therapists can approach disliking their client. But what of clients who dislike or feel unheard by their therapist?

Another takeaway that seemed to emerge from this factor was a sense of ambivalence about therapy. Motivation for treatment has been consistently found to be an important predictor of responsiveness to therapy (Leton-Bryme et al, 20XX). For the purposes this research, it is worth considering whether and how self-stigma might function as a moderating factor toward ambivalence. Research on therapist perspectives has shown that there is a belief that men are more likely to be 'reluctant starters' or bring resistance into the therapy room (Seider et al, 2021). This would often manifest through service users that were only present due to spousal pressures, frequent cancellations, apparent disinterest. It can be difficult here to address where the responsibility from the service provider begins and ends, as of course services have limited capacity to support highly resistant users.

Notably, themes of self-stigma have been identified as a possible factor in this resistance by service providers, who have indicated that the work in terms of overcoming internalised feelings of stigma becoming a significant portion of the work (Seider et al, 2021).

It is worth noting that research does suggest that male uptake of services is increasing and that men are able to avail themselves to treatment. However, it remains unclear what are the specific factors that improve these outcomes (Seidler et al, 2018).

Some findings are suggesting that men have difficulty with specific elements of treatment, such as engaging in a trusting therapeutic relationship. The question of whether therapy is *"for"* men, so to speak, has been raised on several occasions. In fact, as previously outlined, while most high-profile examples of famous pioneering psychologists are largely men, the famous early clientele are almost exclusively

women (Anna O, Sybil, etc.). In addition, therapy is largely seen as a practice for the educated classes or even an indulgence.

In terms of the gender gap with regards to mental health care, a variety of explanations have been offered, including ones critiquing traditional 'values' of masculinity (e.g.: strength, individualism). But a loud chorus has suggested that these forms of conversation shift the power and responsibility away from the clinicians and onto the would-be clients, pointing out that the issues might be better seen as inadequate clinical training in gender socialisation or clinicians' own biases on gender, as well as structural barriers or unappealing service offerings (Seidler et al, 2018).

FACTOR 2 THE HIGH SSOSH GROUP

RECAP

Here we will include a brief recap of the second factor extracted from the High SSOSH group. Highly endorsed statements included:

- *I would feel better if a professional let me know my experiences were normal* (z-score: 2.267)
- *An online mental health intervention would lack the depth of in-person communication and feel superficial* (z-score: 1.765)
- *I wouldn't know what to expect or do in a therapy session* (z-score: 1.09).

Poorly endorsed statements included:

- *I think one-to-one therapy with a professional would be better to draw me out of my shell* (z-score: -1.507)
- *I worry what my community would think if I was seen going into a mental health clinic* (z-score: -1.511)
- *I would be more likely to share my problems if I could do it in writing instead of face-to-face* (z-score: -2.267).

DISCUSSION

This group had themes of valuing in-person work, and valuing the normalizing that could be provided within a traditional therapeutic environment. Normalizing difficulties does seem to be a valuable route to addressing stigma, both at an individual level and a broader level, with research suggesting that disclosure and normalization can help individuals to re-evaluate their self-appraisals upon experiencing mental health difficulties (French, Hutton, Barrett, Parker, Byrne, Shryane & Morrison, 2011).

There have been some treatment programs that have aimed to proactively reduce self-stigma, all of which have had productive results using psychoeducation, of which normalizing is an important aspect (Yanos, Lucksted, Drapalski, Roe & Lysaker, 2015). Many of the successful programmes addressing self-stigma are unique in their approaches, for example tailored toward youth or tailored toward gay men, suggesting that the most valuable approaches will involve some degree of tailoring (Yanos et al, 2015). Normalizing suffering and difficulty is also a facet of self-compassion-based approaches, which have been found to have a moderating impact on self-stigma and help users to take action despite internalised stigma (Vogel et al, 2017).

On the other hand, themes of skepticism and uncertainty emerged, including the idea of not knowing 'what to do' in therapy. And the fact that one of the more poorly endorsed statements was: "I think one-to-one therapy with a professional would be better to draw me out of my shell" suggests quite a bit of uncertainty about whether traditional talk therapy would be helpful. It appears participants who loaded onto this factor may be apprehensive about mental health support in general, although the nature of the q-sort forced them to align themselves with some preferences in terms of e-therapy versus in-person. In addition to the disagreement that one-to-one therapy might allow space for clients to open up, this factor was also the only one that positively endorsed the statement: "I'm skeptical about meeting a therapist, because they might have psychological problems themselves." This statement was drawn from a quantitative survey that examined attitudes of individuals suffering from depression who chose not to seek treatment. Of this the 210 participants recruited, 20% endorsed concerns that the therapists might have psychological difficulties themselves as a decision-point in not seeking treatment (Moritz et al, 2013). These concerns may stem from stereotypes that students pursue psychology to 'find out what's wrong with them'. That questions about the service provider's own mental health is a limiting factor for users further emphasizes the weight of stigma and negative stereotypes in driving users away from treatment. However, these fears may also not be entirely unfounded, as therapist anxiety has been found to be a factor in 'therapist drift', a phenomenon in which clinicians move away from evidence-based

practice (Waller & Turner, 2016), especially in limiting therapist's willingness to engage in 'tougher' or more challenging methods, such as exposure therapy.

In response to the open-ended question about whether anything was missing from the q-sort, one user drew a comparison between a therapist and a waiter, suggesting that it is not their responsibility to develop a therapeutic relationship, but rather the role of the service provider to meet the needs of the client. This raises questions about what the role is of the therapist in terms of helping clients to overcome discomfort within the therapy room.

The idea of uncertainty about how to engage in therapy underscores issues identified by Seidler (2022) identifying male service users as being less equipped for therapy than their female counterparts. However, it remains unclear if women experience therapy as less anxiety-provoking then men. Concerns about therapy as a source of anxiety also harkens back to theories about experiential avoidance and how that impacts men's engagement with mental health care.

4.4 IMPLICATIONS FOR PRACTICE

There are no clear or obvious answers that emerge from the body of research or from this specific paper. Nonetheless, there are areas of consideration.

Firstly, this research underscores that it does not serve therapists to be "gender-blind" in their practice. It is important to hold in mind the context of ever-shifting ideas about sex and gender and how these traits, once considered to be fixed, are now understood to be more fluid, both biologically and culturally informed and, in a sense, unique to each individual; gender being simultaneously a broad cultural phenomenon and a deeply personal one. There is no denying the gender gap that reveals itself. It is increasingly recognized that service providers cannot take for granted an understanding of their client's identities, and that it is counter-productive and invalidating to not proactively examine biases around others identities (Sue, 2004), and while admittedly the buik of these discussions often hone in on ethnicity and sexuality, gender identity is intrinsically linked with these.

Happily, there has been an increase in awareness around self-stigma, as well as an increase in treatment approaches meant to address and ameliorate its impact on therapy (Yanos et al, 2015). The impact that self-stigma has on help-seeking and engagement suggests that training and understanding on this topic is

necessary for service providers, especially in order to understand how their initial contacts with possible service users can be either a positive and supportive experience or an obstacle. While this research did not look specifically at discourse around self-stigma and gender in the therapy room, there is an argument to be made that service providers should not be afraid to ask questions or prompt thoughts about self-stigma, doubts and scepticism over treatment, and how gender norms might impact the way service users engage.

Research suggests that proactively addressing self-stigma during treatment is possible (Yanos et al, 2015) and necessary (Seigel et al, 2022), as it will otherwise be a serious barrier to engagement. Some of the factors identified underscore the idea that therapeutic relationships, normalizing and psychoeducation can be valuable tools for helping service providers address this barrier. Additionally, the literature suggests that self-compassion may be an avenue (Vogel et al, 2017). Another way of engaging with gender and self-stigma may be to look at the service pathways and consider whether steps can be adjusted in order to accommodate for users who might struggle more with experiential avoidance. For example, not requiring diagnostic interviews unless absolutely necessary, or reducing medicalised language. In particular, there is the question of whether medicalised language around mental health centres social and circumstantial problems as happening 'within' the service user, thereby inadvertently reinforcing ideas that these problems should be addressed individually.

It is also increasingly clear that social stigma and internalised stigma are linked, so efforts to address self-stigma need also continually push back against social stigma. A number of researchers have therefore advocated continued formal education on help-seeking and when it is useful to seek help (Lynch et al, 2018).

Overwhelmingly, these results as well as the literature review underscore how engaged therapists need to be with their practice. There is a body of evidence on 'therapist drift' which documents the not-uncommon phenomenon of well-meaning clinicians moving away from evidence-based treatment in their practices. While several factors contribute to this, a significant one appears to be therapists own self-biases, which shows that most therapists rate themselves highly above average in their practice. Therapists also tend to overestimate or overvalue the impact of the therapeutic alliance as a factor of change, relative to how important research suggests this is (Waller & Turner, 2016). There are a few possible reasons for this. Perhaps embarrassingly, it has been suggested that this might reflect some passivity on the part of service providers, as the social bond doesn't necessarily require study or upkeep in the way that an emotional connection does (Waller & Turner, 2016). But in addition, we can wonder

whether clients are likely to be frank about cracks in the therapeutic alliance, especially as there is relatively little immediate benefit to them for doing so, which means that therapists may overestimate how high quality their alliances are.

Another area of applicability could be the incorporation of e-therapies into practice. While they were not explicitly addressed in this research, long wait times remain a significant issue for service users, especially in the public sector. The difficulty in finding a therapist was raised as an issue by a participant who loaded significantly on to Factor 1 for the Complete Group. Given the myriad of structural and internalised barriers that can interfere with help-seeking, it seems pertinent that services aim to encourage and bolster those who reach out for support, even if they are not able to be seen immediately. With new technologies, there is a question of whether e-therapies or similar computerised tools could help ease the time on the waitlist and allow users to remain engaged. In fact, should this have a positive impact on their symptoms, it may help with the therapeutic alliance and build motivation and engagement prior to starting therapy.

4.5 LIMITATIONS AND REFLECTIONS

There are several significant limitations on this work, as well as aspects that could have been navigated differently. Primarily, it needs to be stressed that q-methodology is a qualitative approach, that invariably will reflect some of the researcher's own biases and ideas. The extracted factors cannot be generalised to a population, nor can we consider them faithful representations of any individual viewpoint. Rather, they represent different ways of configuring existing viewpoints, in a way that allows us to explore different angles on a subject.

During the research process, numerous decision points were grappled with. One of the primary decisions with the length and breadth of the q-set. On one hand, the set had to be completed online and participants had no external incentives for their completion, meaning that attrition would likely be higher with a lengthy questionnaire. A brief pilot study was conducted, and subjects acknowledged that completing the q-set was an involved process that involved cognitive load. Because participants were completing the q-set electronically and remotely, there was no way for the researcher to ensure that users were considering the statements in front of them and not rushing through to get to the end, a known problem often labelled 'survey fatigue' that is especially likely with online research where users are unobserved. Additionally, the population group this research was interested in was young men who

had never previously sought mental health support/intervention, which may be a cohort that is less motivated to participate in psychological research.

Therefore, the decision was ultimately made to keep the q-set relatively small, with only twenty-eight items. This was a compromise as it meant that certain elements, such as a therapist demographic, type of e-therapy, modality and waitlist barriers were not included in the q-set.

Traditionally, q-methodology would be undertaken with the researchers in the same room as the participants. The process of watching participants sort through and think through their q-sort can be illuminating and bring out ideas that researchers may have previously not considered (Watts & Stenner, 2005). While in-person completion would have no doubt been a wonderful opportunity, this was decided against to better attract a less engaged population. In addition, the COVID-19 lockdown was in place during portions of the data gathering, meaning that this compromise may have been forced if it was not decided upon. However, for further research, much could be gleaned by listening to participants think through their q-sort in real time, especially if there was confusion over the statements or different ways of interpreting that may not seem obvious.

There were also instances which suggested that participants may have had more complex views on therapy. For example, the users that loaded onto Factor 2 from the High SSOSH group seemed to be sceptical of therapy in general. However, the nature of the q-sort forced them to rank preferences. Another issue that could be approached better in the future was definitions and labelling. Unfortunately, 'talk therapy', 'individual therapy', 'one-to-one' or 'face-to-face' therapy all invoke slightly different ideas for different participants. Similarly, there is a plethora of language used to describe e-therapies, including cCBT, computerised mental health, self-guided computer-based therapy, and so and so forth. In retrospect, this research was not always specific enough about language there and the participants could have received more thorough definitions and introductions to these concepts.

4.7 AREAS FOR FURTHER RESEARCH

One aspect that is left out of this research but that deserves significant further scrutiny is the demographics of service providers and how their gender might reinforce ideas about who therapy "is for".

This research did not explore the distinction between different types of e-therapy. There is increasingly a broad swath of offerings, with new programmes being introduced at a pace that often out clips research.

A more abstract concept that could be further explored is how e-therapies blur the line between formal/professional and informal modes of mental health treatment. While some e-therapies, such as Silvercloud, are often administered via the NHS and are explicitly substitutes or complements to traditional talk therapy, other programmes, such as mindfulness apps like Calm, use therapeutic elements but are not explicitly treatment-driven. There is perhaps scope for further development of these therapy-adjacent programmes, which could harness the self-improvement and independence themes that surface in the research. Given that previous research has noted that self-compassion can have a dampening effect on self-stigma (Vogel, 2017), these programmes could function as 'softer' entry points to the mental health system by helping users to adjust to the idea that seeking help is not a failing.

It would also be interesting to see more qualitative data on structured e-therapies programmes that include some therapist touchpoints. So far, e-therapies and traditional therapies appear to remain relatively siloed from one another, especially outside of government or research-based programmes, where there is often a financial incentive to move through waitlists efficiently. It would be interesting to see if and how private therapists have incorporated e-therapy into their practice, especially if they have done so in a more tailored manner. Additionally, there could be scope for e-therapies and similar therapy-adjacent programmes to act as a stopgap after therapy ends or during breaks.

Factor 1 for the High SSOSH group had results which suggested that actually social stigma was a bigger consideration than self-stigma. This raises questions about whether further research is needed to separate out these very highly interwoven traits, especially as it remains unclear whether computerised therapies are able to effectively ameliorate self-stigma.

Gatekeeping of service pathways and human touch points along this route were major themes in this research, both in the literature review and in the endorsed statements from the q-set. It is clear that a more robust understanding how service pathways alternatively support or discourage help seekers would be beneficial, especially when considering access points for users who may be high in self-stigma.

5.0 CONCLUSION

Crucially, psychological treatments have been shown to be equally effective across genders (Cochran, 2005) despite the gender gap that exists in accessing services. Also importantly, research suggests that men are increasingly engaging with services, even if the gap remains.

In her renowned book, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors and the Collision of Two Cultures* (1997), reporter Anne Fadiman intimately details how well-meaning informal carers and well-meaning formal/professional carers failed to effectively communicate, ultimately resulting in a tragic incident. Fadiman does not offer a pat 'lesson' from her writing, but I suggest that one can be taken: that the training, intention and expertise of service providers is only as valuable as their ability to effectively find and communicate to users.

It is incumbent upon counselling psychology to consider new technologies and how these might help us reach a broader population. There is clearly significant scope for e-therapies to be harnessed and developed in a way that allows them to reach young men and men for whom self-stigma is a significant barrier to treatment.

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7.0 APPENDIX

7.1 PARTICIPANT INFORMATION SHEET

PARTICIPANT INFORMATION SHEET

Title of Study: An Exploration Subjective Views on Online and In-Person Mental Health Interventions with Relation to Self-Stigma

Principal Investigator: Johanna Kenrick
Research Supervisor: Alison McGourty

What is the purpose of the study?

Research has consistently found that young men are less likely than their female counterparts to seek out mental health care. This suggests that the mental health care profession needs to make sure they're providing services that young men will find useful and relevant.

This study will ask about attitudes and feelings towards seeking mental health care, and will then ask about preferences for in-person or online treatment options.

Why have I been invited?

This research is interested in men between the ages of 18 and 25, living in the UK.

Do I have to take part?

Participation in the project is voluntary. You can withdraw at any stage of the project without being penalised or disadvantaged in any way.

If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. However, please note that once data has been anonymised, it will be impossible to withdraw a specific set of data.

What will happen if I take part?

You will be given access to a brief online questionnaire, along with a set of statements that you will be asked to order based on if you agree, disagree, or feel neutral towards the statements. Together, they take roughly eight minutes to complete.

If you choose to leave your email, you may request a copy of the final results (please note that then the researcher will have your email on record, but not affiliated with your data)

Participant Information Sheet
Dated: 11.11.2020, Version 2

7.2 INFORMED CONSENT SHEET

PARTICIPANT INFORMATION SHEET

REC Reference Number: ETH2021-0864

Title of Study: An Exploration Subjective Views on Online and In-Person Mental Health Interventions with Relation to Self-Stigma

Principal Investigator: Johanna Kenrick
Research Supervisor: Alison McGourty

I confirm that I have read and understood *Participant Information Sheet - Version 2, 11.11.2020* for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily. **I understand that my participation is voluntary and that I am free to withdraw without giving a reason without being penalised or disadvantaged.**

I understand that I will be able to withdraw my data up to completion of the survey, at which point my data will be anonymised.

I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).

I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.

I agree to take part in the above study.

Name of Researcher: Johanna Kenrick

Researcher Signature: [redacted]

Date signed by Researcher: 12/12/2020

7.3 REDDIT AD

[Academic] Comfort With and Personal Views of Professional Mental Health Interventions (18-26, M, UK, who have not previously had a professional mental health intervention)

This is an academic research project aimed at better understanding the subjective viewpoints of young men on seeking professional support for mental health. The goal of this study is to

contribute to the body of research examining how the mental health community can better support the needs of young men.

It is a two-part study. The first portion takes about ~4 minutes and collects data on attitudes towards seeking mental health interventions. The second portion takes ~10 minutes and is a sorting task.

Please note that the survey will provide a 2-digit anonymized participant ID which you must remember and enter into the sorting tool.

Residents of the UK who have **not** received professional support for their mental health, identify as male and are between the ages of 18 and 26 are invited to participate.

The study can be accessed at:
https://cityunilondon.eu.qualtrics.com/jfe/form/SV_egv82F1Zkk521nv
This anonymous link is unable to track identifying information of respondents.

Thank you for your consideration of this research. Questions or comments may be sent to [redacted] (ethics reference number: ETH2021-0864)

7.4 RECRUITMENT MESSAGE

I am a counselling psychology student at City, University of London conducting research on young men's perspectives around mental health support. Research suggests that men often feel isolated and unsupported with their mental health difficulties, and they are less likely than their female peers to seek professional support.

I'm interested in learning more about views around seeking help and what help is available to them, in order to better understand how professional services could meet these needs.

I'm currently recruiting residents of the UK who have **not** previously sought support for their mental health, who identify as male and are between the ages of 18 and 26.

The study can be accessed at:
https://cityunilondon.eu.qualtrics.com/jfe/form/SV_egv82F1Zkk521nv

This anonymous link is unable to track identifying information of respondents.

Thank you for your consideration of this research. Questions or comments may be sent to [redacted] (ethics reference number: ETH2021-0864).

If you are currently struggling and feel you need support, or worried about someone you know: **help is available.**

Participant Information Sheet can be accessed here:

https://theraputicpreferences.files.wordpress.com/2021/01/participant-information-sheet-version-2-11.11.2020.pdf

7.5 SELF-STIGMA OF SEEKING HELP SCALE

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = Agree 5 = Strongly Agree

1. I would feel inadequate if I went to a therapist for psychological help.

2.My self-confidence would NOT be threatened if I sought professional help.

3.Seeking psychological help would make me feel less intelligent.

4.My self-esteem would increase if I talked to a therapist.

5.My view of myself would not change just because I made the choice to see a therapist.

6.It would make me feel inferior to ask a therapist for help.

7.I would feel okay about myself if I made the choice to seek professional help.

8.If I went to a therapist, I would be less satisfied with myself.

9.My self-confidence would remain the same if I sought professional help for a problem I could not solve.

10.I would feel worse about myself if I could not solve my own problems.

Items 2, 4, 5, 7, and 9 are reverse scored.

7.6 Q-SORT EXAMPLE, BLANK