

A thesis submitted in partial fulfilment for the degree of

Doctor of Clinical Psychology (DClinPsych)

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Note: Grammarly Pro was used in this integrated thesis to check grammar and punctuation only, in accordance with my diagnosis of dyslexia. The University's Learning Disability Services are aware of this diagnosis and have a copy of my diagnostic report.

Word Count by Component

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Abstracts

Systematic Review of the Literature

Aim: This systematic review aimed to explore the factors influencing the disclosure and non-disclosure of male childhood sexual abuse (MCSA). The objectives were to (1) identify barriers and facilitators to disclosure, (2) examine the role of gender in the disclosure process and (3) assess the quality of the existing research in this area.

Method: The review followed Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines. A structured literature search was used to identify qualitative and quantitative studies on MCSA disclosure. Studies were included if they focused on men's experiences of disclosure, service provider perspectives, or the influence of cultural, religious, and societal factors. Study quality was assessed using the Mixed Methods Appraisal Tool (MMAT). Qualitative and quantitative data was analysed using thematic synthesis.

Results: Sixteen studies met the inclusion criteria. Barriers to disclosure included societal norms related to masculinity, stigma, emotional suppression, and limited awareness and access to professional support. Men were less likely to disclose abuse than women, often waiting until adulthood. Psychological distress (such as externalising behaviours), cultural factors and potential health inequalities regarding service access contributed to delayed and non-disclosure. Facilitators of disclosure included supportive social networks, positive responses to disclosure, and increased public and healthcare service awareness of MCSA. Areas for service development were identified, these included training and trauma-informed care approaches sensitive to the gender specific challenges of MCSA.

Discussion: The findings identified key barriers to MCSA disclosure and highlighted gaps in service provision with respect to the need for gender-sensitive, trauma-informed approaches to MCSA disclosure and support. Cultural and religious factors highlighted the potential relevance of a population health-based approach to care that is able to respond to the local need. Future research could seek to integrate qualitative and quantitative data to better understand the mediators and moderators influencing MCSA disclosure in order to inform evidence-based policy and service provision.

Service Improvement Project

Aim: This study aimed to explore the impact of team formulation (TF) on psychological thinking and practice in an older adult Community Mental Health Team (CMHT). The study aimed to (1) assess how TF influences psychological thinking and clinical practice, (2) evaluate TF delivery and related outcomes, (3) identify barriers to TF effectiveness, and (4) develop recommendations to improve the TF process.

Method: The study employed a qualitative design. Six older adult CMHT staff members from the multi-disciplinary team (MDT) took part in semi-structured interviews. Participants were selected on a first-come, first-served basis according to their roles in the MDT. Interviews were conducted via Microsoft Teams and were analysed using thematic analysis following Braun and Clarke's (2006) six-step framework. A trainee psychologist quality-checked samples of the data for inter-rater reliability and validity.

Results: Participants reported finding TF valuable for fostering psychologically informed discussions about clients and encouraging case formulation in clinical work. TF also influenced clinical practice by helping participants reframe service user behaviours and promoted shared learning within the MDT team. The 5P model was found to help structure psychological thinking, though some participants felt it was rigid and complicated. Barriers to TF engagement included unclear outcome plans, difficulty tracking the progress of outcome plans following TF meetings, and confusion about how TF data was stored. Participants expressed an openness to involving service users and carers in TF but identified reasons why this might be challenging to implement.

Discussion: The findings highlighted the need for structured TF training, user-friendly TF models, clearer outcome planning, and improved TF documentation. Recommendations included refresher training, trialling alternative TF models, piloting

service-user and carer involvement in a separate session to the main TF meeting and improving TF data storage.

Theory Driven Research Project

Aim: This study aimed to explore the relationship between adherence to traditional masculine norms and depressive symptoms and the potential role of emotional regulation (ER) as a mediator. A qualitative component explored men's experiences of masculinity, the degree to which they conformed over time, and how this influenced strategies for coping with stress.

Method: A mixed-methods design was utilised. In Stage 1, a cross-sectional online survey was carried out with 292 men to assess depressive symptoms, adherence to masculine norms and emotional regulation difficulties. In Stage 2, semi-structured interviews were conducted with a subset of participants (*N*=6) who scored highly on measures for depressive symptoms and adherence to masculinity.

Results: Quantitative analyses showed that greater adherence to traditional masculinity norms was associated with higher depressive symptoms and poorer emotional regulation. However, emotional regulation difficulties did not significantly mediate this relationship. Qualitative findings highlighted the influence of early socialisation, male role models, and educational experiences in shaping participants adherence to masculine norms. Participants reported evolving views on masculinity, however, most continued to utilise male-specific coping strategies in response to stress, such as emotional suppression and self-reliance.

Discussion: The findings provided further evidence for the link between adherence to traditional masculinity, depressive symptoms, and difficulties in emotional regulation. The lack of a significant mediation effect indicated the need for replication with clinical samples to further explore the potential role of emotional regulation, as well as other possible mediating variables. The qualitative findings suggested that for participants

masculinity is a socially constructed and evolving identity, shaped by early experiences and societal expectations, and subject to ongoing negotiation throughout the lifespan.

Systematic Review of the Literature

Barriers and Facilitators to the Disclosure of Male Childhood Sexual Abuse: A Systematic Review

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Proposed Journal: Journal of Trauma, Violence and Abuse was chosen for its emphasis on research relevant to clinical practice, particularly in the areas of trauma and abuse.

Conflict of Interest Statement: The author(s) declare that there are no conflicts of interest related to the research, authorship, or publication of this review.

Data Availability Statement: Data supporting the findings of this study are available from the corresponding author upon reasonable request. However, due to the qualitative nature of the data and to maintain participant confidentiality, full interview transcripts cannot be shared publicly.

Abstract

This systematic review examined factors influencing the disclosure and non-disclosure of male childhood sexual abuse (MCSA). The reviews objectives were to explore gender differences, identify barriers and facilitators, and assess the quality of existing research. Following PRISMA guidelines, a structured literature search was conducted in October 2024 across PubMed, PsycINFO, Web of Science, and the Cochrane Collaboration databases. Search terms related to MCSA (e.g., child, sexual trauma), barriers (e.g., obstacle, delay), facilitators (e.g., enable, help), disclosure (e.g., report, tell), and men (e.g., male, men). The review was registered on PROSPERO (CRD42023402010).

Studies were included if they investigated the barriers and facilitators to MCSA disclosure, including contributing factors such as gender, culture, religion, or service provider perspectives. Eligible participants included adult men (aged 18 and older) with a history of MCSA before age 18, and healthcare professionals working with this population. Both qualitative and quantitative studies were considered, including those using secondary data, provided that male-specific findings were reported separately.

Sixteen studies met inclusion criteria. Barriers to disclosure included stigma, emotional suppression, traditional masculinity norms, cultural influences, and limited awareness and access to support services. Men were less likely to disclose than women and often delayed disclosure until adulthood. Contributing factors to delayed or non-disclosure included psychological distress (e.g., externalising behaviours), cultural norms, and health inequalities in service access.

Facilitators of disclosure included strong social support, validating responses from others, increased public awareness, and greater professional sensitivity to MCSA. The review

highlighted key areas for service improvement, emphasising the need for gender-informed, trauma-sensitive approaches to support disclosure and recovery among men affected by MCSA.

Keywords: *Male Childhood Sexual Abuse; Disclosure; Barriers; Facilitators; Stigma; Masculinity Norms; Cultural Influences.*

Introduction

Childhood sexual abuse (CSA) is a significant global issue that includes contact and non-contact forms of sexual abuse (Domhardt et al., 2015). CSA is estimated to be prevalent in 12% of the global population on average, with higher rates among women (18%) than men (7.6%) (WHO, 2020), though underreporting likely underestimates its prevalence (Stoltenborgh et al., 2011). CSA can have long-term effects on individuals' mental and physical health, socioeconomic outcomes, and interpersonal relationships (Sanjeevi et al., 2018). In this review, the term male child sexual abuse (MCSA) is used to refer specifically to men who have experienced CSA.

Male Childhood Sexual Abuse

Men often encounter distinct barriers in disclosing experiences of MCSA. Societal expectations and traditional masculinity norms often conflict with experiences of abuse (Hudspith et al., 2023), resulting in men being less likely to than women to disclose MCSA, which in turn increases their risk of long-term mental health issues (Wolf & Pruitt, 2023). Additionally, healthcare services often report being inadequately prepared to provide support to men (Gressier & Essadek, 2023). The majority of existing CSA research has focused on women; leaving men's experiences relatively underexplored (Rapsey et al., 2020).

The impact of MCSA varies depending on several factors, including duration of the abuse, perpetrator's relationship to victim, and availability of support (Lahtinen et al., 2019). Men with histories of MCSA often struggle with trust, managing emotions, sexual maladjustment, as well as maladaptive coping strategies (Said & Costa, 2019; Kogan, 2005).

While CSA is more prevalent in women, men and women experience similar long-term negative mental health outcomes, such as, anxiety, post-traumatic stress, and mood disorders (Coventry et al., 2020). MCSA is also linked to high-risk behaviours, including substance misuse and unsafe sexual practices (Di Bianca & Mahalik, 2020; Kaiser et al., 2020). Delayed disclosure of MCSA can further exacerbate psychological distress and likelihood of men displaying externalising behaviours which are often associated with male-specific markers of distress, such as aggression and addiction (Neilson et al., 2020). Men with MCSA histories are up to 30 times more likely to attempt suicide (Rhodes et al., 2011), which highlights the necessity for timely interventions for an at-risk population.

Stigma, Help-Seeking and Disclosure

Men who have experienced MCSA often encounter various forms of stigma: public, self, and structural. These forms of stigma frequently intersect; making it challenging for men to talk about their experiences of abuse or to seek help. This dynamic likely deters men from disclosing MCSA and contributes to a sense of isolation.

Corrigan and Watson's (2002) model provides a framework for understanding these various forms of stigma. Public stigma refers to negative societal attitudes and stereotypes. Masculinity norms tend to depict men who have experienced MCSA as 'weak', complicit, or even responsible for the abuse. If the perpetrator is a woman, the abuse is usually downplayed or dismissed due to harmful assumptions that early sexual experiences are beneficial for boys (Spataro et al., 2001).

Self-stigma can occur when men internalise these societal attitudes, which can significantly impact self-esteem and lead to a reluctance to disclose their experiences or to seek help. Men often report feeling that their experiences of abuse conflict with notions of

traditional masculinity and what it means to be ‘a man’; leading to fears of being judged, not believed, or labelled as ‘weak’, ‘gay’, or even as a potential abuser (Kia-Keating et al., 2005; Lemaigre et al., 2017; Said & Costa, 2019).

Structural stigma refers to barriers inherent within systems, such as healthcare or mental health services. Research shows that professionals (i) can hold biases that men are not ‘victims’ of MCSA or (ii) may lack the necessary training to appropriately assess and support these men (O’Leary & Barber, 2008). Furthermore, traditional mental health approaches often emphasise emotional expression and more overt forms of distress, which may not align fully with known male-specific ways of expressing trauma, such as emotional suppression or social withdrawal. This disconnect can unintentionally perpetuate the silencing of abused men, leaving them feeling unsupported or misunderstood (Holmes, 2008).

At an individual level, Corrigan’s ‘Coming Out Proud’ model (2009) suggests that disclosure of MCSA can actively challenge stigma by empowering men to reclaim their narratives. However, the model emphasises that, for disclosure to be effective, men must feel sufficiently safe and supported to withstand potential stigma. This raises important questions about how MCSA disclosures are received by the individuals offering support and, more broadly, by healthcare services in their capacity to provide compassionate, gender-sensitive care.

Rationale for Study

Men who experience MCSA often face significant barriers to disclosure, shaped by societal gender norms and broader systemic challenges. Several systematic reviews have explored factors influencing CSA disclosure (e.g., Alaggia et al., 2019; Lemaigre et al., 2017; McElvaney, 2015). Most recently Latiff et al. (2024) examined socio-ecological factors in quantitative studies from 2000-2022 involving both men and women that either facilitate or hinder CSA disclosure. The present review differs in several key aspects. Firstly, it focused specifically on men, an under-researched population despite the well-documented mental health risks associated with non-disclosure or delayed disclosure (Rice et al., 2022). Secondly, it incorporated literature published between 2011 and 2024, offering a more current and male-specific synthesis of findings within this evolving field.

To address these gaps, the present paper conducted a mixed-methods synthesis examining the factors that influence whether and under what conditions, men disclose experiences of MCSA. The review aimed to consolidate existing findings, identify gaps in the literature, and inform both clinical practice and future research. By critically evaluating the literature, the review aimed to improve understanding of why men tend to disclose less frequently and later in life, assess the quality of existing studies, and highlight key thematic findings.

Research Questions

This review aimed to:

1. Identify key barriers and facilitators of MCSA disclosure.
2. Examine gender differences in disclosure patterns.

3. Assess the quality of existing research on MCSA disclosure.

Method

Search Strategy

A systematic search was initially conducted in October 2024 across PubMed, PsycINFO, Web of Science, Embase and Cochrane Collaboration databases. The search was updated in July 2025. Reference lists were manually searched using Google Scholar to identify relevant full-text studies for inclusion. The search strategy followed PRISMA guidelines (Page et al., 2021) and was registered on PROSPERO (CRD42023402010). Search terms relating to MCSA (e.g., child, sexual trauma), barriers (e.g., obstacle, delay), facilitators (e.g., enable, help), disclosure (e.g., report, tell), and men (e.g., male, men) were used (see Appendix 2).

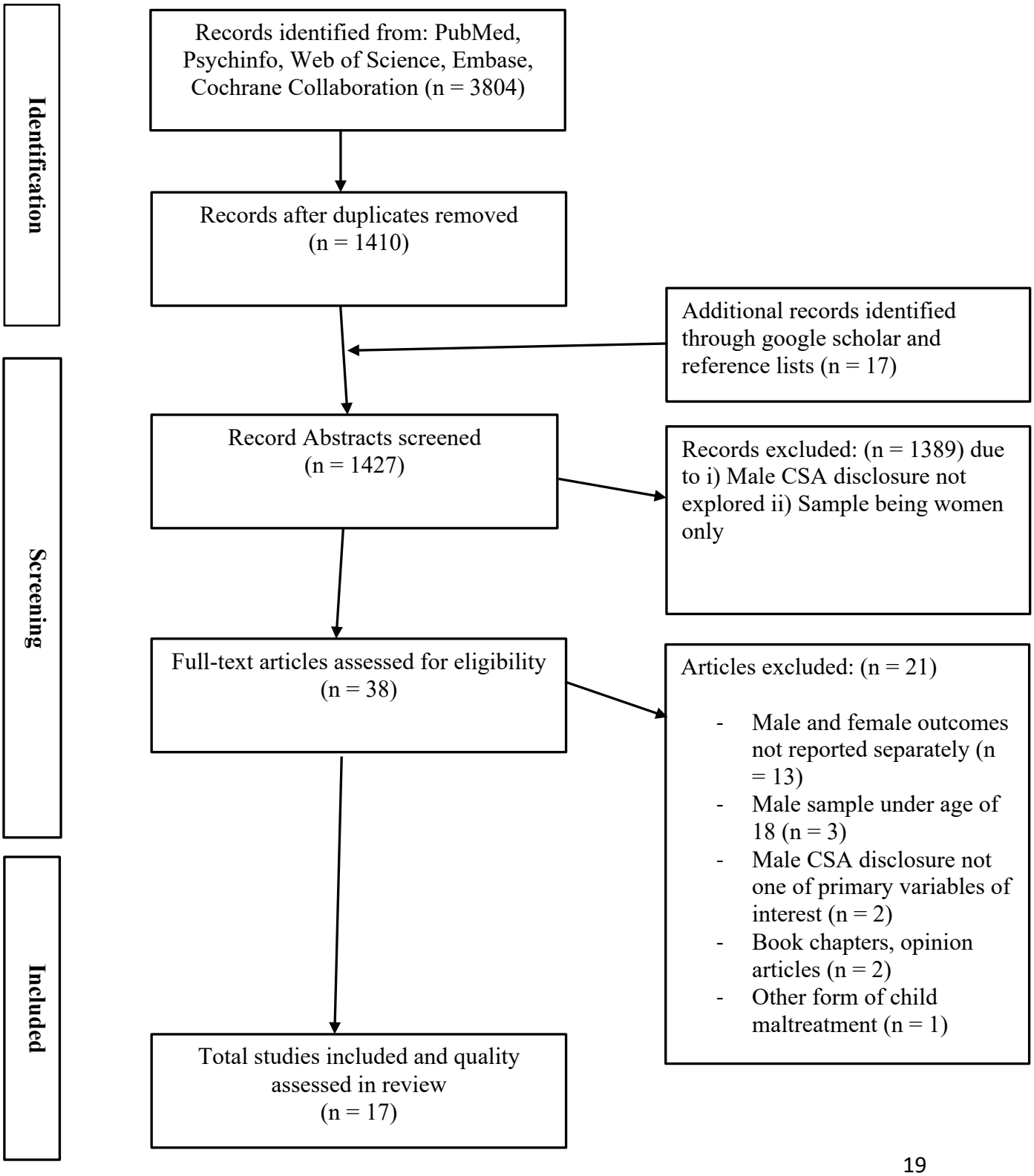
Study Eligibility

Studies were included if they examined MCSA disclosure, addressed barriers and facilitators, as well as the influences of gender, culture, religion, and service provider perspectives. Eligible participants were men (18+) with a history of MCSA before age of 18 or healthcare professionals who worked with this population. Both qualitative (e.g., interviews, thematic analysis) and quantitative (e.g., cross-sectional, cohort) methods with clinical or non-clinical samples were considered if male-specific data were reported separately or compared to female experiences. Studies using secondary data were included if they analysed distinct aspects of a dataset that were not examined in the other included studies.

Studies were excluded if they only focused on women, did not separate male data, or did not specifically examine MCSA disclosure from other childhood maltreatment. Titles and abstracts were screened by the first reviewer (J.R.B), with 25% independently screened by a second reviewer (T.T), for which a Cohen's kappa of $\kappa = .91$ was achieved. The first reviewer screened full texts of eligible studies, with 25% re-screened by the second author, of which a Cohen's kappa of $\kappa = 1.00$ was achieved. The study selection process is outlined in the PRISMA flowchart (Figure 1).

Figure 1

PRISMA flowchart of study selection



Data Extraction

Data was extracted using a standardised form, including study details (e.g., country, sample size, demographics, methodology). The first reviewer extracted all data, with 50% independently verified by a second reviewer for reliability (Cohen, 1960). Discrepancies were resolved through discussion.

Data Synthesis

For the qualitative component, this review used the thematic synthesis approach developed by Thomas and Harden (2008). This involved line by line coding of each study, developing descriptive themes, and creating analytical themes that extend beyond the original study content. Quantitative findings were synthesised using a narrative approach, with descriptive comparisons to identify patterns and trends across studies. Qualitative and quantitative data were then integrated narratively, allowing for comparison of findings across methods and the identification of areas where findings aligned or diverged.

Results

Description of Included Studies

This review analysed 17 studies published between 2011 and 2024, comprising 4,703 participants aged 21-67. The 2011 starting point reflected a shift in academic and public discourse on MCSA, marked by increased advocacy, media attention, and research focused on male-specific experiences of CSA, psychological effects, and barriers to help-seeking (Dorahy & Clearwater, 2012). Key policy developments further shaped its focus, including UK Crown Prosecution Service Guidance (2012), recognising men as 'victims'

of sexual offences; WHO Clinical Guidelines (2013), promoting gender-inclusive treatment approaches; and NICE Guidelines (2016), recommending trauma-focused therapy for men.

Fourteen studies focused exclusively on men; while three included both men and women. Most studies were conducted in high-income countries, including the USA (4), Canada (3), UK (3), Netherlands (2), Israel (2), Australia (2) and New Zealand (1). Ethnicity data were inconsistently reported; however, most studies featured a predominantly Caucasian sample.

The studies examined MCSA disclosure by exploring barriers and facilitators, the influence of gender, stigma, culture and religion, and recipients' responses to disclosure. Eleven studies specifically focused on men with histories of MCSA, of which three compared male and female experiences, and two looked at service provider perspectives on supporting men affected by MCSA.

Data collection methods included self-reporting measures and semi-structured interviews, with most using cross-sectional or descriptive designs. Quantitative studies used correlation analysis and logistic regression, while qualitative studies employed interpretative phenomenological analysis (IPA), thematic analysis, grounded theory, and narrative approaches.

Three studies by Easton (2013, 2014, 2021) were derived from the same dataset comprising 487 men aged 19-84. Each study analysed different subsets of the data and addressed distinct research questions. The dataset was obtained from a cross-sectional survey that used purposive sampling from three national organisations supporting males affected by MCSA: SNAP, MaleSurvivor, and 1in6.org.

Table 1

Summary of Included Studies

Source	Country	Sample	Number of Participants	Age (range)	Gender/ Sex	Ethnicity	Education	Study Type	Methodology and Analysis	MMAT Rating
Attrash et al. (2023)	Israel	Patients Only (*n* = 51)	Patients (*n* = 51)	18-60	51M (sex)	48 Jewish 3 other or no information	No information	Qualitative	Qualitative inductive thematic analysis	5/5
De Jonge (2013)	Netherlands	Patients only (*n*=1,352)	Patients (*n*=1,352)	18-25	1,042F, 310M (sex)	No information	No information	Quantitative	Cross-sectional survey, logistical regression	2/5
Easton (2013)	USA	Patients only (*n*=487)	Patients (*n*=487)	19-84	487M (sex)	White Caucasian (90.9%), Bi-racial (2.9%), African American (1.0%), Native-American	Level of education measured on an 8-point Likert scale ranging from less than high school diploma (1) to doctorate or	Quantitative	Cross-sectional survey design, bivariate tests were conducted (chi-square test, t-tests, sample t-test, Pearson'son's correlation, logistic regression).	5/5

Source	Country	Sample	Number of Participants	Age (range)	Gender/ Sex	Ethnicity	Education	Study Type	Methodology and Analysis	MMAT Rating
						(1.0%), Asian (0.4%), Pacific Islander (0.4%), Other race (3.3%)	professional degree (8). Mean level of education 5.associate's degree).			
Easton and Parchment (2021)	USA	Patients only (*n*=339)	Patients (*n*=339)	19-84	339M (sex)	Caucasian (90.6%), African American (1.0%), Native-American (1.0%), Asian (0.4%), Bi-racial (2.9%), Other race (4.9%).	Master's degree or higher (29.3%), bachelor's degree (30.2%), college (30.8%), high school diploma or less (9.7%)	Qualitative	Open-ended item on an online survey, content analysis	5/5
Easton et al. (2014)	USA	Patients only (*n*=460)	Patients (*n*=460)	19-84	460M (sex)	No information	High school diploma or less (10.7%), college or technical courses (22.8%),	Qualitative	Open-ended item on an online survey, content analysis	5/5

Source	Country	Sample	Number of Participants	Age (range)	Gender/ Sex	Ethnicity	Education	Study Type	Methodology and Analysis	MMAT Rating
							associate's degree (8.0%), bachelor's degree (30.0%), master's degree (20.0%), doctorate or professional degree (8.3%).			
Gagnier and Collin-Vezina (2016)	Canada	Patients only (*n*=17)	Patients (*n*=17)	19-67	17M (sex)	No information	No information	Qualitative	Semi-structured interviews, phenomenological approach	5/5
Gill and Begum (2023)	UK	Patients only (*n=8*)	Patients (*n=8*)	No information	8M (sex)	No information	No information	Qualitative	Semi-structured interviews, interpretive phenomenological analysis	5/5
Gruenfeld et al. (2017)	USA	Mental health therapists (*n*=9)	Social work (*n*=5)	No information	9M (sex)	No information	No information	Qualitative	Semi-structured interview, content analysis	5/5

Source	Country	Sample	Number of Participants	Age (range)	Gender/ Sex	Ethnicity	Education	Study Type	Methodology and Analysis	MMAT Rating
			clinical psychology (*n*=2) marriage and family therapy (*n*=1) Education (*n*=1)							
O'Leary and Barber (2011)	Australia	Patients only (*n*=296)	Patients (*n*=296)	Majority 30-39	151F, 145M (sex)	No information	Majority attended secondary school	Quantitative	Independent samples t-test, Hierarchical log-linear modelling	3/5
Okur et al. 2020	Netherlands	Patients only	Patients (*n*=586)	18-25	475F, 111M (sex)	No information	Vocational school (n=413), university of applied science (n=173)	Quantitative	Chi-square analyses, independent samples t tests, correlation analysis, logistic binary regressions.	3/5
Patterson et al. (2023)	New Zealand	Patients only	Patients (*n* = 9)	42-67	9M (sex)	New Zealand (n=7) European (n=2)	No information	Qualitative	Interpretive phenomenological analysis	5/5

Source	Country	Sample	Number of Participants	Age (range)	Gender/ Sex	Ethnicity	Education	Study Type	Methodology and Analysis	MMAT Rating
Roberts (2020)	UK	Patients only (*n*=18)	Patients (*n*=18)	23-67	18M (sex	No information	No information	Qualitative	Semi-structured interviews, Inductive approach	5/5
Romano et al. (2018)	Canada	Patients only (*n*=253)	Patients (*n*=253)	18-59	253M (sex)	White Caucasian (78.2%), East and South Asian (9.9%), Middle Eastern (4.3%), Hispanic (2.4%), Mixed (2.4%), Black (1.6%), Indigenous (1.2%)	Elementary (7.4%), High School (57.7%), University – undergraduate (27.1%), University – graduate (7.8%)	Quantitative	Online survey, Pearson correlation, linear regression	3/5

Source	Country	Sample	Number of Participants	Age (range)	Gender/ Sex	Ethnicity	Education	Study Type	Methodology and Analysis	MMAT Rating
Sharma (2022)	Australia	Patients only (*n*=11)	Patients (*n*=11)	2 0-59	11M (sex)	No information	No information	Qualitative	Semi-structured interviews, interpretative phenomenological analysis	5/5
Sivagurunathan et al., 2019	Canada	Service providers (*n*=11)	Service providers (*n*=11)	No information	7F, 4M (sex)	White Caucasian (n=11)	No information	Qualitative	Semi-structured interviews, thematic analysis	5/5
Villardos et al. (2022)	UK	Patients only (*n*=4)	Patients (*n*=4)	No information	4M (sex)	No Information	No Information	Qualitative	Narrative approach	5/5
Zalcberg (2011)	Israel	Patients only (*n*= 40)	Patients (*n*=40)	18-44	40M (sex)	No information	No information	Qualitative	In-depth interviews, grounded theory	5/5

Summary of Findings

Following an initial quality assessment, the first reviewer categorised the studies into seven themes. Several studies were included in multiple themes to ensure that studies with broad or diverse findings were not limited to a single category.

Table 2:

Theme	Studies
1. Gender Differences in CSA Disclosure	De Jong (2013); Okur (2020); O'Leary (2017)
2. Context of Disclosure and Mental Health Impact	Romano (2019); Easton (2013)
3. Masculinity Norms and Role of Stigma in Deterring Disclosure	Easton (2013); Gagnier (2016); Roberts (2020); Patterson (2023); Sigurunathan (2018); Gruenfeld et al. (2017)
4. Disclosure Experiences and their Impact	Gagnier (2016); Roberts (2020); Easton & Parchment (2021); Gruenfeld (2017); Sigurunathan (2018)
5. Cultural and Religious Contexts	Zalberg (2017); Attrash Najjar (2023); Sharma (2023) (Gill & Begum, 2023)
6. Healthcare and Systemic factors	Roberts (2020); Gruenfeld (2017); Sigurunathan (2018); Easton (2014); Villardos (2022)
7. Role of Support Systems	Gagnier (2016); Easton & Parchment (2021); Villardos (2022)

Quality of Studies

Seventeen studies met the inclusion criteria, including twelve qualitative and five quantitative studies. All qualitative studies were rated as high quality, demonstrating strong methodological rigour, and using methods such as thematic analysis, content analysis, grounded theory, or IPA. Sampling varied from large, diverse cohorts to smaller, more homogenous samples, allowing for in-depth exploration.

The five quantitative studies varied in quality, with one rated as high (Easton, 2013), three rated as moderate (O'Leary & Barber, 2011; Okur et al., 2020; Romano et al., 2018), and one rated as low (De Jong, 2013). Generalisability was limited in some studies due to non-representative samples, often comprising of predominantly Caucasian men or help-seeking populations, introducing the possibility of self-selection and non-response bias. Statistical analyses generally aligned with the research questions; however, it was noted that some studies used unvalidated survey instruments (De Jong, 2013; O'Leary & Barber, 2011), leading to potential measurement errors and possibly limiting generalisability. Non-response bias concerns arose from inadequate reporting of recruitment processes and participation rates (Easton, 2013), unaccounted missing data (De Jong, 2013), and unclear handling of participant exclusions (Okur et al., 2020; Romano et al., 2018).

Since the majority of studies were of a high or moderate quality, all were weighted equally in the synthesis. The analysis focused on overarching patterns and themes across the studies though variability in reporting reflected differences in study designs and data availability. Qualitative studies generally provided richer, more detailed ideographic

narratives, while quantitative studies provided comparatively concise and potentially generalisable or predictive conclusions.

Theme 1: Gender Differences in Disclosure

Three quantitative studies investigated gender differences in CSA disclosure. All three studies found that men were significantly less likely to disclose CSA informally than women. Two studies analysed gender differences at a multivariate level and one at a bivariate level.

At a multivariate level of analysis, De Jong (2013) reported that women were 2.45 times more likely to disclose than men (OR = 2.45, $\chi^2(1) = 19.76$, $p < .01$), with this relationship remaining significant after controlling for abuse characteristics and feelings of guilt (OR = 2.04, $\chi^2(9) = 46.32$, $p < .01$). Similarly, Okur et al. (2020) found that women were 2.2 times more likely to disclose informally (OR = 0.45, 95% CI [0.28, 0.71]), even after adjusting for abuse characteristics and gender role attitudes (OR = 0.45-0.50, 95% CI [0.25, 0.99]). However, formal disclosure rates were low for both genders (9.7% for women and 7.1% for men).

At a bivariate level, O'Leary and Barber (2011) found that men were significantly less likely to disclose at the time of abuse (26.2% of men vs. 63.6% of women, $\chi^2(1, N = 273) = 40.28$, $p < .001$) and were more likely to delay disclosure for over 20 years (44.9% of men vs. 25.4% of women, $t(175) = -2.97$, $p < .01$).

Non-disclosure findings varied. At a bivariate level, O'Leary and Barber (2011) reported higher rates of non-disclosure among men (73.8%) compared to women (36.4%). In contrast, De Jong (2013) found similar rates for both genders (men: 34.52%, women:

35.03%), while Okur et al. (2020) reported higher rates of non-disclosure among women (men: 42.4%, women: 57.6%).

Taken together, the studies indicated that gender may predict the timing and context of disclosure. Men were found to be less likely to disclose CSA than women but more likely to disclose later in life. Formal disclosure rates were low across genders. However, men were less likely to disclose informally, therefore highlighting the challenges men encounter in the disclosure process.

Theme 2: Context of Disclosure and Mental Health Impact

The context of disclosure (specifically timing and choice of receiver) and its impact on mental health were examined in one quantitative study (Romano et al., 2019) and one mixed-methods study (Easton, 2013). In line with the above findings, both studies reported that men delayed disclosure for decades (De Jong, 2013; Okur et al., 2020; O'Leary & Barber, 2011). At a univariate level, Easton and Parchment (2013) reported an average delay of 21.45 years, with a mean age of first disclosure at 32 years. Similarly, Romano et al. (2019) found an average delay of 15.4 years, with 57.7% disclosing in adulthood, 25.7% in adolescence, and 16.6% in childhood.

Both studies reported variations in disclosure receivers. At a univariate level, Romano et al. (2019) found that disclosures were most commonly made to friends (44.7%), followed by mothers (22.5%) and fathers (16.2%). While 68% received support, negative reactions included blame (7.5%), being ignored (10.7%), and disbelief (13.8%). Formal reporting was rare, with 77.5% of first disclosures not made to authorities. Similarly, Easton (2013) found that 27% first disclosed to a spouse or partner, 20% to a mental health professional, and only 15% to authorities.

Both studies highlighted associations between age of sexual abuse onset, age of first disclosure and various negative outcomes. At a bivariate level, Easton (2013) found that a longer delay before first disclosure was associated with higher levels of distress. The likelihood of reporting MCSA to authorities decreased by 14% with each year of additional age. Similarly, Romano et al. (2019) found that the age of sexual abuse onset and age of first disclosure were linked to increased externalising behaviours, greater substance misuse, and more frequent rule-breaking behaviours. However, first disclosure at an earlier age was associated with more supportive responses and a reduction in internalising behaviours, externalising behaviours, and substance use problems. Similarly, Easton (2013) found that as men got older, they were more likely to disclose MCSA and engage in deeper discussions about the abuse.

Additionally, both studies identified further associations between disclosure variables and negative outcomes. At a bivariate level, Easton (2013) found that disclosure responses (e.g., response to first disclosure, maternal support) and victimisation-related variables (e.g., severity of MCSA, number of other maltreatment experiences) were significantly associated with poorer mental health. At a multivariate level, Romano et al. (2019) further found that disclosing to a greater number of individuals was linked to fewer somatic complaints (e.g., headaches, fatigue), lower levels of aggressive behaviours and intrusive memories, and fewer rule-breaking behaviours.

In summary, Romano et al. (2019) and Easton's (2013) findings further indicate that men are more likely to disclose experiences of MCSA later in life. The findings also confirm that formal disclosure is a rarity; whilst informal disclosure typically occurs with friends and families. Further, late disclosure correlated with poor mental health outcomes, often manifesting as externalising behaviours associated with male-specific markers of

distress. In contrast, early disclosure, and disclosure to a network of people contributed to improved mental health and reduced male-specific distress.

Theme 3: Masculinity Norms and Role of Stigma in Deterring Disclosure

Four qualitative studies explored how traditional masculinity norms and societal stigma deterred men from disclosing MCSA experiences. A recurrent theme in two studies was the fear of being perceived as 'less masculine' or 'gay' in light of the abuse (Gagnier & Collin-Vézina, 2016; Easton et al., 2014), with homosexual men facing additional stigma that linked their sexual orientation to the abuse. A further theme identified in three studies was the role of societal myths in discouraging non-disclosure. The 'vampire myth,' which suggested that abused men become perpetrators, heightened fears for abused men of being viewed as threats (Roberts, 2020; Gagnier & Collin-Vézina, 2016). Roberts (2020) also highlighted the unique challenges faced by men abused by women, as societal attitudes often normalised such abuse as a 'rite of passage', and the presence of positive relational aspects, such as feeling ‘cared for’, complicated the recognition and disclosure of abuse.

Four studies identified traditional masculinity norms, particularly ‘self-reliance’ and ‘emotional restraint’ as key barriers to disclosure. Easton et al. (2014) found that acknowledging the abuse often conflicted with men’s sense of masculine identity, triggering fears of emotional overwhelm. Other studies (Gagnier & Collin-Vézina, 2016; Roberts, 2020; Patterson et al., 2023) linked non-disclosure to feelings of shame, guilt, embarrassment, and self-blame.

Two studies involving service provider perspectives identified how societal beliefs reinforced men’s tendencies to suppress vulnerability in the context of CSA disclosure (Sivagurunathan et al., 2019; Gruenfeld et al., 2017). Sivagurunathan et al. (2019)

referenced the 'man box' concept, describing rigid masculinity norms that discourage emotional expression; while Gruenfeld et al. (2017) noted the dissonance between masculine identity and ‘victimhood’, which further deterred disclosure.

Coping strategies, including minimisation, avoidance, and memory suppression, were identified as barriers that exacerbate distress. Sivagurunathan et al. (2019) found that men often downplayed MCSA's impact and struggled to connect their trauma to maladaptive behaviours, such as substance abuse and relationship difficulties. Gruenfeld et al. (2017) reported that men tended to suppress memories associated with the abuse and struggled to articulate their trauma experiences.

Similarly, Patterson et al. (2023) found that men suppressed memories, avoided trauma-related cues, and distracted themselves from distressing thoughts. While these strategies provided short-term relief, they often perpetuated long-term psychological effects of abuse, including hypervigilance, flashbacks, and relational difficulties. Patterson et al. (2023) also linked avoidance to maladaptive behaviours such as hypersexuality, risk-taking, and emotional withdrawal.

Two studies identified the fear of repercussions due to societal stigma surrounding MCSA as another barrier. Easton et al. (2014) and Roberts (2020) found that men refrained from disclosing MCSA due to concerns about judgment, criticism, rejection, false accusations, and the loss of relationships. The desire to protect friends and family served as an additional barrier to disclosure. Roberts (2020) also noted that men’s fears of retaliation from perpetrators and negative responses from others made disclosure feel unpredictable and risky.

The clinical picture of delayed disclosure and the resultant negative outcomes raises questions about the potential mediators in this relationship. While the above studies suggested that masculine norms, associated stigma, and male-specific coping styles as possible contributing factors, the predictive power of these variables is limited due to the idiographic nature of the research.

Theme 4: Disclosure Experiences and their Impact

Five qualitative studies examined the impact of receiver responses to MCSA disclosure. Four studies identified negative responses to first disclosure as a barrier, often leading to long-term reluctance to disclose again. Gagnier and Collin-Vézina (2016) and Roberts (2020) reported that disclosures were often met with disbelief, minimisation, coercion into silence, and lack of parental protection, with some disclosures resulting in further abuse. Similarly, Gruenfeld et al. (2017) and Sivagurunathan et al. (2019) found that negative reactions contributed to social silencing, reinforcing stigma, and discouraging future disclosures.

Two studies linked negative disclosure responses to long-term consequences. Gruenfeld et al. (2017) and Sivagurunathan et al. (2019) linked negative responses, such as being disbelieved, to prolonged non-disclosure, reluctance to seek help, and negative mental health outcomes. Sivagurunathan et al. (2019) also identified concerns over job loss, social labelling (being seen as 'different'), loss of friendships and family, and fears of being perceived as 'weak' or 'damaged'.

Additionally, concerns about retriggering the abuse further deterred disclosure. Men who felt complicit in their abuse, notably when they experienced a sense of pleasure, reported heightened feelings of guilt and shame. Read together, these findings highlight

the psychological complexity and emotional burden that might run in parallel to the decision to disclose MCSA.

Two studies highlighted the potential benefits of disclosure. Gagnier and Collin-Vézina (2016) found that a minority of men had positive disclosure experiences, these were characterised by feeling heard, emotionally supported, and validated. However, only two participants reported exclusively positive experiences, emphasising the rarity of such responses and the important role of empathetic support systems. Easton and Parchment (2021) further suggested that supportive disclosures facilitated cognitive and emotional breakthroughs helping men to recognise their abuse, understand its effects, and reject self-blame. Additionally, some men reported that MCSA disclosure reduced feelings of isolation by revealing that others had experienced similar situations.

In summary, these qualitative studies demonstrate that negative responses can worsen outcomes, discouraging further MCSA disclosure and help-seeking. They also provide further insights into the variables contributing to delayed disclosure, such as a fear of repercussions. Additionally, positive disclosure experiences, such as validation, have were identified as possible moderators of poor outcomes, which may increase help-seeking behaviour.

In overview, the findings highlight the need for greater awareness and the development of support systems that promote safe and validating disclosures. They also highlight the responsibility of healthcare services to challenge stigma, adopt trauma-informed approaches, and create safe and non-judgemental spaces where men feel comfortable seeking help without fear of judgement. However, the idiographic nature of these studies necessitates the need for further research in this area.

Theme 5: Cultural and Religious Contexts

Four qualitative studies explored barriers to MCSA disclosure in cultural and religious contexts. Study samples included two Israeli Jewish communities (one Orthodox) (Zalberg 2017; Attrash-Najjar et al. 2023), an indigenous Indian community (Sharma, 2022), and a South Asian Community in the United Kingdom (Gill and Begum, 2023)

A consistent theme across studies was the perception of sex, sexuality, and particularly CSA, as taboo. MCSA was considered culturally inappropriate for discussion and male rape and sexual victimisation were largely excluded from community discourse (Gill & Begum, 2023; Sharma, 2022; Attrash-Najjar et al., 2023; Zalcberg, 2017). The experienced constraint on speaking about CSA therefore appeared to reduce the likelihood of disclosing MCSA within the community or receiving support

Fear of negative social and familial responses was a key barrier to disclosure across all studies. Participants frequently cited concern that disclosure might result in questions about sexuality. This concern was influenced by fears of being perceived as homosexual, which was itself linked to possible homophobic attitudes within the community. In three studies (Gill & Begum, 2023; Sharma, 2022; Zalcberg, 2017), participants reported a desire to protect family members from emotional distress or reputational harm. Zalcberg (2017) reported that protecting family members extended to protecting offending relatives. In South Asian contexts, concerns about dishonouring one's family were especially pronounced, where the cultural value of *izzat* (honour) held significant social weight (Gill & Begum, 2023). Additional fears included disbelief or blame (Gill & Begum, 2023; Zalcberg, 2017), social isolation (Attrash-Najjar et al., 2023), and minimisation or dismissal of abuse (Sharma, 2022). Zalcberg (2017) further highlighted that some men

feared disclosure would be perceived as gossip or slander and potentially result in stigma rather than support.

Emotional barriers to disclosure, notably shame and guilt were reported in two studies. In Sharma (2022) these emotions were heightened by a cultural context in which sex and sexuality were taboo, leading participants to feel complicit in or responsible for the abuse. This, in turn, created uncertainty about whom they could safely talk to, contributing to silence and ~~r~~eluctance to disclose. Attrash-Najjar et al. (2023) further noted that silence in the Orthodox Jewish community was influenced by the cultural value of modesty. This appeared to contribute to the normalisation of CSA in public contexts, such as weddings, where abuse was dismissed as "play fighting," implying it was something to be tolerated rather than addressed. Consequently, men experienced confusion, powerlessness, and uncertainty about how to respond; further reducing the likelihood of disclosure.

Informal disclosure rates were low across all studies, and formal reporting was particularly rare, with only one case reported (Zalcberg, 2017). Among the few men who disclosed informally, negative responses were frequently reported, particularly from parents and immediate family members. Responses included: indifference, lack of understanding, emotional withdrawal, dismissal, blame and silencing. These responses hindered participant's ability to access emotional and practical support, contributing to a reluctance to disclose again (Attrash-Najjar et al., 2023; Sharma, 2022; Gill & Begum, 2023; Zalcberg, 2017).

Two studies highlighted both familial and communal silencing, noting disclosure was often discouraged to protect either community members or the individual's family

reputation (Zalcberg, 2017; Gill & Begum, 2023). Zalcberg (2017) describes how community and religious leaders minimised or dismissed abuse and were often shielded from prosecution due to social status. Similarly, Gill and Begum (2023) reported that some men were instructed by family members to remain silent in order to preserve family honour. In this context, men were more likely to disclose to non-family members, such as a general practitioner or Imam.

By contrast, two studies (Zalcberg, 2017; Gill & Begum, 2023) also highlighted that a minority of men did receive supportive responses to disclosure. These positive responses from friends, spouses, parents, and an Imam included empathy, active listening, and validation. Positively received disclosure reduced feelings of guilt and self-blame. However, in both studies it was unclear how supportive responses influenced future disclosure and help seeking.

Taken together, these four qualitative studies highlight the influence of cultural and religious norms, alongside community-specific pressures, in shaping men's experiences of MCSA disclosure and help-seeking. Across diverse cultural contexts, these factors contributed to gender-specific barriers, such as fear of stigma, the burden of family honour, emotional distress, and the scarcity of social support available. While a small number of participants described positive disclosure experiences, these were the exception rather than the rule. Given the cultural specificity of the four samples further research is needed to explore the generalisability of these findings across different cultural and religious contexts.

Theme 6: Healthcare and Systemic Factors

Five qualitative studies (Roberts, 2020; Gruenfeld et al., 2017; Sivagurunathan et al., 2019; Easton et al., 2014; Viliardos et al., 2022) identified healthcare and systemic barriers to MCSA disclosure. Three of these studies noted the limited capacity of healthcare systems to meet the needs of men affected by MCSA. (Easton et al., 2014; Gruenfeld et al., 2017; Viliardos et al., 2022). Easton et al. (2014) found that trauma services were often designed around women's experiences, with an emphasis on emotional expression, which conflicted with masculine norms that discourage emotional vulnerability. This mismatch often resulted in men experiencing feelings of shame and isolation, creating further barriers to disclosure and help-seeking.

Gruenfeld et al. (2017) highlighted that therapeutic settings were often perceived as failing to accommodate masculine norms. Therapists use of 'gendered terminology', such as 'victim' or 'survivor' was found to discourage men from seeking and engaging with professional help. In this context, gendered terminology referred to terms that men perceived as connoting a sense of vulnerability and weakness, traits that were seen as at odds with western social constructs of masculinity. Internalised stigma, concerns about masculinity, and fears of being labelled as homosexual were additional barriers, aligning with the above findings. Viliardos et al. (2022) also identified structural barriers, such as long wait times for assessment and treatment, which prolonged psychological distress and feelings of invisibility, further deterring men from engaging with healthcare services.

These studies add to the evidence base by illustrating how reception to disclosure can either reduce or elevate distress and influence help-seeking. They also highlight how

gendered assumptions in trauma care, stigma-driven deterrents, and systemic inadequacies can marginalise men and limit access to meaningful support.

Beyond these limitations, two studies found the potential of media portrayals in positively influencing MCSA disclosure. Gagnier and Collin-Vézina (2016) reported that representations of men in the media helped men to recognise their own experiences as abuse, reducing self-doubt and encouraging help seeking. Similarly, Viliardos et al. (2022) noted that high-profile MCSA cases involving celebrities, often acted as catalysts for disclosure. These portrayals helped to raise awareness and normalise discussions around MCSA, helping men to integrate their experiences into their personal narratives over time.

Two studies identified the role of power and social inequality as barriers to disclosure. Roberts (2020) highlighted how power imbalances between perpetrators and the men affected, such as differences in age, physical strength, and social status, left men feeling disempowered and disbelieved. These imbalances also shielded perpetrators from accountability, which further discouraged MCSA disclosure. Sivagurunathan et al. (2019) noted that such power dynamics extended to institutional settings, such as schools and religious organisations. Institutional reluctance to address MCSA was reflected in the lack of safe spaces for disclosure, further perpetuating stigma and discouraging men from speaking out.

Taken together, these studies highlighted the systemic barriers faced by men when disclosing MCSA, including societal stigma and underdeveloped institutional and healthcare responses. In contrast, celebrity disclosures suggested potential in shifting public perceptions of MCSA and encouraging help-seeking. The findings highlighted the

importance of gender-sensitive, trauma-informed approaches able to consider male-specific challenges and improve access to timely and appropriate support (OHID, 2022).

Theme 7: Role of Support Systems

Expanding on the role of healthcare and social systems, three qualitative studies (Gagnier & Collin-Vézina, 2016; Easton & Parchment, 2021; Viliardos et al., 2022) explored how support systems, including friends, family, and professionals, can help to facilitate MCSA disclosure.

Empathy, compassion, and emotional openness were identified as key interpersonal qualities in helping to create safe spaces for disclosure (Easton & Parchment, 2021; Viliardos et al., 2022). Viliardos et al. (2022) emphasised the importance of a strong therapeutic relationship characterised by active listening, non-judgment, and acceptance was particularly influential in facilitating disclosure. Easton and Parchment (2021) also highlighted that patience and understanding helped to reduce feelings of shame and foster trust, thereby facilitating the disclosure process. Similarly, Viliardos et al. (2022) found that trust in the therapist was fundamental, with feeling believed considered to be a prerequisite for men to feel safe enough to disclose their experiences.

Two studies also identified professional knowledge as a facilitator to safe disclosure and meaningful treatment. Easton and Parchment (2021) and Viliardos et al (2022) found that men who disclosed to professionals who demonstrated expertise in CSA benefited from reduced guilt and shame, indicating the role of knowledge and a non-judgemental attitude in facilitating disclosure and receiving help.

Two studies identified the role of shared experiences in encouraging MCSA disclosure. Gagnier and Collin-Vézina (2016) found that knowing others with similar experiences, such as friends helped reduce feelings of isolation, normalised the experience of MCSA and increased the likelihood of disclosure. Similarly, Easton and Parchment (2021) reported that disclosure to individuals with personal experience of CSA led to deeper empathy and more meaningful support.

Familial relationships, particularly those involving maternal figures, had a complex and multifaceted impact on disclosure in one study. Viliardos et al. (2022) found that mothers played a central role in shaping men's willingness to disclose and process their experiences of abuse. However, responses varied; while some provided support, others responded with disbelief and rejection, causing significant distress. In one case, the mother was the perpetrator, further complicating the individual's ability to seek support.

Overall, these findings highlighted key variables that may assist in creating supportive environments within healthcare settings and beyond, such as trust-enhancing relationships, professional competence, and social validation. The studies underscore the importance of relational, systemic, and cultural sensitivity in shaping disclosure experiences and outcomes.

Discussion

This systematic review critically analysed 16 studies focusing on exploring barriers and facilitators to MCSA disclosure. The findings indicated that gender may influence both the frequency and timing of MCSA disclosure. Men were found to disclose less often and later in life when compared to women. However, findings on non-disclosure were mixed, with some studies reporting higher rates among men, others among women, while

several found similar rates for both genders. Formal disclosure or reporting to authorities was low for both genders.

Some quantitative studies also suggested that men were more likely to disclose to family members or friends but were less likely when the perpetrator was a family member. Notably, delayed disclosure was associated with poorer outcomes, particularly markers of male-specific distress (e.g., externalising behaviours) and negative reception to disclosure. In contrast, supportive responses to disclosure served as a protective factor, and early disclosure was linked to improved mental health outcomes and a reduction in male-specific markers of distress.

Qualitative findings highlighted a range of potential barriers to disclosure. Masculinity and stigma were recurrent themes, with fears of being perceived as gay and the 'vampire myth' often discouraging men from disclosure. Masculine coping strategies such as emotional suppression, avoidance, and adherence to the 'man box' concept were also potential barriers and were associated with poor mental health outcomes. Men also feared negative consequences from both receivers and perpetrators, such as job loss or social exclusion. Cultural and religious disclosure barriers (such as taboo and shame) were also identified in context of Jewish and Indian communities. However, these idiographic findings should be viewed tentatively, as they have limited generalisability and ability to predict clinical risk. Quantitative studies could build on the small qualitative evidence base on barriers by examining variables, such as stigma and male coping styles, as potential mediators of delayed disclosure.

Consistent with quantitative findings, qualitative studies indicated that the reception to disclosure plays a key role in either exacerbating or moderating distress and

influencing mental health outcomes. Negative disclosure experiences reduced the likelihood of future disclosure and contributed to poor mental health outcomes. Key variables in negative disclosure experiences included disbelief, denial, and the role of cultural and religious norms in potentially silencing disclosure.

Key variables that may positively influence disclosure reception and moderate outcomes were also identified. Interpersonal qualities such as warmth, trustworthiness, and compassion played an important role in reducing feelings of shame and fostering a sense of safety. Peer disclosure, where individuals shared their MCSA experiences with others, was found to help normalise speaking out and encouraged men to come forward. Professional knowledge and understanding of MCSA also played an important role in facilitating disclosure through reducing stigma and fostering a more supportive environment. Additionally, positive media portrayals of males affected by MCSA helped to further normalise disclosure and empowered men to share their experiences.

Finally, service-related barriers were identified that highlighted potential health inequalities. Healthcare services were primarily designed for women and did not account for male-specific challenges related to stigma, shame, and coping strategies typically employed by men. Professionals often lacked the necessary training to recognise and assess trauma in men. Treatment was also frequently medicalised and relied on medication rather than addressing the underlying causes of distress. Additionally, mandatory police reporting before granting access to treatment further delayed disclosure and men's ability to engage with services.

The results of present review are largely consistent with previous research. Existing studies have shown that compared to women, men disclose less frequently, later in life, or

may not disclose at all (e.g., Wolf & Pruitt, 2023; Coburn et al., 2019). Additionally, delayed disclosure has been associated with an increased risk of poor mental health outcomes (e.g., Said & Costa, 2019). Previous research has also highlighted that service providers often lack the necessary knowledge, expertise, and resources to adequately treat this population (e.g., Gressier & Essadek, 2023). Furthermore, masculinity-related barriers, such as as the conflict between experiencing MCSA and adhering to traditional masculine values, have been widely documented (e.g., Lemaigre et al., 2017). However, the identification of religious and cultural barriers to disclosure represents a novel finding that has been underexplored in previous research.

The findings support Corrigan and Watson's (2002) model of stigma. This review highlighted evidence of public stigma, often rooted in societal beliefs about masculinity, as well as self-stigma, where men internalise these attitudes. This sense of internalisation was found to contribute to a reluctance to seek help and a fear of appearing "less masculine." Furthermore, systemic issues within healthcare services were identified as contributing factors, leading many men to feel unsupported, misunderstood, or overlooked.

Clinical and Service Implications

This review highlighted general and community-specific challenges faced by an at-risk population and associated health inequalities. These risks and inequalities relate to low and delayed rates of CSA disclosure in men with delayed disclosure associated with poorer outcomes and male-specific markers of distress. Barriers to disclosure may include gender-related norms and coping styles, and possible cultural or religious factors. The findings highlight importance of reducing late and non-disclosure whilst promoting positive disclosure experiences to improve mental health outcomes.

The findings of this review have several clinical implications for future research and service development. Given the link between delayed disclosure and negative outcomes, quantitative studies could build on the small qualitative evidence base on disclosure barriers by exploring the role of variables, such as stigma and male coping styles, as potential mediators in late disclosure. An improved understanding of mediators would allow public health and services to understand better which variables predict risk. An improved understanding of mediators also needs to consider the potential role of cultural and religious variables in predicting risk.

The synthesised findings also highlighted how reception to disclosure positively or negatively moderates outcomes. With respect to service development, the findings underscore the importance of clinical interface variables in adopting a gender-sensitive approach to reducing health inequality for men who have experienced MCSA. This includes fostering interpersonal qualities that facilitate disclosure and developing trauma-informed training and care that accounts for possible gender differences of trauma in assessment and treatment. As Corrigan (2009) outlines in 'Coming Out Proud' model, when men feel safe and supported to disclose their experiences, disclosure can become a transformative act of resistance, allowing men to confront internalised stigma**,** reclaim a sense of identity, and begin healing through connection and self-expression**.**

Given that the evidence highlights the underreporting of MCSA, a clinical audit of MCSA disclosure, engagement, and outcomes would assist services in monitoring access and improving provision. The role of peer support in positive outcomes may also play a role in service development, together with the role of service-user feedback and possible expert-by-experience knowledge in shaping services responsive to the effects and challenges of MCSA.

Although a small evidence base, the potential role of cultural and religious factors in disclosure and treatment access highlights the relevance of a 'population health' approach that considers the local demographic of services served rather than applying a one-size-fits-all model (Holmes, 2022). Service commissioning could incorporate these factors when shaping provisions to address inequality and risk within this cohort. Such an approach requires integrating service delivery with broader community networks, including community hubs and religious organisations and developing community-specific training and awareness of MCSA and its related challenges.

Limitations

This review had several limitations. The small number of quantitative studies (5), methodological heterogeneity, and the predominance of qualitative research (11) prevented a meta-analysis or statistical synthesis of key associations. These limitations hindered the ability to draw more robust conclusions on gender differences in disclosure, perpetrator characteristics, timing of disclosure, and mental health outcomes (De Jong, 2013; Okur et al., 2020; Easton, 2019; Romano, 2019).

Study quality varied, with some datasets used across multiple studies. For instance, all three studies by Easton (2013, 2014, 2021) analysed different aspects of the same dataset, but their inclusion was deemed necessary given the limited available research (Brown & Mann, 2023). Despite variations in study designs across qualitative and quantitative research, the consistency of descriptive characteristics and key findings suggested that male participants across studies may be representative of the broader population. Many of the studies relied on unvalidated measures or adapted existing tools without sufficient justification, potentially compromising reliability and validity. To

enhance research quality, future studies could prioritise development and use of psychometrically validated instruments.

As discussed above, a greater understanding of late disclosure and non-disclosure mediators is required to predict risk in this cohort and develop public and service awareness that can promote earlier disclosure and improved outcomes. Given richness of qualitative data, building on existing qualitative insights might involve a data-driven, grounded theory that can clarify psychological processes that influence disclosure and potential help-seeking behaviour.

Given the potential influence of cultural and religious factors, a more detailed analysis of disclosure demographics could inform the population health approach described above. Identifying demographically nuanced higher-risk groups could support responsive service provision, potentially increasing positive disclosure experiences and access to better mental health outcomes.

Conclusion

This systematic review synthesised quantitative and qualitative research data and identified key barriers and facilitators to MCSA disclosure, highlighting the influence of stigma, masculinity, cultural factors, and service-related obstacles. The findings emphasised the need for a gender-sensitive, trauma-informed approach to MCSA disclosure and a population health-based approach to targeted services able to respond to community demographics and enhance access. Future research could integrate qualitative and quantitative findings to enhance understanding of MSCA disclosure mediators and moderators and inform evidence-based policy and intervention strategies.

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Service Improvement Project

Future Directions for Team Formulation in the Older Adult Oxford Central Community Mental Health Team

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Data Availability Statement: The data supporting the findings of this study are available from the corresponding author upon reasonable request. However, due to the qualitative nature of the data and consideration for participant confidentiality, full interview transcripts are not publicly available.

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Abstract

Service Improvement Project

Objectives: Team formulation (TF) is an increasingly recognised approach for working collaboratively within multidisciplinary teams (MDT) to promote psychologically informed care. Despite its growing use, there is currently limited research on TF, particularly within older adult community mental health teams. This project aimed to explore the delivery, experience of, and impact of TF in this setting, in order to identify barriers and develop recommendations for improvement.

Design: A qualitative design was employed to explore staff experiences of participating in TF. Semi-structured interviews sought to explore four key areas: (1) how TF influences psychological thinking and clinical practice, (2) the implementation and outcomes of TF, (3) barriers to effectiveness, and (4) suggestions for improvement.

Methods: Six MDT members took part in the study. Participants were selected on a first-come, first-served basis and according to professional roles to ensure views expressed were representative of the MDT. Interviews were conducted online via Microsoft Teams. Interview data were analysed using Braun and Clarke's (2006) six-stage approach to thematic analysis.

Results: TF was found to be beneficial in promoting psychologically informed discussions and collaborative case formulation. TF helped staff to reframe patient behaviours and supported shared learning in the MDT. While the 5P model provided structure to the

sessions, some participants experienced it as rigid or overly complicated. Barriers to TF engagement included unclear outcome planning, difficulty tracking the progress of outcome plans beyond TF, and a lack of clarity around where documentation is stored. Participants also expressed an openness to involving service users and carers in TF, though they noted several potential practical challenges.

Conclusion: TF was valued by MDT staff working in an older adult community service, particularly for promoting psychological thinking and collaborative case formulation. Recommendations included ongoing TF training, exploring alternative or simplified models, establishing clearer outcome planning processes, piloting involvement of service users and carers in separate sessions, and improving TF documentation and data storage systems.

Keywords: *Team Formulation; Older Adult Community Mental Health; Psychologically Informed Care; Multidisciplinary Teams; Thematic Analysis; Service Improvement; Implementation Barriers*

Introduction

Team formulation (TF) is increasingly recognised as a method for engaging and working collaboratively with multi-disciplinary teams (MDT) to promote psychologically informed thinking in clinical practice (Division of Clinical Psychology, 2011). TF is the "process of facilitating a group of professionals to create a shared understanding of a service user's (SU's) difficulties" (Johnstone & Dallos, 2014; p.5). In essence, TF involves sharing and integrating information from the MDT to create a meaningful narrative about a SU difficulties, which can then inform treatment decisions.

There is limited research on TF in MDT's, a concern previously highlighted by the DCP (2011). A recent systematic review by Bealey et al. (2021) found the existing evidence base to be of mixed quality. Notwithstanding the overall lack of research, the available studies reported a range of potential benefits and drawbacks of TF, which are summarised below. Bealey (2021), however, noted that some of the studies lacked sufficient information to assess their quality adequately. Additionally, most of the research employed quantitative methods with little focus on qualitative approaches.

Hollingworth and Johnstone (2013) audited the use of TF in adult inpatient and CMHT teams. TF was found to help staff develop a shared understanding of SU difficulties and strengths, as well as generating ideas for treatment planning and risk management. Similarly, Berry (2016) evaluated TF within a rehabilitation unit and reported that it enhanced staff understanding of SUs and improved therapeutic relationships. Staff also benefited from a sense of containment, psychological support, and reduced work-related stress. Dexter-Smith's (2015) study, one of the few within OA

services, found that the structured framework of TF created a sense of containment, allowing staff to discuss and comprehend challenging and distressing SU presentations.

Several studies utilised attribution theory to explain how TF positively influences staff attitudes and clinical practice (Kellet et al., 2014). Attribution theory proposes that individuals attribute beliefs (and intentions) to events when interpreting them, which then shapes their emotional and behavioural responses to social situations. This theory is particularly relevant in the context of staff perceiving SU behaviour as challenging. For example, Ingham (2011) found that engaging with a SUs' life history and reflecting on systemic factors (including staff responses to SUs') during TF led to changes in how staff appraised such behaviour, which in turn led them to adopt a more compassionate and empathic approach.

Despite the aforementioned advantages, some studies have identified challenges associated with TF. These include the time and resources required to incorporate agreed outcomes into treatment plans, which may not always be possible when balanced with the healthcare staff's core job responsibilities. Ensuring sufficient attendance for representative and meaningful TF discussions can also be challenging (Johnstone & Dallos, 2014). Additionally, staff may feel overwhelmed when discussing distressing presentations of SU's (Berry et al., 2009). Power dynamics within teams may also affect the TF process; senior staff may exert a disproportionate influence on discussions and decision-making, while other staff may not feel they have a voice (Mannix & Sauer, 2006). Moreover, TF may be deprioritised in favour of task-oriented activities or disrupted by crises such as staff shortages or sickness (Down, 2010).

In summary, while existing research suggests that TF can lead to broad benefits, including supporting a shared, enhanced understanding of SUs' difficulties, and improving therapeutic relationships between staff, the literature remains limited in its scope and depth. Most of the research has focused on adult inpatient settings and used quantitative research methods. Further, concerns have been raised regarding the methodological quality of some of the studies. There is also a notable lack of qualitative research, particularly in exploring TF within OA community services.

Project Background and Aims

Since 2017, TF in the OA CMHT has been delivered using the 5Ps model (Johnstone & Dallos, 2014) without input from SUs' and carers. TF has become a regular part of the monthly meeting schedule, influencing the team's thinking and approach to working with SUs'. However, attendance and participation in TF changed following the COVID-19 outbreak and the transition to online meetings. TF continued to be well supported by medical staff, unqualified staff, and students but was less well attended by core staff members, such as care coordinators.

As outlined above, TF remains an under-researched topic, particularly within OA CMHT settings, where little is also known about the barriers to participation. Although the OA CMHT has previously evaluated TF through feedback from an adapted version of Johnstone's (2014) questionnaire, no changes were implemented. There was a requirement, therefore, for a project that explored staff experiences of TF, and to develop recommendations aimed at enhancing staff engagement with TF in the MDT.

The project aimed to evaluate and improve TF meetings within OA CMHT. Specifically, it sought to explore staff perceptions of the usefulness of TF meetings, and to

identify barriers that may impact engagement with the TF process. The project also aimed to explore staffs' experiences of participating in TF, and to develop recommendations based on such findings.

Method

The project proposal was developed in collaboration with project supervisors and with input from the team manager. The trainee held meetings with the project supervisors and the team manager to discuss the project idea and obtain permission to proceed. The project received approval from Oxford University PAS and the Oxford Health Research and Development team.

Six staff members from the OA CMHT, representing all disciplines within the team, were interviewed about their experiences with TF. Participants included a nurse, psychiatrist, assistant psychologist, occupational therapist, care coordinator, and a team manager with a social work background. The project was presented at an MDT meeting and was followed up with an email to the team outlining the study. Staff were invited to express their interest in participating by emailing the researcher. Participants were chosen on a first-come, first-served basis, with one person from each job role selected to ensure the interviews reflected a range of views from the MDT team. Participants were provided with an online participant information form and a consent form. Once consent forms were received, a suitable time and date for interview was arranged.

Interviews were conducted via Microsoft Teams and lasted up to 1-hour. Interviews were semi-structured, comprising six questions, allowing the researcher to gather open-ended data and detailed descriptions of staff perceptions of TF (Maguire & Delahunt, 2017; see Appendix C for the interview schedule). This approach allowed for

follow-up questions and probes, aiding further exploration and a deeper understanding. One-to-one interviews were designed to help participants feel comfortable discussing TF, without concern for how their contributions might be perceived by other team members. Interview questions were developed with the project supervisors and an expert-by-experience, whose feedback was incorporated over two meetings.

Interview data were transcribed and analysed using thematic analysis (TA). TA was selected for its flexibility, allowing the researcher to summarise, identify patterns and themes, and interpret participants' personal accounts of TF. Braun and Clark's (2006) six-step framework was followed, providing a structured approach to the thematic analysis. To support inter-rater reliability and validity, a trainee clinical psychologist from the University of Oxford reviewed samples of the data, including (1) a ten-minute extract of an interview and the corresponding transcript and (2) a full participant interview transcript.

Based on the findings, recommendations were developed to inform interventions, aimed at improving the TF process. The researcher delivered a feedback and reflection session with the team on the 20th October 2022 to discuss the findings and agree on next steps regarding implementation. The team were also provided with a final copy of the project, including an executive summary via email.

Findings

Staff reported a range of views regarding their experiences attending and participating in TF. The themes from the interviews are discussed below.

Theme 1: Value of Team Formulation

This theme explored participants' perceptions of the value of TF and its impact on their approach to clinical practice. All participants reported finding TF helpful. In contrast to other team meetings, TF allowed for a "*psychologically focused*" "*in-depth*" discussion on a "*single case*". Participants noted that it felt distinct from MDT team discussions, which often centred around "*social care*" and the "*medical model*". One participant said:

> *"To be able to have the time to look and see how things like early experiences...previous trauma…or how seeing how much of people's past experiences and ways of thinking how much they influence the situation now."*

Here, we see the importance placed on exploring a SU's background history to help reach a better understanding of the person and the links between past events and current difficulties. TF was seen to encourage a shift in staff perspectives, influencing how they perceived SU's presentations and the challenges of working with such individuals.

Another staff member shared:

> *"There's always this real psychological theory behind it that you kind of reflect and go, 'that makes sense' if they've had, you know, a difficult*

childhood and then they're putting up boundaries, and their agitation is actually a form of self-preservation".

This participant suggested that TF enabled them to adopt a psychological perspective, which in turn, helped to reframe SU's presenting difficulties (e.g., agitation as a form of self-preservation), allowing for deeper empathy and reducing the emotional impact on the clinician. TF was also valued for facilitating a space to "*learn about individual clinicians*" and their "*professional backgrounds*", especially psychology colleagues whom staff reported they get "*less exposure*" to due to them being located away from the main base. One participant shared:

"Drawing that from different aspects, so from other psychology colleagues or…from nursing colleagues or other OTs".

Participants reported that the "*psychological techniques*" discussed during TF influenced their clinical practice in so far that they could be applied to clinical interventions. As one participant put it:

"Being more aware of psychological techniques that one can employ within the portfolio of support work techniques, I think, has been useful".

Staff provided examples of this, including 1. Incorporating questions about early life experiences into assessment, 2. Using psychological terms or phrases that move away from describing SUs through the lens of diagnoses, and 3. Knowing when and how to make a referral to psychology. However, one participant questioned the extent to which TF influenced the wider team's clinical practice, attributing this to a lack of integration with supervision processes:

"What sort of supervision should the person have? Should they have a little bit of short-term…psychology supervision to embed that thinking…(and) let's make sure that we make use of that (new insights and learning) in the ongoing intervention".

For this participant, a formal process within the supervision structure was necessary for staff to be able to embed insights and learning from TF into SU careplans, in addition to supervisors monitoring and supporting staff's progress in applying psychological thinking to clinical practice. For most participants, a key function of TF was as a space to process "*conflicting*" emotions and receive "*support*" from colleagues when managing the challenges that can arise from working with SU's:

"Nurses said goodness gracious, good luck. And it was kind of like an affirmation that I was doing OK because everyone thought that this was difficult".

Here, we see the importance attached to staff bearing witness to the challenges of working with a complex case and receiving acknowledgement and validation from other team members for the difficulties they are experiencing.

Theme 2: Lack of Outcome Planning

This theme explored participants' concerns regarding the lack of planned outcomes in TF, including 1) Meeting aims and objectives, 2) Timing and structure of sessions, 3) Patient careplans and their implementation, and 4) How information gleaned from TF is recorded and made accessible to staff.

Participants reported that when presenting a client at TF, there were times when, despite a "*rich*" discussion, they left the session without a "*clear plan*" or "*solution to the problem*". The reasons for this were wide-ranging, including sessions generating "*more questions than answers*", "*getting caught up in past events*", and not having "*sufficient time to discuss a plan*".

> *"As much as we've got a really good insight into the person, there was no outcome like, well, what are they supposed to do and often felt like messaging whoever it was being like hope you're alright after that because that was quite heavy, and I don't know if you've got the answers you needed".*

Another participant said:

> *"If somebody leaves with a more robust careplan that in itself is an incentive, and then formulation demonstrating its utility to people who are quite practically minded".*

These extracts suggest that for TF to be helpful for staff, the discussion needs to balance formulating SU's difficulties with creating a "*robust plan*". A lack of a plan left staff feeling a sense of being burdened by the emotional impact of formulating the SU, with no clear direction on how to proceed. One participant reported that a lack of a clear plan discourages "*practically minded*" staff from attending, as they require a plan in order to recognise the value of TF. Most participants also reported not being aware of progress made with outcome plans beyond the TF meeting unless it was raised in informal conversations with the staff directly involved. One participant said:

"We don't really get feedback unless I've said to someone in passing, "How did you get on with that patient, or what's happening with them?"

Several participants expressed a desire for structured follow-up and "*review*" of TF outcomes during weekly MDT meetings. Other participants expressed a want to be able to access team formulations and outcome plans retrospectively, for example, if they were unable to attend the session.

"I…wondered was the sort of that was trying to capture it now where is it? Is there a record of that? Where is that?"

Theme 3: Barriers to Participation

This theme explored staff's experiences of the perceived barriers to active participation in TF discussions. While most participants reported "*feeling comfortable*" contributing, several commented that this was not the case for all staff:

"I'm quite a confident person I don't necessarily worry about talking…but I can obviously appreciate that some people aren't as confident expressing their views".

One participant described feeling less comfortable initially and that it took time and encouragement from her supervisor, who was a psychologist, to develop the confidence to contribute:

"I…sat in the background in the beginning…(but) as formulations have gone on, I personally got a bit more comfortable…contributing to them. But I would probably give a lot of credit to my supervisor for that".

This extract suggested that encouragement and support from a supervisor can help staff to develop the confidence to contribute to TF discussion. However, this support might only be available to some staff and may also depend on the supervisor's interest and level of involvement with TF. Another participant commented that while she feels comfortable contributing to TF discussion, her contributions hinged on whether she felt knowledgeable about the SU's background history and clinical presentation:

"For me, not so much unless it's a situation I know a lot about…everything else I'd be more interested to know what everyone else's opinion was"

Here, participation depended on staff's perception of their own expertise, with them contributing only if they felt they were able to offer specialist knowledge. Without this sense of expertise, staff in the MDT may prefer to remain quiet and listen to the contributions of others. Additionally, participants reported a tendency for certain staff members to contribute routinely to the discussion based on their experience and position held within the team. This contrasted with new and less experienced staff who were more likely to remain quiet:

"The usual suspects that normally pipe up during the bigger discussions would be clinicians that have been around for a long time or senior members of staff like the Band 7's or the medics, but you don't tend to hear the junior members".

This participant draws attention to a potential link between staff grade, length of time within the team, and feeling comfortable contributing to TF. Experienced senior members regularly contributed, while junior, less experienced staff had a tendency to give less input. For less experienced team members, navigating the hierarchy within the MDT presented a further obstacle to *"piping up"* and contributing to the discussion. This felt sense of one's place in the team hierarchy may have reinforced the notion that for some staff, contributing hinged on having a sense of expertise on the subject matter. Some participants also reported a noticeable decrease in contributions following the move from in-person to online TF meetings.

> *"It's quite easy for people to not contribute because they're sort of behind the screen, and they're not in person…they don't feel like they have to input".*

In contrast with in-person sessions, online sessions permitted some staff to remain silent or keep their cameras off, making it difficult for other staff to gauge their engagement with the TF discussion. This appeared to perpetuate a pattern of reduced online participation. Another participant commented more generally on the challenges of interacting with the team online, such as finding natural breaks in the conversation to express their viewpoint:

> *"Being on teams, it can be difficult to have a conversation when… there's back and forth between two or three people…to then sort of interrupt that and say, actually, this is what I want to say".*

Here, we see how the challenges of online meetings compound the obstacles to engaging with TF, particularly for less experienced staff, who may struggle to find

opportunities to interrupt the regular "*back and forth*" between more vocal or experienced team members.

Theme 4: Strengths and Weaknesses of the 5P model

This theme explored the strengths and weaknesses of the 5P model, the current framework used to structure TF sessions, along with staff's views on introducing alternative models.

4.1 Strengths of the 5P model

All participants reported that the 5P model was "*in-depth*", "*clear*" and provided "*structure*" to the discussion. Some participants noted that the model helped them to "*think psychologically*" and to see the links between the different categories. One participant commented:

> *"You can see where the sort of strands of the conversation into which sort of categories it leads".*

One participant also shared that the 5P model was a helpful frame of reference when preparing to bring a client to TF.

> *"If you're bringing someone to formulation, you've got in your mind that you will…discuss those different aspects. Have you got all that information and…is there discussion you can have with the patient before?"*

4.2 Weaknesses of the 5P Model

Two participants reported that while the 5P model provided a structure for in-depth discussion, its weaknesses perhaps "*mirrored the strengths*".

> *"You do feel limited to talking about those five areas, and there might be other things going on for that patient that aren't discussed in as much detail".*

This extract highlights the limitations of the 5P model in constraining the discussion to five specific areas, at the expense of other important factors that may not be covered, such as more "*creative*" and "*solution-based*" thinking. Some participants reported that 5P terminology "*throws me off*" and is "*difficult to get used to*". This was evident when all the participants struggled to recall the 5P terms during the interviews:

> *"I can't remember, if at the start of formulation, maybe to check in with people to see 1. If they had done formulation before 2. If they understand what it's for 3. If they understand the five p's cause, I'd be like oh yeah, no, definitely".*

According to this participant, staff often found 5P terminology challenging to understand but may feel uncomfortable raising this. This suggested a need for a "*check-in*" at the beginning of TF and the need for clear and regular guidance on the 5P language.

4.3 Exploring New Models

With one exception, all participants expressed an interest in exploring new TF models. However, none of the participants could identify alternatives due to a lack of

experience with other models. The rationale put forward for introducing new models included bringing a sense of "*variety*", using a model with "*less terminology*", and one that best fits the client's clinical presentation. One participant said.

> *"I think it's important to not just stick to something because it's comfortable, and like I say, if there was quite a complex case, then yeah, it might benefit from having a different model that suits better to talk about that person".*

However, one participant expressed concerns about introducing new models, stating that a lack of familiarity could impact on attendance and make team members feel more uncomfortable contributing to TF discussion.

> *"If it was made more complicated, you know, people might not want to attend, or they might not feel that they can contribute to it, or you really need some, you know, proper training to be able to use the model".*

This participant suggested that if new formulation models were introduced, sufficient training on the theory and application would be important to facilitate staff engagement.

Theme 5: Service User and Carer Involvement: Opportunities and Obstacles

This theme explored staff's views on SU and carer involvement in TF, including discussion regarding opportunities and obstacles, the potential impact on staff and SU's, and practical considerations were this to be introduced.

All participants reported being open to involving SU's and carers in TF. Participants described the prospect as "*person-centred*", "*fantastic for information*

gathering", and helpful if staff were "s*tuck*" on how to move forward with a SU. SU's and carers might also benefit from the "*lightbulb moments*" generated from TF discussion and a clearer understanding of the team's thinking, as well as the opportunity to have their say. This approach would also encourage the "*sharing of power*" and foster a sense of "*ownership*" over SU's treatment plans and overall well-being. Further, half of the participants questioned whether it was in fact "*ethical*" for TF to take place, as it is currently, without the SU's knowledge or input.

Nevertheless, participants also reflected on the potential challenges of SU and carer involvement. For example, the impact of SU's being in a room with "*lots of people*" who know "*every single thing that's ever happened to them*", which might then make them feel "*under the microscope*". One participant said:

> *"They might feel that there's certain things that they couldn't address or would feel unsure whether they can talk about, especially…if there was historical abuse or things that that patient hasn't necessarily you know, disclosed to our team but is in the notes".*

This extract highlighted the possibility of TF being too exposing for SU's, potentially making them feel uncomfortable disclosing personal information in the presence of unfamiliar staff. Additionally, those unfamiliar staff would likely be privy to sensitive details pertaining to the SU through MDT discussions and Carenotes, raising possible confidentiality concerns.

Participants also highlighted that SU's discussed at TF were often individuals who were acutely unwell or in crisis and may not have "*insight into their needs*" or "*acknowledge that there is a problem*".

> *"When we bring people to formulation, it's often when their backgrounds are quite complex…so it may be difficult for them to engage in the process and quite upsetting emotionally for them".*

Here, we see the participant emphasising the potential challenges of SU's participating in TF when struggling with acute mental health difficulties. This suggested that careful consideration should be given on a case-by-case basis to determine whether involvement in TF is in the SU's best interests at that time.

Participants also reflected on the potential impact on staff's experience of TF. Participants reported that a key component of TF was having the space to reflect honestly on the emotional impact of working with SU's. There were concerns, therefore, that involving SU's and carers would "*deprive staff of having that safe environment*" to discuss these challenges.

> *"Staff members not being open, and you know, even just talking about how that patient makes them feel, they wouldn't be able to do that as part of formulation, which I think is really important".*

Participants put forward several ideas to help mitigate these challenges. Specifically, how to make TF less "*exposing*" for SU's and carers whilst also protecting the space for staff to be able to discuss the emotional impact of SU's. These included: 1. Having a separate "*follow up*" meeting for SU and carer involvement, 2. Offering the option of "*joining remotely*" if this was perceived as less "*intimidating*" than in person, 3. A "*pre-meeting*" for carers allowing staff to provide information and answer questions about the TF process 4. Reducing the staff group in attendance to those who have a pre-

existing relationship with the SU, and 5. Small gestures to help SU's and carers feel more comfortable, such as offering hot drinks.

Discussion

This project aimed to evaluate TF in the Oxford OA CMHT. TF remains an under-researched area, although a small but growing body of research is emerging. Most of the existing research is quantitative and varies in quality (Bealey et al., 2021). This study represents one of the few conducted within an OA community setting using qualitative methods. Six participants, representative of the range of disciplines within the MDT, participated in semi-structured interviews. The interviews explored participants' perceptions of the usefulness of TF, and the barriers and challenges to the current format.

All participants reported valuing TF, describing, it as an opportunity for in-depth, psychologically focused discussion on a single SU, distinct from weekly MDT case discussions, which typically focused on issues related to diagnoses and social care. TF was found to encourage staff to think about SU's from a psychological perspective and to develop formulation skills, such as linking early life experiences with the current presenting difficulties. This psychological thinking often extended to staff's clinical practice outside of the TF, for example, by reframing behaviours that were challenging as indicators of insecurity and distress. These findings corresponded with previous studies, which found that TF helped staff to develop a shared and enhanced understanding of the SU, as well as generating ideas for treatment plans (Hollingworth & Johnstone, 2013; Berry, 2016).

Participants also valued learning from MDT colleagues' perspectives, particularly psychology colleagues, whose approaches they might otherwise have limited exposure to.

The findings support attribution theory, suggesting that engaging in TF can lead to a shift in staff's beliefs and interpretations of challenging aspects of SU presentations, helping to build and sustain empathy (Kellet et al., 2014).

Regarding the 5P model, all participants reported that it provided a helpful structure for integrating theory and understanding of the SU, supporting psychological thinking, and identifying links between the different categories within the model. Participants also noted that the model influenced their clinical practice, for example, by prompting them to ask about early life experiences during assessment. However, some participants raised concerns about the model's complex terminology. For example, one staff member felt that it might discourage staff, particularly newer staff from speaking up, thus impacting negatively on engagement with TF.

Further, some participants felt that the 5P model was too rigid and restricted thinking to the five categories at the expense of more creative and solution-focused thinking. While all participants expressed a willingness to experiment with new models, they were unable to recommend any alternatives having only experienced the 5P model. Most participants suggested that additional training on the theory and application would be necessary were new models be introduced to the staff team. For one participant, this related to concerns that introducing new models without adequate training may further reduce staff engagement by increasing feelings of uncertainty and a lack of confidence.

All participants highlighted the need for a clear outcome plan to be developed and agreed upon during TF. Participants noted that TF discussions largely focused on the SU's background, leaving insufficient time for action planning. One participant reported that this led some team members, particularly more "*practically minded*" staff, to question

whether the process was a good use of time. Further, the lack of a clear plan and the sense of being left with "*more questions than answers*" led some participants to experience increased stress and a sense of overwhelm, echoing findings from Charlesworth's (2010) study. However, participants reported more positive experiences and outcomes when a clear plan was established.

Participants also raised the need for regular review of outcome plans, noting that in the current format it is difficult to gauge progress or determine whether plans have been effective. One participant emphasised the need to overhaul the supervision structure to ensure the learning from TF is integrated into care plans and to support staff in understanding and applying psychological thinking in their clinical practice. Another participant raised concerns about data storage and not knowing where to access formulations retrospectively. For example, in instances where staff become involved in a SU's care months after the TF has taken place.

All participants expressed a willingness to trial SU and carer involvement in TF. Staff spoke positively about the potential benefits, such as improved information gathering and empowering SU's to contribute to and take ownership of careplans. However, participants also acknowledged the potential challenges that could arise from this. For instance, the SU's brought to the TF are often in crisis and may therefore not be in a position to participate meaningfully in the discussion at that time.

Further, participants valued having a space to process difficult emotions, speak candidly about the impact of working with SU's, and receive support from colleagues. This finding mirrored those of Dexter-Smith’s (2015) study, also conducted in an OA service, which found that TF provided sense of containment, allowing staff to discuss and make

sense of emotive SU presentations. There was concern that this supportive space would be lost if SU and carer involvement were to be introduced. As a result, several participants suggested having a separate meeting from the main TF for SU's and carers.

Limitations

Whilst those who participated were representative of all disciplines within the MDT, a limitation was that only one representative was interviewed from each discipline. Since the interviews were conducted, there have also been significant changes in team personnel, with over half of the participants no longer working in the team. Additionally, the researcher was on placement with the team for 6-months in 2020/21. which may have influenced how freely participants responded despite assurances regarding confidentiality.

Service Recommendations

The following recommendations were based on the issues raised during participant interviews and were discussed with team members during the feedback and reflection session held on 20th October 2022, prior to developing the implementation plan.

Table 1

Summary of Recommendations

Recommendation
1. Re-introduce TF training for new starters and offer refresher sessions for existing team members.
2. Provide an overview of TF and the chosen model at the beginning of each session, including setting mutual expectations (e.g., having cameras on and active participation).
3. Give 'quieter' team members opportunities to participate and ensure contributions to the discussion are representative of the MDT team.
4. Encourage presenters to clearly state their aims for the TF session at the beginning and review these at the end.
5. Allocate a timekeeper to ensure adequate time allocation for developing outcome plans.
6. Supplement the complexity of 5P terminology with simpler alternatives to support staff understanding.
7. Assign specific actions to individual staff members and review these monthly, including evaluating the TF process.
8. Explore the possibility of introducing a new TF model accompanied by staff training on its theory and application.
9. Consider trialling SU/Carer involvement as a separate meeting from the main TF sessions.

Recommendation
10. Create a shared folder for SU formulations and outcome plans, enabling staff to access them retrospectively.

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Theory Driven Research Project

Exploring the Link Between Depression, Masculinity Adherence, and the Mediating Role of Emotional Regulation: A Mixed Methods Study

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Proposed Journal: Journal of Psychology of Men and Masculinities was chosen for its focus on research exploring the experiences of boys and men, particularly in relation to gender norms, mental health, and emotional functioning.

Abstract

Theory Driven Research Project

Aim: This study aimed to explore the relationship between adherence to traditional masculine norms and depressive symptoms, and the potential mediating role of emotional regulation. A qualitative component examined men's experiences of and conformity to masculinity over time and its influence on mental health coping strategies.

Method: A mixed-methods design was used. In Stage 1, a cross-sectional online survey was conducted with 292 men to assess depressive symptoms, adherence to masculine norms, and difficulties in emotional regulation. In Stage 2, semi-structured interviews were conducted with a subset of participants (n=6), who scored highly for depressive symptoms and adherence to masculinity in Stage 1.

Results: Quantitative analyses showed that greater adherence to traditional masculine norms was associated with higher levels of depressive symptoms and greater difficulties in emotional regulation. However, difficulties in emotional regulation did not significantly mediate this relationship. Qualitative findings highlighted the influence of early socialisation, male role models, and educational experiences in shaping masculinity. While participants reported evolving views on masculinity, most continued to rely on male-typical coping strategies, such as self-reliance and emotional suppression.

Discussion: The findings provide further evidence for the link between traditional masculinity, depressive symptoms, and difficulties in emotional regulation. The lack of a significant mediation effect suggests the need for replication in clinical samples to further investigate emotional regulation as a potential mediator, as well as other possible

mediating variables. Qualitative findings suggested that for participants masculinity is a socially constructed and evolving identity, shaped by early experiences and societal expectations, and subject to ongoing negotiation throughout the lifespan.

Keywords: *Masculinity; Depression, Emotional Regulation, Men's Mental Health, Coping Strategies, Gender Roles.*

Public Significance Statement

Adherence to traditional masculinity may be strongly linked to depressive symptoms and difficulties in emotional regulation. However, emotional regulation did not mediate this relationship, suggesting the need for further research either through replication, or by exploring alternative explanatory variables. Additionally, masculinity can also be understood as a social construct, shaped by early experiences and societal expectations, and subject to change throughout an individual's life.

Exploring the Link Between Depression, Masculinity Adherence, and the Mediating Role of Emotional Regulation: A Mixed Methods Study

Introduction

In recent years, attention on men's mental health has increased due to rising concerns about psychological distress. Suicide is the leading cause of death among men under 40, with men four times more likely to die by suicide compared with women (World Health Organisation, 2022). These statistics indicate a significant public health issue, exacerbated by barriers men often face in accessing mental health support, such as societal stigma and discomfort with traditional therapy approaches (Mahalik et al., 2020; Seidler et al., 2021).

While lifetime prevalence of depression, a significant risk factor for suicide, is similar for men and women, men often present with different clinical symptoms (Rosenfield & Mouzon, 2013). Boys and men are more likely to exhibit *externalising* behaviours, such as aggression, substance misuse and risk-taking, while girls and women are more likely to report *internalising* behaviours, such as anxiety or depression (Gong et al., 2024; Merikangas et al., 2010). These gendered expressions of distress suggest a more nuanced understanding of men's depressive symptoms is necessary to improve accessibility and treatment options.

The following section synthesises the literature on the factors influencing depression in men integrating theoretical perspectives and empirical findings to provide context for the current study.

Masculinity

Masculinity refers to traditionally male traits such as emotional control, independence, and being a provider (Kimmel & Bridges, 2018). These norms are shaped and reinforced by culture, family, and institutions (Addis & Mahalik, 2023). Traits associated with masculinity evolve over time in response to shifting social and cultural influences (Kilmartin & Berkowitz, 2014). However, strong adherence to traditional masculinity norms has been associated with risk taking, interpersonal difficulties (Berke et al., 2017), and negative health outcomes, including depression, aggression, substance abuse, and risk-taking behaviours (Wong et al., 2017).

Childhood Socialisation

The emphasis on masculinity typically begins in early life through childhood socialisation. Boys often receive messages that noticeably differ from those given to girls, helping define their emotional expression and coping strategies (Mahalik et al., 2022). Primary caregivers play an important role in the process of modelling and reinforcing masculine norms (Denham, 2023). For example, softer emotions like sadness are often encouraged in girls while emotional expression in boys is generally discouraged (Cassano et al., 2014). Rather than dictating specific emotional responses, gender socialisation may be better understood as shaping how boys interpret and manage emotions through internalised gendered self-schemas, cognitive frameworks that continue to influence emotional processing once in adulthood (O'Neil, 2015).

Cognitive and Experiential Factors

Building on the role of masculinity and childhood socialisation, cognitive and experiential factors may also shape how masculinity norms affect men's mental health. Men internalise beliefs about masculine norms to varying degrees; impacting how they interpret and respond to emotional experiences (Di Bianca & Mahalik, 2020; Vandello et al., 2013). These include descriptive norms ('boys don't cry') and prescriptive norms ('men should appear tough') which often discourage emotional expression such as anger, fear, as well as positive emotions (Runak & Lapinski, 2015). Men who strongly adhere to these norms are more likely to suppress their emotions, a behaviour that is linked with increased risk of depression, anxiety, aggression, and impaired emotion regulation (Iwamoto et al, 2018; Shephard, 2002).

The Gender Role Strain Paradigm (GRSP) (Pleck, 1981) explains how conflicting and restrictive masculine norms can cause psychological unease or stress when men feel they are not meeting or conforming to such expectations. When a man experiences unease or discomfort that he is not living up to societal expectations around masculinity, this can lead to overcompensation through exaggerated masculine behaviours and emotional avoidance (Lebeau et al., 2024). This form of masculine over-compensation is also linked to negative outcomes, such as mood disorders, aggression, and substance misuse (Reidy et al., 2016), highlighting the potentially longstanding nature of gendered risk factors in this area. The gender role strain paradigm views this gap between the lived experience of being a man and masculine expectations as relating to a particular form of stress referred to as 'discrepancy stress' (Pleck, 1981; Reidy et al. 2016), which we will return to in the below section on stress.

Emotional Regulation

Emotion regulation refers to the ways in which individuals influence the experience, expression, and adjustment of their emotional responses to internal or external stimuli (Gross, 2015). It can encompass a range of strategies, both conscious (such as cognitive reappraisal, or reinterpreting a situation to change its emotional impact) and unconscious (such as suppression, or pushing emotions down), that individuals use to manage emotional arousal. These strategies can be either helpful (adaptive) or harmful (maladaptive) depending on how they are applied (Aldao et al., 2010). Emotional regulation is not about eliminating or avoiding emotions altogether, nor is it limited to emotional suppression; rather, it involves modifying emotional responses in ways that support healthy functioning and well-being (Gratz & Roemer, 2004).

Gendered self-schemas or beliefs about oneself shaped by gender norms can also significantly affect how men learn to regulate emotions. Men who are socialised to conform to traditional masculine norms, such as restraint, self-reliance, and avoiding vulnerability, often learn to suppress certain emotional responses from an early age. This suppression can hinder the development of healthier, more adaptive regulation strategies and may result in difficulties coping with emotional experiences (Berke et al., 2018). Consequently, men may be more likely to rely on maladaptive strategies, such as emotional avoidance and suppression, which are associated with increased risk of depression and other negative mental health outcomes (Visted et al., 2018).

While extensive research has examined how women regulate emotions, often highlighting tendencies toward rumination or catastrophising (Nolen-Hoeksema, 2012; Garnefski et al., 2004), less attention has been given to how men regulate emotions,

particularly in relation to masculine identity. Emotional regulation has been proposed as a transdiagnostic mediator linking adherence to traditional masculinity norms with a range of negative mental health outcomes, including depression (Berke et al., 2018). However, further empirical research is needed to better understand this connection.

Psychological Stress

Exposure to both acute and chronic adverse or stressful events is strongly associated with the onset of depression in community and clinical samples (Hammen, 2005; Abravanel & Sinha, 2015). Stress, understood as a psychological construct, is a dynamic process involving cognitive appraisal, emotion regulation, coping strategies, social support, and developmental background (Hammen, 2005). For example, an individual's appraisal of an event can influence their behavioural responses, including their ability to cope. Appraisal may also function as an emotion regulation strategy; for instance, 'accepting' an event may reduce emotional arousal and contribute to improved mental health outcomes, including depression and anxiety (Min et al., 2013). Similarly, the use of adaptive coping strategies such as problem-solving, or seeking social support is generally associated with better mental health outcomes in the context of adverse events, in contrast to maladaptive strategies like avoidance or rumination (Compas et al., 2017).

Within the broader literature on psychological stress, the cognitive-vulnerability stress model posits that negative beliefs (e.g., hopelessness) can predispose individuals to depression when encountering adverse events (Mezulis et al., 2009; Hammen, 2005). Chronic exposure to stressors has also been shown to compromise emotional regulation, thereby heightening vulnerability to depressive symptoms (Abravanel & Sinha, 2015). With respect to gendered differences in cognitive vulnerability to stress, there is mixed

evidence that gendered differences in cognitive style may predict depressive symptoms (Mezulis et al, 2009).

As noted above, Gender Role Strain Theory (Pleck, 1981) posits that societal expectations around masculinity can produce a particular kind of stress referred to as 'discrepancy stress'. Stress in this context lies in the negatively valanced belief that one is failing to live up to traditional male gender norms. For example, the appraisal of an adverse event, such as job loss, might be influenced by internalised beliefs about failing to be 'the man of the house'. 'Discrepancy stress' (Reidy et al., 2016) can then result in men reverting to gendered expectations of masculinity (e.g., self-reliance) and so compromise willingness to engage in adaptive coping strategies with potentially negative mental health consequences, including depression (Wong et al., 2017).

Taken together, these models of psychological stress indicate the importance of understanding the role of stress in men's mental health and point to the need for further research into how beliefs about masculinity might influence how men cope in the context of adverse events.

Rationale for Study

Despite increasing research on men's mental health, gaps remain in understanding gender-specific factors contributing to male depression. Addressing these gaps is key to developing accessible and effective interventions. Studies suggest adherence to traditional masculinity is a risk factor for depression and externalising behaviours. However, the mechanisms underlying this connection are not adequately understood. One possible explanation is emotional regulation, which may be shaped by masculine socialisation and

associated with depressive symptoms. While emotion regulation may mediate a link between masculinity and depressive symptoms, this has not been empirically tested. Clarifying this relationship could help improve targeted interventions for men who strongly adhere to traditional masculine norms.

This study, therefore, explored whether emotion regulation mediates the relationship between masculinity and depressive symptoms**.** In addition, the qualitative component explored how a sense of masculinity develops across the lifespan and the potential role of adherence to masculine norms in shaping how men appraise and cope with stressful events. By employing a mixed-methods approach, the study aimed to provide a nuanced understanding of men's mental health in the context of masculinity, emotional regulation, and depression.

Hypotheses and Research Questions

Stage 1:

H1: The group with lower mood (higher Patient Health Questionnaire-8 scores [PHQ-8]) will show greater adherence to masculine norms (higher scores on Gender Role Conflict Scale [GRCS]) compared to the group with higher mood (lower PHQ-8 scores).

H2: Greater adherence to masculine norms (higher GRCS scores) will be associated with poorer emotional regulation (higher Difficulties in Emotional Regulation Scale scores [DERS]).

H3: Poor emotional regulation (higher DERS scores) will mediate relationship between lower mood (higher PHQ-8 scores) and greater adherence to masculine norms (higher GRCS scores).

Stage 2:

The qualitative component of study aimed to explore:

1. Messages participants received about masculinity during childhood, adolescence, and adulthood.
2. Extent to which these messages shaped their self-perception and influenced how they believed others perceived them.
3. Participants' experiences of masculinity over the lifespan and the potential influence of masculinity on how men cope with adverse or stressful events.

Method

Stage 1:

Procedure

This study used a comparative group design, in which participants completed an online survey. Participants were recruited through mental health charities and advocates on Twitter and Facebook (March-May 2023). The survey was conducted in four phases: the first phase collected basic demographic information and allowed participants to opt into an interview for the second stage of study. The second phase assessed severity of depressive

symptoms. The third phase examined adherence to traditional masculinity norms, and the fourth phase evaluated difficulties in emotional regulation.

Sample Size

A priori power analysis was conducted using G*Power (Faul et al., 2009) based on a two-tailed one-way ANCOVA with two groups. A medium effect size (d = .50) and an alpha of .05 were specified, indicating that 102 participants were needed to achieve a power of .80.

Inclusion and Exclusion Criteria

Participants had to:

- Be over 18
- Identify as biologically male,
- Be able to read English and provide consent.
- Score within the clinically relevant range for depressive symptoms (clinical group) or outside of it (non-clinical group).

Measures

Emotional Regulation Measure

The Difficulties in Emotion Regulation Scale (Gratz and Roemer, 2004) assessed challenges in regulating emotions across multiple domains, including identifying emotion, goal-directed behaviour, and impulse control.

Depression Measure

The Patient Health Questionnaire-8 (Kroenke et al., 2009) assessed severity of depressive symptoms such as mood, sleep problems and loss of interest.

Adherence to Masculinity Measure

The Gender Role Conflict Scale (O'Neil et al., 1986) assessed psychological distress related to traditional masculinity norms across several domains, including restrictive emotionality and work-family conflict.

Further details on these measures are provided in Appendix J.

Data Analytic Strategy

Normality was assessed using histograms and the Kolmogorov-Smirnov test. Levene's test for homogeneity of variance was applied for between-subjects t-tests and the ANCOVA. Mediation analysis assumptions (linearity, normality, homoscedasticity, and independence) were met. A one-way between-subjects ANCOVA examined differences in GRCS scores (adherence to masculinity norms) between depressive and non-depressive groups, using PHQ-8 scores as the independent variable and GRCS scores as the dependent variable. A multiple regression analysis predicted GRCS scores based on DERS scores (emotional regulation difficulties). Both analyses controlled for age, sexuality, and education, based on prior research indicating these factors can influence adherence to masculinity (e.g., age: Vandello & Bosson, 2013; sexuality: Griffith et al., 2011; education: Levant et al., 2020). Haye's (2018) PROCESS Model 4 mediation analysis was used to assess whether DERS scores mediate the relationship between PHQ-8 scores (depressive symptoms) and GRCS scores (adherence to masculinity norms).

Ethical Considerations

Ethical approval was obtained (CUREC Ethics no: R84009/RE001; Appendix G). Participants gave informed consent and were provided with mental health signposting after completing the survey.

Stage 2

Procedure

Participants who opted to be interviewed in Stage 1 were contacted in order of completing the survey, provided they met two criteria: a PHQ-8 score of 10 or higher and a GRCS score of 128 or higher (based on sample percentiles: 25th = 76, median = 100, 75th = 128). Before interviews, participants received information regarding the protocol via email and provided consent. Interviews (n=6) were conducted via Microsoft Teams, recorded using a separate device, and transcribed verbatim. An Oxford University Clinical Psychology Doctorate trainee reviewed a 20-minute sample of each transcript for quality and accuracy. To reduce bias, the primary researcher took part in bracketing interviews with the same trainee before and after the interview phase to reflect on personal biases and positionality (Smith et al., 2009).

Data Analytic Strategy

Interview transcripts were analysed using Interpretative Phenomenological Analysis (IPA) to explore participants' experiences of masculinity, coping responses to stress, and how their views changed over time and across different social contexts

(Pietkiewicz & Smith, 2012). This approach allowed for an in-depth understanding of how participants made sense of their experiences within their broader sociocultural frameworks.

Ethical Considerations

In addition to Stage 1 protocols, participants received a debrief session post-interview.

Patient and Public Involvement

Stage 2 was co-developed with input from a Patient and Public Involvement (PPI) group, including two men with lived experience of depression, who host a men's mental health podcast. Their feedback helped formulate the interview schedule's wording, appropriateness, and structure at three key stages: study proposal, question development, and finalisation of protocol.

Analysis Stage 1

Participants

In Stage 1, 292 participants completed the questionnaire. Descriptive statistics for demographic variables are presented in the tables below. Table 1 displays the overall participant demographics, while Table 2 presents the demographics for the low-mood and non-low-mood groups. More participants were recruited than initially required to enhance the study's statistical power, increasing likelihood of detecting true effects, reducing risk of Type II errors, and improving generalisability (Columb & Atkinson, 2016).

Table 1

Overall Participant Demographics

	Men (n=292)	
	Frequency	Percentage
Age group		
18-20 (1)	11	3.8
21-30 (2)	122	41.8
31-40 (3)	72	24.7
41-50 (4)	42	14.4
51-60 (5)	33	11.03
61-64 (6)	8	2.7
60+	4	1.4
Ethnicity		
White	213	72.95
Mixed/multiple ethnic groups	24	8.3
Asian/British	34	11.7
Black/African/Caribbean/Black	9	3.1
British		
Any other ethnic Group	12	4.1
Relationship status		

	Men (n=292)	
	Frequency	Percentage
In a relationship	191	65.4
Single	95	32.5
Other	6	2.1
Employment status		
Full-time employment	201	68.8
Part-time employment	26	8.9
Unemployed	17	5.8
Other	48	16.4
Level of Education		
GCSEs	16	5.5
A-Levels	40	13.7
Undergraduate	96	32.9
Postgraduate	140	47.9
Sexuality		
Heterosexual	223	76.4
Gay	37	12.7
Bisexual	24	8.2
Other	4	1.4
Prefer not to say	4	1.4

Table 2

Participant Demographics by Mood Group

	Low-Mood (n=99)		Non-Low-Mood (n=193)	
	Frequency	Percentage	Frequency	Percentage
Age group				
18-20 (1)	6	6.1	5	2.6
21-30 (2)	42	42.4	80	41.5
31-40 (3)	24	24.2	48	24.9
41-50 (4)	15	15.2	27	14.0
51-60 (5)	10	10.1	23	11.9
61-64 (6)	0	0	8	4.1
60+ (7)	2	2.0	2	1.0
Ethnicity				
White	81	81.8	132	68.03
Mixed/multiple ethnic groups	6	6.1	18	9.3
Asian/British	8	8.1	26	13.4
Black/African/Caribbean/Black	3	3.0	6	3.1
British				
Any other ethnic Group	1	1.0	11	5.7
Relationship status				

	Low-Mood (n=99)		Non-Low-Mood (n=193)	
	Frequency	Percentage	Frequency	Percentage
In a relationship	52	52.5	139	72.0
Single	42	42.4	53	27.5
Other	5	5.1	1	0.5
Employment status				
Full-time employment	63	63.6	138	71.5
Part-time employment	8	8.1	18	9.3
Unemployed	3	12.1	5	2.6
Other	16	16.2	32	17.6
Level of Education				
GCSEs	7	7.1	9	4.7
A-Levels	17	17.2	23	11.9
Undergraduate	39	39.4	57	29.5
Postgraduate	36	36.4	104	53.9
Sexuality				
Heterosexual	67	67.7	156	80.8
Gay	13	13.1	24	12.4
Bisexual	13	13.1	11	5.7
Other	3	3.0	1	0.5
Prefer not to say	3	3.0	1	0.5

Results

Hypotheses

H1: The group with lower mood (higher PHQ-8 scores) will show greater adherence to masculine norms (higher GRCS scores) compared to group with higher mood (lower PHQ-8 scores).

A one-way ANCOVA was used to examine how depressive symptoms affects adherence to traditional masculinity while controlling for age, sexuality, and education (Hayes, 2017; see Table 3). After adjusting for these factors, a significant difference in adherence to traditional masculinity was found between high and low PHQ-8 severity groups, $F(2, 287) = 47.96$, $p < .001$. However, none of the covariate's including age ($F(1, 287) = 1.91$, $p = .17$), sexuality ($F(1, 287) = 0.49$, $p = .49$), or education ($F(1, 287) = 3.75$, $p = .05$) were significantly associated with adherence to traditional masculinity.

Table 3

Adjusted and unadjusted means (with and without covariates of age, education, sexuality)

Depressive Severity	N	Unadjusted Mean	SD	Adjusted Mean	SE
High	99	109.63	22.03	122.90	2.35
Low	193	102.72	24.20	102.83	1.68

Note: N = Number of participants, *M* = Mean, *SD* = Standard Deviation, *SE* – Standard Error, *High* = Above cut-off (10 or above), *Low* = below cut-off (9 or below)

H2: Greater adherence to masculine norms (higher GRCS scores) will be associated with poorer emotional regulation (higher DERS scores).

A hierarchical multiple regression was used to examine impact of emotional regulation on adherence to traditional masculinity while controlling for age, sexuality, and education. The analysis was performed in two steps, details of which are provided in Table 4. In Model 1, which included age, sexuality, and education as predictors, a small amount of variance in adherence to traditional masculinity was explained (R^2 =.02, $F(3, 288) = 2.35$, $p = .072$). Model 2, which added Emotional Regulation as a predictor, significantly improved the explanation of variance ($R^2 = .30$, $F(4, 287) = 30.43$, $p < .001$). The addition of emotional regulation resulted in a statistically significant increase in explained variance ($\Delta R^2 = .27$), with a corresponding change in F-statistic ($\Delta F(1, 287) = 111.93$, $p < .001$).

Table 4

Hierarchical Multiple Regression Predicting Adherence to Traditional Masculinity from Difficulties in Emotional Regulation, Age, Sexuality, and Education

Adherence to Traditional Masculinity

	Model 1		Model 2	
Variable	B	β	B	β
Constant	113.91		176.88	
Age,	-2.02	-.10	-1.31	-.07
Sexuality	-2.18	-.06	-.86	-.02
Education	2.59	.10	2.35	.09
Emotional Regulation			-0.52	-.53
R^2	.02		**.30**	
F	2.35		30.43	
ΔR^2			**.27**	
ΔF			111.93	

H3: Poor emotional regulation (higher DERS scores) will mediate the relationship between lower mood (higher PHQ-8 scores) and greater adherence to masculine norms (higher GRCS scores).

The indirect effect of emotional regulation difficulties on the link between depressive symptoms and adherence to masculinity was tested using the PROCESS 4 mediation analysis (Hayes & Preacher, 2014), which included 5,000 bootstrap resamplings and 95% confidence intervals (CI). PHQ-8 scores were the predictor, GRC scores were the outcome, and DERS scores were the mediator. The results (see Table 5 and Figure 1) showed that emotional regulation difficulties significantly predicted higher adherence to masculinity and greater depressive symptoms (β = 1.91, 95% CI [1.49, 2.33]). However, emotional regulation difficulties did not significantly mediate relationship between depressive symptoms and adherence to masculinity (indirect effect β = 1.28, 95% CI [0.82, 1.75]). The direct relationship between depressive symptoms and adherence to masculinity remained significant (β = 0.64, 95% CI [0.04, 1.25])

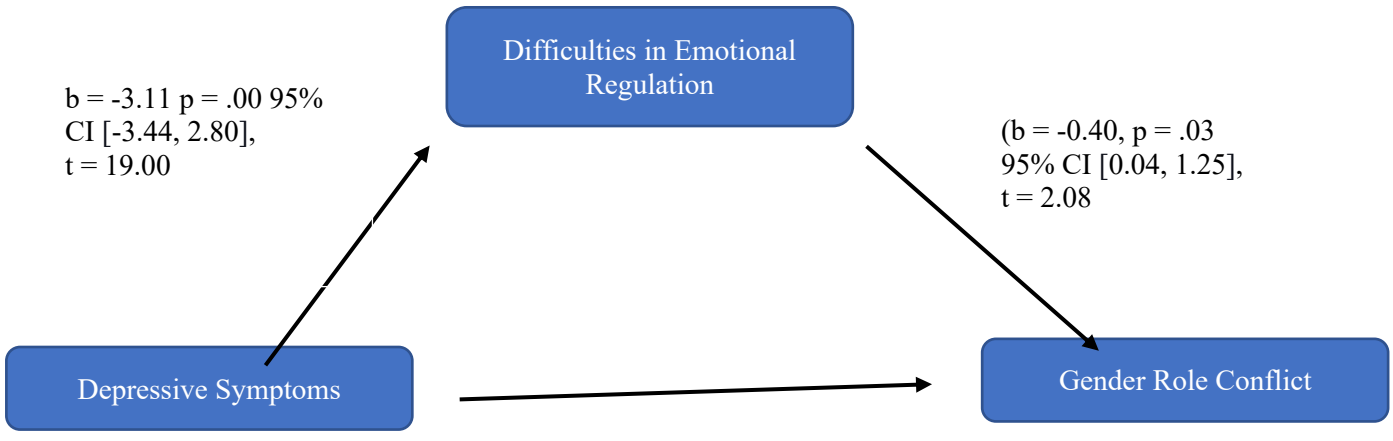
Table 5

Mediation Analysis Results: Direct and Indirect Effects of Depressive Symptoms on Traditional Masculinity via Emotional Regulation Difficulties

Relationship	Total Effect	Direct Effect	Indirect Effect	Confidence Interval Lower	Confidence Interval Upper	Conclusion
Depressive symptoms > difficulties in emotional regulation > adherence to traditional masculinity	*1.91 (.000)*	*0.07 (.04)*	*1.28*	*0.04*	*1.25*	*Direct-only (no mediation)*

Figure 1

Path Model of the Relationship Between Depressive Symptoms, Emotional Regulation, and Traditional Masculinity



Stage 2

The IPA analysis identified four superordinate themes and eight subordinate themes, as discussed below.

Theme 1: Familial Role Models and Traditional Masculinity Development in Childhood

This theme explored participants' experiences with different traditional and non-traditional parental role models, and how these messages integrated into their developing understanding of masculinity and sense of identity during childhood.

Example Quotes:

Quote 1: "So…when I was younger, it's maybe a little bit different from other folks in that I had women around me a lot. I think my mum probably tried, probably quite liked to teach me about being a man. It's about being kind or the kind of nice things that…we try to see masculinity as now" - **Peter, aged 20-30**

Quote 2: "I had an unusual situation, unusual childhood …So, my dad, he's not a very masculine person…he stayed at home to look after me when I was young, and my mum went out to work….So, he was like the main caregiver" - **Jamal, aged 40-50**

Quote 3: "Well, my father was…a classical provider, so the man of the house in my household was the main breadwinner. He worked very hard, but he provided for myself and my mother" - **Ralph, aged 20-30**

Quote 4: "Yeah, I suppose…being calm, being resolute. Being I don't know if "strong" is the right word. You know, resolute in the face of adversity. So yes, I suppose that's the example that was set for me by my father" – **Henry, aged 20-30**

Quote 5: "It seemed like following masculine… norms, stereotypes just seemed silly. Like, why? Why are people like that? They seem like a cartoon character" - **Jamal, aged 40-50**

Quote 6: "Being a man for me, I suppose it's just replicating my dad's approach" **Henry, aged 20-30**

Quote 7: "I had this view of the male role model as somebody that provides for his family" - **Ralph, aged 20-30**

Quote 8: "Looking back now…I'm probably a little bit conflicted because it didn't always match what I felt was maybe in school or in social groups" – **Peter, aged 20-30**

Peter and Jamal described their experiences growing up in what they perceived as "*unusual*" home environments, marked by non-traditional parental roles. Peter, who was raised without a male role model, learned about masculinity from his mother, who emphasised kindness and rejected traditional male stereotypes (Quote 1). Similarly, Jamal's father, the primary caregiver while his mother worked, also challenged traditional gender roles. His father's unconventional interests and being labelled "*weird*" by Jamal's peers, highlighted their atypical family dynamic (Quote 2).

On the contrary, Henry and Ralph grew up with strong male figures who embodied traditional masculine traits. Ralph viewed his father primarily as the *"classical provider"*, with caregiving secondary (Quote 3). Henry's father, with support from his mother, taught him to approach life with a sense of calmness and determination (Quote 4).

Except for Peter, all participants noted that their early family experiences strongly shaped their views on masculinity into adulthood. Influenced by his upbringing with a non-traditional male role model, Jamal rejected conventional masculine norms as "*silly*" and "*caricature-like*" (Quote 5). In contrast, Henry and Ralph followed examples set by their fathers, adopting more traditional masculine traits (Quotes 6 and 7). Peter, however, experienced conflicting expectations at home and school, leading to ongoing confusion and challenges with masculinity in adulthood (Quote 8). Read together, the participants' accounts highlight the longstanding influence of early narratives around masculinity beginning in the home, including those that go against the grain of traditional views.

Theme 2: Schooling's Impact on Traditional masculinity: Conformity or Defiance

This theme explored how peer experiences at school influenced participants' developing identity in relation to traditional masculinity. Participants reported experiences

of either ‘fitting in’ or ‘standing out’, in relation to what was regarded as a traditional sense of masculinity. In particular, the experience of fitting in or standing out related to, for example, pressure to be physically dominant in sports or emotional displays other than accepted male emotions (e.g., vulnerability).

2.1 Expectation to Conform to Physical Strength and Masculine Norms

Example Quotes:

Quote 9: You would have competitions with your friends to be the strongest and that's a boy thing to do **(Jerry, 40-50)**

Quote 10: Boys as a bit chaotic…lots of rough and tumble, action-men type figures, very combat-oriented…not in malevolence…just very…into physical things…like rugby **(Ralph, 20-30)**

Quote 11: It was often young lads would...couldn't control their emotions and feelings that you would see it. And that would normally be violence or aggression….violence as a reflection of their feelings or their unmet needs **(Peter, 20-30)**

Quote 12: Yeah, I'd say secondary school….I guess there were at that point…the sporting guys, the alphas of the school or whatever **(Jamal, 40-50)**

Quote 13: I don't remember any discussions on mental health or masculinity or gender happening in primary school at all….maybe it was the influence of having girls there and them being able to neutralise all of those hyper-masculine ideals **(Henry, 20-30)**

Quote 14: I think that was quite stark in terms of their expectations of what a man does or how a man should act and that was with very little, very little emotion **(Henry, 20-30)**

Four out of five participants reported that pressure to conform to masculine norms increased in secondary school; with a stronger focus on “*competition*”, “*dominance*” and emotional restraint, reinforced through playing sports such as rugby (Quotes 9, 10, 11, 12). Peter observed that violence and aggression were common in his all-male secondary school and interpreted such behaviours as a way for boys to channel distress.

Henry, who attended a mixed-gender secondary school, found that while “*hyper-masculine ideals*” were present, female students had a “*neutralising effect*” and created space for some emotional expression (Quote 13). However, at his all-boys sixth-form

college, Henry experienced stricter expectations for masculine behaviour and emotional control (Quote 14).

2.2 Struggling to Fit in and Feeling Different

Example Quotes:

Quote 15: I think I got a hard time at school…just because I was different. Like people would call me things **(Peter, aged 20-30)**

Quote 16: I think I…had the persona of an outsider by that point. So…it wasn't like it wasn't something I felt like I belonged to or something that I felt that I wanted to belong to **(Jamal, aged 40-50)**

Quote 17: I…preferred going to socialise in the playground with the girls rather than the boys. And the reason was… girls were more into… delicate things that didn't involve physical contact **(Ralph, aged 20-30)**

Like Harry and Jerry, Jamal and Ralph, felt pressured to conform to expectations of physical strength and dominance at secondary school, but either struggled or resisted. Ralph found the transition from a mixed-gender primary school to an all-boys secondary school challenging and preferred spending time with girls who took part in less physical activities.

Jamal, raised by a non-stereotypical male role model, distanced himself from the pressures of masculinity, seeing them as "*artificial*" and "*uninteresting*". He preferred watching niche films and creating his own language through imaginative play. However, this made him feel, a lack of belonging and sense of "*difference*".

Peter also had difficulty 'fitting in', as he refused to take part in physical fights, which led to him being bullied and having a "*hard time*" at school. For these participants, not meeting traditional masculine expectations often resulted in feeling "*different*", or a sense of 'otherness'. Read together, the accounts indicate the power of masculine-based hierarchy in school settings and the effects of this on individuals who struggle to conform or have to find their own way of being without directly conforming.

Theme 3: Reframing Masculinity in Adulthood: Defining a 'Good Man'

This theme explored how adulthood offered opportunities for participants to redefine their sense of masculinity. Participants spoke about how adulthood allowed them to develop their own ideas of what it means to be a *'good man'*, a sense of being a man that might feel more comfortable or offer opportunities for growth. This theme suggested a complicated negotiation between traditional expectations of masculinity and more alternative perspectives as participants sense of identity as men evolved over time.

3.1 Developing a New Sense of Masculinity in Adulthood

Example Quotes:

Quote 18: Being a good partner to X and cooking and cleaning… I've (also) mentioned before about being a father and…that transition of wanting to be a father, feeling those feelings of caring father feelings…. **(Peter, aged 20-30)**

Quote 19: I'm quite comfortable being a man now. I think I do it quite well….Being…more comfortable in myself, not feeling as if I have to prove everything all of the time. I feel nowadays that I am a man, that that's what being a man really is **(Jerry, aged 20-30)**

Quote 20: You're allowed to become a lot more serious. You're thinking about things in the future. And…that's…the time to turn into or have an idea, really pull an idea about what sort of man you want to be and then try and turn into it **(Henry, aged 20-30)**

Quote 21: Yeah, there are lots of things that you should and shouldn't do and I know what they are. But it seems such a tiny box of behaviour that you can be involved with **(Jamal, aged 40-50)**

All participants, except Jamal, described how their sense of masculinity changed after leaving secondary school. With less external pressure to conform, they felt more able to define what being a "good man" meant to them, even if differed from conventional norms.

For example, Peter embraced nurturing qualities, seeing tasks like cooking and cleaning as preparation for fatherhood (Quote 18). Jerry felt more "*comfortable*" after redefining his masculine role, having let go of need to "*prove everything all of the time*"

(Quote 19). Similarly, Henry valued the freedom to shape his identity without following societal expectations (Quote 19). Jamal, however, remained detached from societal pressures, viewing masculinity as a narrow set of behaviours (Quote 21).

3.2 Incorporating Traditional Masculinity into an Idiosyncratic Understanding

Example Quotes:

Quote 22: It's often physical, I can't deny…you know, like when I help people move house, you know, carry lots of boxes, that feels more male **(Peter, aged 20-30)**

Quote 23: I'm not saying it's a competition…if (partner's name) did earn more than me, it wouldn't matter, but I do see the man as the breadwinner **(Peter, aged 20-30)**

Quote 24: I'm…very physically protective of pretty much everybody in my family….I (also) see it as my job to… provide for my partner and…eventually for our children **(Ralph, aged 20-30)**

Some participant accounts suggested that part of the transition to a more personal sense of masculinity involved integrating traditional masculine values. Peter, for example, affirmed his masculinity through physical activities like going to the gym and moving boxes (Quote 22). He also aspired to be the primary breadwinner, earning more than his female partner (Quote 23).

Similarly, Ralph felt a strong sense of responsibility to protect his family and stayed alert in public to ensure their safety. He also sought a partner who shared his traditional views and expectations on gender roles (Quote 24). These examples show how Peter and Ralph adapted masculinity to fit their evolving values, keeping aspects they found meaningful while letting go of those they did not. Compared to their earlier experiences in secondary school, these accounts point to resonance rather than pressure in terms of evolving role of traditional masculinity in participants' sense of identity as men.

3.3 Reciprocal Nature of Masculinity and the Role of Being Perceived as a Man

Example Quotes:

Quote 25: I think it's something you have to bear in mind when talking to other people. It's something that is …undeniable **(Jamal, aged 40-50)**

Quote 26: I've lost a lot of weight in the last year…a lot of weight. And I've noticed that people treat me differently just from that alone **(Jerry, aged 20-30)**

Quote 27: Being a man probably helps…in my particular line of work, seen as a trustworthy pair of hands or something **(Jerry, aged 20-30)**

Quote 28: I'm…hesitant to invite a woman because I don't want her to think it's something that it's not….Or if I do approach a female colleague…I will try and insert subtle signals that it is…completely professional **(Ralph, aged 20-30)**

Quote 29: It comes down to the underlying threat of physicality…I've had a couple of bosses who…treat blokes, particularly blokes that are physically stronger than them, slightly different in the way they react, how they treat each other **(Ralph, aged 20-30)**

All participants reflected on how their sense of identity as men was influenced by social contexts and expectations and perceptions of others. Although Jamal did not strongly identify with traditional masculinity, he acknowledged that being a man was "*undeniable*" and considered this when interacting with others (Quote 25).

Jerry noticed that after losing weight, he received more attention from both men and women; more women smiled at him, while more men started fights with him. He wondered if this made him seem more attractive and less intimidating to women or possibly weaker or more threatening to men (Quote 26).

Jerry also found that being a man was seen positively in his job, where masculine traits like "*strength*" were associated with being a *"good gardener"* (Quote 27). Ralph was also conscious of his masculinity at work and took care to avoid behaviours that could be misinterpreted as sexual advances (Quote 28). He also observed that men were treated

differently based on his bosses' unspoken judgments about their "*physicality*" and "*strength*" (Quote 29).

3.4 Adapting Masculinity to Context

Example Quotes:

Quote 30: I realised…I needed to…put on some kind of performance… to get on with most guys….that was definitely a moment when I realised, "Oh, like, I can't be myself. I've got to pretend to be like that **(Jamal, 20-30)**

Quote 31: I don't want (some people) to know what I had for breakfast, let alone how I was feeling in this particular situation because…you'd be constantly worried that…(their) judgment doesn't fit up to the ideals…that you think they set for someone like you **(Henry, 20-30)**

Quote 32: Yeah, I guess you're much more risk-averse and guarded in the workplace because you know that there are actually people actively trying to get to you, and it's not a crazy conspiracy **(Ralph, 20-30)**

Linked to the role of being perceived as a man in participants sense of masculinity, several participants also reported adjusting their sense of maleness according to differing social contexts. After experiencing rejection for not fitting traditional masculine norms, Jamal felt pressure to "*perform*" masculinity by discussing topics like sports in order to connect with men (Quote 30). Harry carefully assessed whether expressing emotions would be accepted in different situations, choosing to hold back if he anticipated judgment or disappointment (Quote 31).Ralph balanced his personal and professional identities by adapting his behaviour. At work, where the culture was competitive, he embraced traditional masculinity by supressing his emotions. At home with his partner, he felt freer to express vulnerable emotions (Quote 32). This sub-theme highlights the performative quality of masculinity, heightening or reducing masculine characteristics to achieve social acceptance or achieve personally meaningful goals.

Theme 4. Navigating Emotional Suppression in Men: "Boys Don't Cry"

The final theme builds on the idea of masculinity as a negotiation, focusing on how participants managed expectations around gendered emotional expression, such as a pressure to conceal emotions. The theme also highlighted instances where participants, in developing their identities as men, were able to go against the grain of masculine expectations around emotional expression by expressing emotions more openly.

4.1 Felt Pressure to Manage Stress Independently and Indirectly

Example Quotes

Quote 33: I'm someone that really benefits from exercise…my brain chemistry really responds to it….Reaching out to my friends and family, that kind of thing. And just talking to them, but not about what I'm feeling necessarily, just stuff **(Peter, aged 20-30)**

Quote 34: I would say…doing anything that I can to help mitigate it, even though I can't fully control the thing. So, for example, if there's an interview or meeting, prepare very thoroughly for that and go in armed to maximise the chances of a good outcome….Pretty much every day I go to the gym or do some sort of physical exercise. If it's stress because there's a very acute time pressure, then I tend to become more insular, and I generally will just focus on getting done what needs to be done and not really interact with other people until the things done **(Ralph, aged 20-30)**

Quote 35: I try and find something, someone that makes me feel really good, which is in a completely different arena to things that are making me feel bad….And I suppose there are certain people within that that I know are very good at really cheering me up and talking about stuff that is completely different **(Henry, aged 20-30)**

Quote 36: I used to run away from it. I used to just leave. So, if a customer was giving me stress, I would just ghost, not go back, don't answer emails. I've learned, I think through just knowingly, just face it, face it and get through it quicker. Like rip the Band-Aid off, like rip the plaster off. **(Jerry, aged 30-40)**

Quote 37: I keep myself constantly busy all the time, so I don't have time to think about anything. I take on massive projects….So, yeah, I'll realise that that's…why I always want… to be alone cause I feel like I don't like my own behaviour….So, I don't want to, in any way, be a burden to my family (wife and two children). ….For example, I will get in the car and drive for a few minutes into the countryside and just be there by myself and not do anything **(Jamal, 40-50)**

Although all participants developed their own views on masculinity over time and felt less pressure to conform to stereotypes, they still felt need to follow male-specific coping styles, such as managing stress independently (e.g., through solitary pursuits) rather than talking or asking for help.

Peter, Ralph, and Henry found physical exercise helpful for relieving stress (Quotes 33 & 34). Ralph also managed stress by focusing on things he could control, like preparing for a job interview (Quote 34). Jerry had recently started to face stress head-on instead of avoiding it and compared it to ripping off a "*Band-Aid*" to speed up the coping process (Quote 36). Jamal preferred staying busy with big projects and retreating to the countryside alone when feeling overwhelmed, as he did not want to be burden his family (Quote 37). Only Peter and Henry discussed the value of talking with family and friends during stressful times, but they mainly focused on light conversations rather than personal disclosure and discussing the stress itself (Quotes 33 & 35).

4.2 Managing Stress Through Emotional Expression and Visibility

Example Quotes

Quote 38: (my partner) for me, has been a really important thing. It's kind of like (my partner) being there for me when I was being emotional **(Peter, aged 20-30)**

Quote 39: Now I feel somewhat comfortable around show a bit of emotion or saying how I actually feel about the situation or saying something's annoyed me or it's upset me….I surround myself with people who…if I'm upset about something, then I'll just sort of smile through it and not really be okay, and they'll be able to…see when I'm upset… you know, usually (these) people notice… which is quite nice **(Henry, aged 20-30)**

Quote 40: Usually I take no time out when I've really needed it. I'd just plod through, get through. I guess that's masculinity….I guess that's…the manly thing to do, is to man up and get through it….So, I went and joined them (partner and child) and took some time out as opposed to working, which is what I usually wouldn't do. I'd just try and work through it **(Jerry, 20-30)**

Although all participants initially preferred to manage stress through self-reliance and problem-solving, Peter, Henry, and Jerry reported transitional experiences in relation to stress management. All three had started to find comfort in sharing their feelings with trusted individuals and associated this with positive outcomes.

Peter felt validated and supported by his partner while grieving his mother (Quote 38). Henry appreciated his friends' support when they noticed his struggles and sometimes felt comfortable opening up (Quote 39). Jerry had begun to prioritise self-care by recognising the emotional impact of stress and taking time off with his family to recharge, which likely involved talking about his feelings with his partner (Quote 40).

This shift suggested that while emotional suppression is associated with a traditional sense of what it means to be a man, some participants were able to step away from this expectation and experience a different way of expressing emotion through talking to trusted others. This indicated potential for flexibility in an evolving sense of masculinity, which allows for positive experiences and possibly improved well-being.

Discussion

This study used a mixed-methods approach. The quantitative component examined the relationship between adherence to traditional masculinity and depressive symptoms, and the potential mediating role of emotional regulation. The qualitative component explored how masculinity evolves over the lifespan and how adherence to masculine norms may influence men's experiences of and responses to stress.

Stage 1 findings revealed that men with depressive symptoms were more likely to strongly adhere to traditional masculinity compared to those without depressive symptoms. This aligns with existing literature suggesting rigid adherence to masculine norms can contribute to depressive symptoms (Wong et al., 2017). Additionally, the study found that stronger adherence to traditional masculinity was linked to poorer emotional regulation,

supporting the idea that societal expectations of emotional restraint may hinder men's ability to manage their emotions effectively (Berke et al., 2018).

However, difficulties in emotion regulation were not found to mediate relationship between adherence to traditional masculinity and depressive symptoms. This finding does not straightforwardly sit with existing literature, which suggests that poor emotion regulation contributes to depressive symptoms across genders (e.g., Iwamoto et al, 2018; Shephard, 2002; Visted, 2018) and may also be a key mechanism linking masculinity to psychological distress (e.g., Berke et al., 2018). Taken together, these findings indicate that adherence to traditional masculinity contributes to poor emotion regulation and depressive symptoms, but emotional regulation may not be the primary mediator in this relationship . It is important to contextualise these findings to within the broader sociocultural context; this association may reflect a tension between traditional masculine norms and evolving societal norms, rather than indicating that masculine norms are inherently harmful.

Finally, demographic factors controlled for age, sexuality, and education did not significantly affect the relationship between adherence to masculinity norms and depressive symptoms. This finding contrasts with previous research, suggesting that demographic factors can influence the extent to which masculine norms impact psychological distress (e.g., Mahalik et al., 2007; Vandello & Bosson, 2013). The lack of such effects in present study may indicate that the impact of traditional masculinity remains relatively consistent across diverse demographic groups.

In Stage 2, participants' narratives provided important contextualising insight into how masculinity develops across the lifespan and the extent to which pressures around masculinity can influence how men experience and manage stress. In keeping with the

extant literature, family upbringing, male role models, and school environments played a significant role in shaping participants' masculine identities in early life. Participants exposed to non-stereotypical role models tended to develop a more critical view of traditional masculinity, while those surrounded by more conventional male figures were more likely to internalise masculine norms.

Educational settings, particularly single-gender schools, also played a significant role in reinforcing masculine norms as participants moved from childhood to adolescence. Participants described school environments that emphasised emotional suppression, competitiveness, and dominance, traits typically associated with traditional masculinity. As they transitioned to adulthood, all participants except one began to re-evaluate and reshape their understanding of masculinity, integrating traditional norms (e.g., physical strength, assertiveness) with non-traditional norms (e.g., emotional expression and vulnerability).

Despite shifting perspectives on masculinity in certain areas, all participants found it challenging to adjust their emotional responses in the context of situations experienced as stressful. In keeping with a qualitative study, the meaning of stress was idiosyncratic to participants and could relate to 'time pressure' or a 'difficult customer', for example. In the context of perceived stress participants might rely on traditional masculine coping strategies, such as self-reliance (feeling pressure to manage stress independently without seeking support) and emotional suppression (feeling pressure to hide or withhold emotions). This pattern suggests that while participants narratives indicate an ability to negotiate rather than straightforwardly identify with masculine norms over the life course, this negotiation reduced in the context of situations experienced as stressful. It appears

therefore that adherence to masculine norms may hinder psychological flexibility in relation to coping with adversity.

Although participants often reverted to masculine coping in the context of stress, they did not report an experienced pressure to conform to masculine stereotypes. This finding makes it difficult for the study to comment on the role of 'discrepancy stress', which emphasises the 'stressful' experience of falling short of masculine expectations in the lead up to overt male behaviour (Pleck, 1981; Reidy et al. 2016). One explanation might be that the reported negotiation of masculinity over time reduced experiences of discrepancy. Within the extant literature stress has been linked to depression and compromised emotion regulation (Hammen, 2005; Abravanel & Sinha, 2015). Any links between the current studies' qualitative findings and the wider literature on stress and depression can only be tentative. The study provides idiographic accounts of stress and did not specifically explore links between perceived stress and depression.

However, the findings suggest beliefs around traditional masculinity may intensify and influence male specific coping (e.g., withdrawal, emotion suppression) in the context of stress. More specifically, participant accounts of emotion suppression provide a helpful idiographic context to how masculine coping might compromise emotion regulation in the context of stress. With reference to the wider literature, this pattern might then indicate a gendered vulnerability to depressive symptomology should adversity repeat over time (Hammen, 2005; Abravanel & Sinha, 2015). As such, the qualitative findings provide a contextualising narrative to the quantitative finding that increased adherence to masculine norms predicted low mood. Taken together, these findings suggest that masculine norms may influence men's beliefs and coping strategies in the context of perceived stress, even

among those who have begun to redefine their masculine identities in other domains of life.

In contrast to the potential vulnerability factors of male specific coping in the context of stress, it is also important to note that some participants reported increasing emotional openness over time, particularly in supportive environments. For example, participants described talking to partners and friends about personal difficulties and expressing vulnerable emotions, such as sadness. These accounts highlight how differing social contexts can either facilitate or hinder more flexible expressions of masculinity. Participants who expressed their emotions and sought social support described positive experiences, suggesting that engaging in adaptive emotional responses and adaptive coping strategies may help to reinforce shifts in attitude toward masculinity, particularly in recognising the value of openness and connection with others as effective ways of managing stress and reducing depressive symptoms.

Limitations

Several study imitations should be acknowledged. From a clinical standpoint, the non-significant finding that emotional regulation did not mediate relationship between masculinity and depressive symptoms suggests interventions solely targeting emotional regulation may not be effective for men experiencing depressive symptoms. However, this conclusion should be interpreted cautiously and requires study replication to confirm its robustness. Moreover, the use of a non-clinical sample may limit the generalisability of findings to clinical populations. One possible hypothesis is that the mediating role of emotion regulation only becomes more critical in clinical presentations. To build on findings of current study, future research might, therefore, explore the role of emotion

regulation as a mediator for masculinity adherence and depressive symptoms in a clinical sample.

The finding that emotional regulation did not mediate relationship between masculinity and depressive symptoms is also at odds with the existing literature, raising questions about the use of DERS as a measure for emotional regulation. Anderson et al. (2016) suggest that DERS may reflect gender bias, as it was originally developed based on research with female populations. The results of this study suggest that gender bias may exist in several DERS items, raising questions about DERS validity in measuring emotion and the mediating role of the construct robustly with an all-male sample. However, other studies, such as Giromoni et al. (2017), suggest gender has little impact on DERS reporting, highlighting that this is an ongoing debate. Therefore, future research should carefully check the validity of these measures with respect to gender bias and provide clear guidance on interpretation.

Additionally, limitations in the study included the choice of measures, recruitment strategy, and sample homogeneity. The GRC scale, though widely used (e.g., Shepard, 2002), contains outdated heteronormative language (e.g., "*affection with other men makes me tense*"), which may have influenced responses, particularly given over 20% of the sample identified as gay or bisexual. Recruitment via social media may also have introduced selection bias, limiting the sample's representativeness.

Reviewing participant demographics revealed two possible limitations. Firstly, as shown in Table 1, the sample had a high level of educational attainment: 80.8% of participants held a degree, and 47.9% had postgraduate qualifications. This may limit the generalisability of findings to men from more diverse educational backgrounds. Secondly,

with respect to the demographic breakdown of the low-mood and non-low-mood groups (Table 2), two possible confounding variables are identified. In terms of relationship status, 42.4.% of the low mood group were single compared to 27.5% of the non-low mood group. In terms of employment status, 12.1% of the low mood group were unemployed compared to 2.6% of the non-mood group. Social isolation (Solmi et al. 2020) and unemployment (Amiri, 2021) are associated with depression, suggesting that the study could be improved by not only controlling for age, sexuality, education, but also for additional potential confounders, namely employment and relationship status.

In conclusion, this study contributes to existing research on the potential link between adherence to masculine norms and depressive symptoms together with the influence of masculine norm adherence on coping strategies in the context of perceived stress. The study demonstrates that stronger adherence to traditional masculinity is linked to both increased depressive symptoms and poorer emotional regulation. However, in contrast to existing literature, the study found no evidence that emotion regulation mediates relationship between adherence to masculinity and depressive symptoms, suggesting further research and replication are required and the need for the mediator hypothesis to be explored in clinical samples. The qualitative findings supplement quantitative results by providing a contextualised understanding of participants' experiences of masculinity across the lifespan, suggest that male-specific coping may increase in the context of stress, a known risk factor for depression. These findings highlight both the fluidity of masculine norms and persistence of traditional masculine coping styles, even among men who have started to redefine their masculine identities in some areas.

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Executive Summary

Men's mental health is an important and growing public health concern, with suicide the leading cause of death for men aged under 40. Men are often socialised to hide their emotions and be self-reliant, and as such may struggle to seek help when experiencing mental health challenges.

While men and women report similar rates of depression, men often express depression differently. Rather than expressing sadness or seeking help, men are more likely to suppress their emotions and present with anger, risky behaviour, or substance use (Iwamoto et al., 2018). These behaviours are often linked to traditional masculine norms, although the causation and maintenance of these behaviours remain unclear. One possible contributing factor is emotional regulation, the ability to manage emotions in response to life's challenges. However, the relationship between depression, masculinity and emotion regulation has yet to be robustly explored.

This study explored how traditional masculinity affects men's mental health, specifically depressive symptoms, and whether difficulties in emotional regulation mediated this relationship. The study also explored how men make sense of and experience masculinity over time, as well as its influence on mental health.

The study used a mixed-methods approach. First, an online survey of 292 men measured depressive symptoms (PHQ-8), adherence to masculine norms (GRCS), and emotional regulation difficulties (DERS). Next, six men with high scores for depressive symptoms and adherence to masculine norms were interviewed about their childhood, relationships, and views on masculinity.

The results found that stronger adherence to traditional masculine norms was linked with higher levels of depressive symptoms and greater emotional regulation difficulties. However, emotional regulation did not significantly mediate the relationship between masculinity and depressive symptoms, suggesting other explanatory factors may be at play. Analysis of interview data revealed that family, role models, and social expectations influenced men's sense of masculinity and coping from an early age. Although some participants questioned traditional ideas around masculinity, most participants struggled to express vulnerable emotions and often coped alone rather than seeking help.

This study highlights the complex interplay between masculinity, depressive symptoms, and emotional regulation. The study requires replication (preferably with a clinical sample), and other factors may need to be explored to explain the relationship between adherence to masculine norms and depressive symptoms. The study highlights that mental health services should consider the influence of masculinity on male distress and coping strategies in order to better provide gender sensitive support.

Connecting Narrative

This connecting narrative outlines my thought process and experiences while conducting the research projects presented in this thesis.

Theory-Driven Research Project

My interest in this area stems from personal experiences and clinical encounters with men who were reluctant to discuss mental health or seek support. Despite concerning statistics regarding men's mental health, I was struck by how under-researched this area is within the field of clinical psychology and how few services have adapted to better engage men.

With guidance from Consultant Psychologist Dr Matthew Knight and Professor Craig Steel, I designed a mixed-methods study to explore interrelated factors that may impact men's mental health, such as adherence to masculinity norms, depressive symptoms, and difficulties in emotional regulation. The additional layer of qualitative data collection enabled me to explore these issues in greater depth, including the impact of early experiences and how masculinity is negotiated across the lifespan.

Recruitment for the study was surprisingly uncomplicated. Initially, the research team had concerns about recruiting 120 men (60 of whom scored above the PHQ-8 cut-off for depressive symptoms). However, the study recruited twice that number, with more than half expressing interest in being interviewed. I was taken aback by the support from men's mental health charities and individual male and female campaigners who went the extra mile to advertise the study. The same can be said for the number of people who completed the survey and, of those selected, followed through on their initial interest in being

interviewed. However, I was also aware that the study was primarily shared on Twitter, potentially skewing the sample's demographics, as highlighted by the disproportionate number of participants with graduate-level education or higher.

The project's findings were intriguing. Men with depressive symptoms were more likely to adhere to traditional masculinity, which aligned with existing research. However, emotion regulation difficulties were not found to mediate this relationship, which contradicts previous studies that suggest it is a key factor linking masculinity and psychological distress. Additionally, qualitative interviews revealed that early experiences influence how much men conform to these norms. The interviews also highlighted that masculinity is a fluid and multifaceted concept, with both positive and negative aspects that are negotiated across social contexts and throughout the lifespan. This led me to consider the need for future research to focus on replication and exploring the mediator hypothesis in clinical samples.

The interviews were especially powerful and personal. The participants spoke with surprising depth, and I felt privileged to hear their stories. It made me wonder whether research interviews offered a safer space for men to discuss mental health, perhaps even more so than a traditional NHS therapy setting. I also sensed that, as a male speaking with another male, the experience might have been validating for them. It might have helped them feel less alone, and I hope it did.

Service Improvement Project

This project grew out of my interest in integrating psychological perspectives within NHS teams, particularly in exploring how formulation can serve as a bridge between medical and psychosocial models. This approach felt especially relevant in settings where psychologists are often outnumbered by other professionals and where resources are limited. I am a firm believer that psychology should be as accessible and user-friendly as possible.

However, despite its many strengths, I was aware that psychological formulation could be perceived as an abstract or intimidating concept - something I experienced myself as a trainee, questioning whether I was "getting it right". This made me curious about how professionals from other disciplines perceived team formulation and whether they experienced feelings of uncertainty or a lack of confidence. I also wanted to explore the team formulation process, the social dynamic, hierarchies that emerge, and how these factors shape staff experience of TF and perceptions of its usefulness.

As anticipated, recruitment went smoothly, owing to the strong working relationships I had developed during my first-year placement with this team. However, I was mindful that my previous role as a psychology team member might have influenced how comfortable participants felt speaking openly about their experiences with team formulation meetings during the interviews.

The findings from the study were compelling. While team formulation was seen as a valuable resource, psychologists needed to provide further support, such as offering training and spending more time explaining terminology and formulation models to help staff feel more confident in their participation. The findings also suggested that

psychologists could be more flexible in responding to staff requests for a clear action plan following team formulation sessions. Interestingly, this flexibility seemed to have a similar containing effect to team formulation itself, offering staff a reflective space to process the client's challenges and to reach a shared understanding of their difficulties.

Systematic Review of the Literature

Writing a systematic literature review was one of the most challenging aspects of my thesis. At times, self-doubt and anxiety led me to disengage, resulting in delays that were both frustrating and disheartening. I also found that my dyslexia and related processing challenges made it especially hard to read large numbers of papers, fully understand them, and identify key themes through analysis. Each time I stepped away, I had to re-familiarise myself with the material and redo multiple steps, which was discouraging. Learning to trust my research skills and accepting setbacks as part of the process helped me regain confidence and motivation.

As I delved deeper into the literature, I was struck by the lack of research specifically focused on men who had experienced MCSA. The issue seemed almost invisible. Most studies centred on women, and even those that included both genders often failed to report gender-specific findings. This gap made me wonder whether the omission reflected a broader societal stigma, one that often downplays, disbelieves, or denies the prevalence of CSA in men. It also prompted me to think about health inequalities and the importance of improving support for men.

I was particularly alarmed by the systemic barriers that reinforce MCSA stigma, especially within healthcare settings. It was concerning to discover that many clinicians, including those with trauma training, lacked the confidence and skills to assess MCSA and

might overlook it entirely when assessing men's mental and physical health. The absence of a validated and standardised assessment tool further compounded these challenges. These findings strengthened my commitment to supporting the development of better assessment tools, raising awareness, and promoting trauma-informed approaches. I’m especially mindful of the need to create supportive, validating spaces where men feel safe to disclose their experiences and receive the support necessary for healing.

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Appendices

Appendix A: SRL Search Strategy

(Men*s OR male or boy* OR child* OR youth OR adolescen* OR young OR teen*)
AND
Child sexual abuse* OR CSA OR sexual abuse OR rape OR sexual trauma* OR molest* OR harmful sexual behav* OR Child maltreatment OR Child adverse experience* OR childhood advers*
AND
Barrier* OR obstacle* OR delay* OR enable* OR facilitate* OR help* OR allow
AND
Disclosure* OR report* OR reveal* OR tell* OR inform*

Appendix B: SRL Risk of Bias Tools

Mixed Methods Appraisal Tool (MMAT)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Appendix C: SRL Author Guidelines

Trauma, Violence and Abuse Journal

Your article must be within the scope of the journal and be of sufficient quality. If not, it will not be reviewed. Please read the journal's Aims and Scope to see if your article is appropriate.

The manuscript must be your original work, you must have the rights to the work, and you must have obtained and be able to supply all necessary permissions for the reproduction of any copyright works not owned by you, including figures, illustrations, tables, lengthy quotations, or other material previously published elsewhere.

Article types

Reviews:

TVA accepts comprehensive reviews of research or legal reviews that address any aspect of trauma, violence, or abuse. Reviews must be based on a sufficient number of studies to justify synthesis. Reviewed literatures may come from the social or behavioral sciences or the law.

Reviews should begin with a clear description of the knowledge area that is being researched or reviewed and its relevance to understanding or dealing with trauma, violence, or abuse and provide a clear discussion of the limits of the knowledge that has been reviewed.

Please include two summary tables: one of critical findings and the other listing impications of the review for practice, policy, and research. Please also include a discussion of diversity as it applies to the reviewed research. See below for the journal's policy on addressing diversity in manuscripts for more information.

Length: No longer than 40 double-spaced pages, inclusive of references, tables, and figures. Title page, main document (including references), tables, figures, author biographies, and any supplemental materials should be uploaded as separate files.

Abstract: Up to 250 words describing the topic of review, method of review, number of research studies meeting the criteria for review, criteria for inclusion, how research studies were identified, and major findings

Formatting: All files must be formatted according to the Publication Manual of the American Psychological Association (7th edition). All files must be submitted as Word docs, not PDFs. Text should be in Times New Roman, 12-point font. Margins must be at least one inch on all sides.

Standard APC for Sage Choice OA: $3700

Journal policy on addressing diversity in manuscripts:

TVA requires all submissions to include a discussion of diversity as it applies to the reviewed research. For example: What are the diversity characteristics of the studies included in the review and how might these be related to the findings? How do these findings relate to other samples? If diversity data are not included in the study, how does this impact relevance or generalizability? What are the implications of the research for understanding in different settings or cultures? What research is called for related to your topic in terms of diversity? The discussion should address the body of knowledge reviewed as it addresses or fails to address issues of diversity. The nature of the discussion and amount of space devoted to the discussion is the responsibility of the author(s).

TVA understands diversity to include all aspects of human differences such as socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, ability, age, and culture. As a core value, diversity embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for expanding knowledge and practice with all human beings. While science seeks knowledge that can be generalized, it must appreciate that specific findings, while important in understanding the unique experiences of individuals or groups, are not necessarily applicable to all.

Clinical trial registration

The journal endorses the ICMJE requirement that clinical trials are registered in a WHO-approved public trials registry at or before the time of first participant enrollment. However, consistent with the AllTrials campaign, retrospectively registered trials will be considered if the justification for late registration is acceptable. The trial registry name and URL, and registration number must be included at the end of the abstract.

Reporting guidelines

Your manuscript **must** follow the relevant EQUATOR Network reporting guidelines, depending on the type of study. The EQUATOR wizard can help identify the appropriate guideline. You will need to upload the appropriate checklist with your submission.

Other resources can be found at NLM's Research Reporting Guidelines and Initiatives.

If your research involves animals, you will be asked to confirm that you have carefully read and adhered to the ARRIVE guidelines.

Formatting your manuscript

Accepted file types
The preferred format for your manuscript is Word. You do not need to follow a template, but please ensure your heading levels are clear, and the sections clearly defined.

Your article title, keywords, and abstract all contribute to its position in search engine results, directly affecting the number of people who see your work. For details of what you can do to influence this, visit How to help readers find your article online.

Title
Your manuscript's title should be concise, descriptive, unambiguous, accurate, and reflect the precise contents of the manuscript. A descriptive title that includes the topic of the manuscript makes an article more findable in the major indexing services.

Abstract
Please include an unstructured abstract of no more than 250 words between the title and main body of your manuscript that concisely states the purpose of the research, major findings, and conclusions. If your research includes clinical trials, the trial registry name and URL, and registration number must be included at the end of the abstract. Submissions that do not meet this requirement will not be considered.

For clinical trials, the trial registry name and URL, and registration number must be included at the end of the abstract.

Keywords
Please include a minimum of 4 keywords, listed after the abstract. Keywords should be as specific as possible to the research topic.

Artwork, figures, and other graphics
For guidance on the preparation of illustrations, pictures, and graphs in electronic format, please read Sage's artwork guidelines.

Figures supplied in color will appear in color online.

Please ensure that you have obtained any necessary permission from copyright holders for reproducing any illustrations, tables, figures, or lengthy quotations previously published elsewhere. For further information including guidance on fair dealing for criticism and review, please see the Frequently Asked Questions page on the Sage Journal Author Gateway.

Title page
To ensure fair and anonymous peer review, your manuscript must be fully anonymized. Please ensure any identifying information is removed from the main manuscript document and included on the Title Page instead. Do not include any author names in the manuscript file name and remove names from headers and footers. This version of the manuscript **will** be sent to the peer reviewers. The Title Page **will not** be sent to peer reviewers. See the Sage Journal Author Gateway for detailed guidance on making an anonymous submission.

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- Article title

- The full list of authors including names and affiliations of each
    - **The listed affiliation should be the institution where the research was conducted**. If an author has moved to a new institution since completing the research, the new affiliation can be included in a note at the end of the manuscript – please indicate this on the title page.
    - **All persons eligible for authorship must be included at the time of submission (please see the authorship section for more information)**.
- Contact information for the corresponding author: name, institutional address, phone, email
- Acknowledgments section
- Declaration of conflicting interest
- Funding statement
- Ethical approval and informed consent statements
- Data availability statement
- Any other identifying information related to the authors and/or their institutions, funders, approval committees, etc, that might compromise anonymity.

Acknowledgments
If you are including an Acknowledgements section, this will be published at the end of your article. The Acknowledgments section should include all contributors who do not meet the criteria for authorship. Per ICMJE recommendations, it is best practice to obtain consent from non-author contributors who you are acknowledging in your manuscript.

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Statements and declarations
To ensure proper anonymization, please include a section with the heading 'Statements and Declarations' on your title page, after the Acknowledgements section [and Author Contributions section if applicable] including each of the sub-headings listed below. If a declaration is not applicable to your submission, you must still include the heading and state 'Not applicable' underneath. Please note that you may be asked to justify why a declaration was not applicable to your submission by the Editorial Office. This information will be added to the end of your published paper.

Ethical considerations
Please include your ethics approval statements under this heading, even if you have already included ethics approval information in your methods section. If ethical approval was not required, you need to explicitly state this. You can find information on what to say in your ethical statements as well as example statements on our Publication ethics and research integrity policies page.

All papers reporting studies involving human participants, human data or human tissue must state that the relevant Ethics Committee or Institutional Review Board approved the study, or waived the requirement for approval, providing the full name and institution of the review committee in addition to the approval number. If applicable, please also include this information in the Methods section of your manuscript.

Consent to participate
Please include any participant consent information under this heading and state whether informed consent to participate was written or verbal. If the requirement for informed consent to participate has been waived by the relevant Ethics Committee or Institutional Review Board (i.e. where it has been deemed that consent would be impossible or impracticable to obtain), please state this. If this is not applicable to your manuscript, please state 'Not applicable' in this section. More information and example statements can be found on our Publication ethics and research integrity policies page.

Consent for publication
Submissions containing any data from an individual person (including individual details, images or videos) must include a statement confirming that informed consent for publication was provided by the participant(s) or a legally authorized representative. Non-essential identifying details should be omitted. Please do not submit the participant's actual written informed consent with your article, as this in itself breaches the patient's confidentiality. The Journal requests that you confirm to us, in writing, that you have obtained written informed consent to publish but the written consent itself should be held by the authors/investigators themselves, for example in a patient's hospital record. The confirmatory letter may be uploaded with your submission as a separate file in addition to the statement confirming that consent to publish was obtained within the manuscript text. If this is not applicable to your manuscript, please state 'Not applicable' in this section.

Declaration of conflicting interest
The journal requires a declaration of conflicting interests from all authors so that a statement can be included in your article. For guidance on conflict of interest statements, see our policy on conflicting interest declarations and the ICMJE recommendations.

If no conflict exists, your statement should read: 'The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article'.

Funding statement
All articles need to include a funding statement, under a separate heading, **even if you did not receive funding**. You'll find guidance and examples on our Funding page.

Data availability
The Journal is committed to facilitating openness, transparency and reproducibility of research, and has the following research data sharing policy. For more information, including FAQs please visit the Sage Research Data policy pages.

Subject to appropriate ethical and legal considerations, authors are encouraged to:

- Share your research data in a relevant public data repository
- Include a data availability statement linking to your data. If it is not possible to share your data, use the statement to confirm why it cannot be shared.
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English language editing services
Authors seeking assistance with English language editing, translation, or figure and manuscript formatting to fit the journal's specifications should consider using Sage Author Services. Visit Sage Author Services for further information.

Appendix D: SIP Interview Schedule

Pre-interview questions

- How long have you been in the team?
- How many times have you attended team formulation?
- Have you attended regularly?
- Did you have any prior experience in team formulation before starting your role?

Interview Questions

What is your experience of team formulation?

- Have you found it helpful? If so, in what ways?
- Are there drawbacks or ways in which TF is not beneficial?
- What changes are required to improve TF?

Have you attended the team formulation training?

- Was it helpful? If so, in what ways
- Do you have any suggestions for how it could be improved?

What are your thoughts on the timing and regularity of the TF?

- Does it take place too often? Not enough?
- Are you happy with the current time slot?

How do people decide who to bring to team formulation?

- Have you brought somebody to the discussion?
- If so, what was your decision-making process (e.g., individual decision/in supervision/mentioned in CMHT meeting/team "stuck")
- Did you make use of the pre-meeting questions sent out?
- Do you have any ideas about how psychology could support staff to bring clients to the discussion?

Using an example, please describe your experience of participating in the TF?

- Do you feel you get the opportunity to express your view?
- What would help to improve your experience of participating?

What are the strengths and weaknesses of the 5P's model used to structure the TF?

- Do you have a preferred formulation model/s that you would like psychology to consider?
- Would you prefer a variety of models to be used? If so, why?

What are your thoughts on service users and carers being involved in the TF?

- What are the pros and cons?
- If in favour, how would that be useful?
- Do you have any ideas on how you would involve them?

What is your experience of the outcomes of TF, and how are they put in place?

- Have you helped put a treatment plan in place following a team formulation?

- How did you find that experience?
- Did you encounter any challenges?

In what ways does team formulation develop your psychological thinking?

- What do you find yourself learning and reflecting upon?
- Does it have an impact on you emotionally?
- Does it impact the way you approach your work with clients?

Appendix E: SIP Author Guidelines

British Journal of Clinical Psychology

1. Submission

2. Aims and Scope
3. Manuscript Categories and Requirements
4. Preparing the Submission
5. Editorial Policies and Ethical Considerations
6. Author Licensing
7. Publication Process After Acceptance
8. Post Publication
9. Editorial Office Contact Details

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

New submissions should be made via the Research Exchange submission portal. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com.

All papers published in the *British Journal of Clinical Psychology* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

Data protection:

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at https://authorservices.wiley.com/statements/data-protection-policy.html.

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This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time.

Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

The *British Journal of Clinical Psychology* publishes original research, both empirical and theoretical, on all aspects of clinical psychology:

- clinical and abnormal psychology featuring descriptive or experimental studies
- aetiology, assessment and treatment of the whole range of psychological disorders irrespective of age group and setting
- biological influences on individual behaviour
- studies of psychological interventions and treatment on individuals, dyads, families and groups

For specific submission requirements, read the Author Guidelines.

The Journal is catholic with respect to the range of theories and methods used to answer substantive scientific problems. Studies of samples with no current psychological disorder will only be considered if they have a direct bearing on clinical theory or practice.

The following types of paper are invited:

- papers reporting original empirical investigations;
- theoretical papers, provided that these are sufficiently related to empirical data;
- review articles, which need not be exhaustive, but which should give an interpretation of the state of research in a given field and, where appropriate, identify its clinical implications;
- Brief Reports and Comments.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Papers describing quantitative research should be no more than 5000 words (excluding the abstract, reference list, tables and figures). Papers describing qualitative research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures and references). Brief reports should not exceed 2000 words and should have no more than one table or figure. Any papers that are over this word limit will be returned to the authors. Appendices are included in the word limit; however online appendices are not included.

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length

(e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Refer to the separate guidelines for Registered Reports.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

4. PREPARING THE SUBMISSION

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British Journal of Clinical Psychology now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (If you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-anonymous peer review policy. Anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

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To submit, login at https://wiley.atyponrex.com/journal/BJC and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use this template for your title page. The title page should contain**:**

i. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
ii. A short running title of less than 40 characters;
iii. The full names of the authors;
iv. The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
v. Abstract;
vi. Keywords
vii. Data availability statement (see Data Sharing and Data Accessibility Policy);
viii. Acknowledgments.

Author Contributions

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our Author Services site.

Abstract

Please provide a structured abstract under the headings: Objectives, Methods, Results, Conclusions. For Articles, the abstract should not exceed 250 words. For Brief Reports, abstracts should not exceed 120 words.

Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

Keywords

Provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet points, following the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.

Main Text File

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.
Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or
.docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation "Main Document – LaTeX .tex File" on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as "Main Document - LaTeX PDF." All supporting files that are referred to in the LaTex Main Document should be uploaded as a "LaTeX Supplementary File."

LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

- PDF of the finalized source manuscript files compiled without any errors.
- The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if

authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.
- Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Abstract structured (objectives/methods/results/conclusions);
- Up to seven keywords;
- Practitioner Points: Authors will need to provide no more than 2-4 bullet points, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below).

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

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For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association. The following points provide general advice on formatting and style.

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- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

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Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

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- The Gold Standard Publication Checklist from Hooijmans and colleagues
- FAIRsharing website

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The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

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Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: https://www.crossref.org/services/funder-registry/

Authorship

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

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Appendix F: TDRP Ethical Approval

MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, Boundary Brook House, Churchill Drive, Headington, Oxford, OX3 7GB
Tel: +44(0)1865 616575
ethics@medsci.ox.ac.uk

CONFIDENTIAL

Dr Matthew Knight & Joshua Rumble-Browne
Oxford Institute for Clinical Psychology Training
(OxICPT)
Isis Education Centre
Warneford Hospital
Oxford

25 January 2023

Dear Dr Knight & Joshua,

Research Ethics Approval - CUREC 1

Ethics Approval Reference: R84009/RE001

Study title: Exploring The Relationship Between Adherence to Traditional Masculinity, Low Mood, and Emotional Regulation in Adult Men

Short title: Masculinity, and difficulties with low mood and emotional dysregulation

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted for a period of **1 year**, commencing on **25th January 2023.**

Amendments

Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form.

Yours Sincerely

DocuSigned by:
Leah Butts
9F14889D2BC549A...

Mrs Leah Butts
Research Ethics Administrator

for
Dr Helen Barnby-Porritt
Research Ethics Manager

Appendix G: TDRP Recruitment Poster

The Oxford Institute of Clinical Psychology Training and Research
Email: joshua.rumble-browne@hmc.ac.uk
Website: https://oxicptr.web.ox.ac.uk/

Ethics Approval Reference: R84009/RE001

UNIVERSITY OF OXFORD

Male Volunteers Needed for Online Research Exploring Link Between Masculinity, Low Mood, and Managing Emotions

Studies have shown that masculinity, i.e., qualities or attributes regarded as characteristic of men (e.g., men don't cry), can contribute to low mood and difficulty managing emotions.

We want to explore this further including why this might be, so that we can improve our ability to help men with mental health difficulties.

We are looking for **adult men** to complete a set of online questionnaires regarding your thoughts on **masculinity**, your **mood**, and how you manage your **emotions**. The research should take about 10 minutes.

If you are **18 years of age or above**, can **read and write in English**, and were **ascribed as male at birth**, you are eligible to participate.

To take part, please visit:

https://psychiatryoxford.qualtrics.com/jfe/form/SV_cYk1GvyzPLKnlyK

Or scan the QR code:

If you have any questions, please contact joshua.rumble-browne@hmc.ac.uk.
Thank you ☺

Appendix H: TDRP Participant Information Sheet

Exploring the Link Between Adherence to Masculine Gender Norms, Emotional Regulation, and Low Mood: A Mixed Methods Study

Central University Research Ethics Committee Approval Reference: R84009/RE001

Introductory paragraph

My name is Joshua Rumble-Browne, and I am a Trainee Clinical Psychologist at the University of Oxford, working with Dr Matthew Knight and Professor Craig Steel and the research team. This is an invitation to take part in our research study.

Before you decide, it is important that you understand why the research is being done and what it would involve for you. Please take time to read this Participant Information Sheet and discuss it with others if you wish. If there is anything that is not clear, or if you would like more information, please ask us by emailing the researcher at Joshua.rumble-browne@hmc.ac.uk.

Why is this research being conducted?

For some men, pressure to conform to masculinity (i.e., behaviours or characteristics considered socially acceptable for boys and men) can make them more likely to experience depression (e.g., feeling hopeless and unhappy) and find it challenging managing their emotions. Our study aims to learn more about the possible relationship between adherence to masculinity and low mood and difficulty managing emotions in men. To do this, we are interested in asking a range of men about their mood, whether they conform to masculinity, and how they handle emotions. We hope to develop a better understanding of factors that may contribute to distress in these areas, with the view to tailoring and improving treatments for these individuals.\

Why have I been invited to take part?

We are happy to hear from a range of biological males aged 18 years and above with no upper age limit.

Do I have to take part?

No, taking part is completely voluntary. You have the right to withdraw from the project at any point during the study without giving a reason. As the data collected is anonymous you will be unable to withdraw your data once you complete the study. \

What will happen to me if I take part in the research?

The study will be carried out in two stages. Stage one will be a series of online questionnaires, and stage two will be an online interview. If you wish to participate in the study, the researcher will provide you with a link to a series of questionnaires. The questionnaires will ask about your mood, managing emotions, and relationship with

masculinity. The link will also include 1. Participant Information Sheet with details regarding the research 2. The researchers contact details and 3. a consent form, which you will be asked to complete before filling in the questionnaires.

We also want to interview a sample of participants about their relationship to and what it means to be a man. The interviews will be semi-structured, in other words, a pre-prepared set of questions combined with the opportunity to explore themes in the discussion. The interviews will take place online via MS teams and will last up to 60-minutes. The Interviews are recorded so that the researcher can capture everything that is discussed. You will be given the option to provide your contact details if you would be interested in being interviewed. Providing your contact details would not oblige you to take part in an interview if invited.

The researcher will contact you to provide information regarding the interview, answer any questions you may have, and ask if you remain willing to consent to be interviewed. If so, the researcher will arrange a time and date for the interview that is convenient for you. We will audio record the interview to have an accurate record of what is said. Following the online interview, you will be given the opportunity to ask questions, find out more about the study, and be signposted to support services if appropriate.

What are the possible disadvantages and risks in taking part?

Taking part in the Stage 1 questionnaires will take approximately 20 minutes of your time. Taking part in the Stage 2 interview will take up to 60-minutes. Some of the survey and interview questions inviting you to reflect on your early life and your relationship with masculinity, managing emotions, and your mood may be difficult to think about.

The questionnaires were designed with feedback from people with lived experiences of having these problems to minimise the potential for distress. However, you may find answering the questions upsetting.

You can either take a break from the study and return to it later or withdraw from the survey at any point. At the end of the survey, or if you withdraw at any point during completion, you will be provided with contact details of services and third-party organisations that will be able to offer support and guidance if you experience distress.

Are there any benefits in taking part?

We hope that your participation will help us to develop a better understanding of factors that may contribute to distress in men, with the hope of tailoring and improving treatments for these individuals. However, there are no direct benefits to those participating.

What information will be collected and why is the collection of this information relevant for achieving the research objectives?

The information you provide during the study is the **research data**. Any research data from which you can be identified (i.e. audio recordings (of interviews), email address, telephone number and home address, should you request the questionnaires by post) is known as **personal data**.

Personal data will be stored on a password protected Oxford University Computer, accessible only on University sites and separate from the research data. Personal data will be stored for 6 months after the study has concluded and then permanently deleted.

Other research data (including consent forms, questionnaire data and interview transcripts) will be stored for at least 3 years after publication or public release of the work of the research. This information will then be shredded or permanently deleted and destroyed.
The researchers involved in this study will have access to the research data. Responsible members of the University of Oxford may be given access to the data for monitoring and and/or audit of the research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

Using the **research data**, we hope to report our findings in academic journals and present them to relevant charities, and to health professionals at conferences. The findings will also contribute to Joshua Rumble-Browne's Doctorate in Clinical Psychology. You will not be identified in any reports or publications arising from the study.

Will the research be published? Could I be identified from any publications or other research outputs?

The findings from the research will be written up in a thesis and may be written up in academic publications and conference presentations. A copy of the thesis dissertation will be deposited in print and online in the Oxford University Research Archive. It will be publicly available to facilitate its use in future research. However, access will be restricted to individuals affiliated with Oxford University. If taking part in an interview, we would ask your permission to use direct quotations but without identifying you, e.g., using a pseudonym. **It will not be possible for participants to be identifiable in any of the above outputs.**

Data Protection

The University of Oxford is the data controller with respect to your personal data, and as such will determine how your personal data is used in the study. The University will process your personal data for the purpose of the research outlined above. Research is a task that is performed in the public interest. Further information about your rights with respect to your personal data is available at https://compliance.admin.ox.ac.uk/individual-rights.

Who has reviewed this study?

This study has received ethics approval from a subcommittee of the University of Oxford Central University Research Ethics Committee. (Ethics reference: R84009/RE001)

Who do I contact if I have a concern about the research or I wish to complain?

If you have a concern about any aspect of this study, please contact Joshua.rumble-browne@hmc.ac.uk, 01865 226431) or Dr Matthew Knight (matthew.knight@hmc.ac.uk, 01865 226431) and we will do our best to answer your query. We will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with. If you remain unhappy or wish to make a formal complaint, please contact the Chair of the medical Sciences Interdivisional Research Ethics Committee at the University of Oxford who will seek to resolve the matter as soon as possible:

Email: ethics@medsci.ox.ac.uk; Address: Research Services, University of Oxford, Boundary Brook House, Churchill Drive, OX3 7GB.

Further Information and Contact Details

If you would like to participate, please email: Joshua.rumble-browne@hmc.ac.uk for a link to the online survey.

Thank you for taking the time to read this information sheet and for your interest in the project



Oxford Institute of Clinical Psychology Training
Isis Education Centre
Warneford Hospital
Headington, Oxford
OX3 7JX
joshua.rumble-browne@hmc.ox.ac.uk

You can also speak to the supervisors of the project about any questions or concerns using the details below:

Dr. Matthew Knight (University of Oxford)	Matthew.knight@hmc.ac.uk

Professor Craig Steel (University of Oxford)	craig.steel@hmc.ac.uk

Appendix I: TDRP Measures

Psychometric Properties of Measures

Demographic data

Each online survey will include demographic questions for each participant. including age, gender, educational level attained, ethnicity, marital status, and occupation.

The Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer 2004).

The DERS is a widely used 36-item self-report measure used to evaluate clinically significant difficulties in emotional regulation. It evaluates difficulties across several areas, such as acceptance of emotions, recognition and understanding of emotions, ability to engage in goal-orientated behaviour and appropriate use of strategies to manage emotions, and capacity to withhold from impulsive behaviour when undergoing negative emotions. The DERS has strong internal consistency ($\alpha = .93$) and good test-retest reliability ($\rho = .88$, $p < .01$), and sufficient construct and predictive validity.

Patient Health Questionnaire (PHQ-8; Kroenke, 2009)

The PHQ-8 is a commonly used 9-item self-report measure used to measure key symptoms and attitudes of depression (Kroenke, 2009). The 8 symptoms and attitudes included in the PHQ-8 mirror the range of symptoms and attitudes frequently found among clinically depressed individuals (e.g., low mood, poor self-view, social withdrawal, sleep problems). The PHQ-8 has a high internal consistency 0.82 and a good test-retest reliability 0.92 and a high construct validity (Pressler et al. 2011).

The Gender Role Conflict Scale (GRCS; O'Neil, Helms, Gable, David, & Wrightsman, 1986)

The GRCS is a widely recognised 37-item instrument used to measure gender role conflict, specifically personal and related distress because of adherence to traditional masculine norms (O'Neil, 2008). The scale dimensions are comprised of Factor 1: success, power and competition, Factor 2: restrictive emotionality, Factor 3: restrictive and affectionate behaviour and Factor 4: conflict between work and family relations. The GCRS has high

internal consistency ranging between .75 and .85 and good test re-test reliability ranging from .72 -.86 for each factor.

Appendix J: TDRP Guidance for Patient and Public Involvement (PPI)

Background to Interview Questions

- We are looking to explore how participants experience masculinity in relation to their mental health and to try to understand how they make sense of these experiences.

- As such, questions will be asked about the following areas: messages participants have received about being a man as a child, adolescent and adult, the extent to which it shapes how they see themselves and are perceived by others, and experiences and ways of managing mental ill health.

What would be helpful from you XXXX

- It would be great to get your view on the wording of the questions, as we are keen to make the questions accessible and easy to understand. For example, you might feel some of the wording is too academic or whatever else it might be.

- It would also be great to get your take on whether you feel we have missed any questions you think would be helpful to find out about or if there is anything you would change about the questions in general.

- Lastly, we are really open to feedback, so please do not feel you have to hold back! We're also not expecting loads of feedback, so please feel no pressure whatsoever; we are just keen to get some general comments from someone outside the project! As I mentioned in the chat, do let me know how long you spend looking at the questions, as we can reimburse you 10 pounds for every hour you spend (not saying it should take hours, but just so you know!). It would also be great to meet by telephone or MS teams to briefly discuss the feedback if ok with you, or alternatively, you could send me written feedback. Again, you would be reimbursed for any time you spend giving the feedback.

- Hope that makes sense; please do not hesitate to ask any questions on FB chat. My email is also Joshua.rumble-browne@hmc.ox.ac.uk if you prefer to get in contact this way

Appendix K: TDRP Survey

Exploring the Relationship Between Adherence to Traditional Masculinity, Low Mood, and Emotional Regulation in Adult Men.

Thank you for your interest in our study, which explores the relationship between traditional masculinity, low mood, and managing emotions.

You will now be invited to complete Stage One of the study, comprised of demographic questions and three online questionnaires. The questionnaires will ask you about 1. Your relationship with masculinity (GRCS), 2. Your mood generally (PHQ-8), and 3. How you manage your emotions (DERS).

For Stage Two of the study, we wish to interview a sample of participants about their relationship to traditional masculinity and what it means to be a man. The interviews will take place online and will last between 45-60 minutes. If you are interested in participating in Stage Two, please express your interest and provide your contact details when prompted on the next web page. The researcher will then contact you to provide information regarding the interview and answer any questions you may have. If you remain willing to consent, the researcher will arrange a time and date for the interview that is convenient for you.

Please read through the statements on the next page and indicate with 'yes' to give your consent for Stage One. Please note that you may only participate in this survey if you are aged 18 or older.

Consent Form

I certify that I am 18 years of age or over

Yes No

I have read the information above and agree to participate in the survey with the understanding that the data (including any personal data) I submit will be processed accordingly.

Yes No

Expression of Interest for Online Interview

I have read the information on the previous web page and can confirm that I am interested in taking part in an online interview.

Yes No

Interview Contact Details

Please provide your first name, email address and telephone number below.

N.B. If you do not wish to provide a telephone number, please write N/A in the relevant box.

First Name and Email Address:

<u>Demographics Questionnaire</u>

For each question, please mark the circle that describes you best and add a description in the box (if applicable)

1. Age

18-20 | 21-30 | 31-40 | 41-50 | 51-60 | 61-64 | 65+

2. Ethnicity

White

English/Welsh/Scottish/Northern Irish/British | Irish | Gypsy or Irish Traveller | Any other white background, please describe below

Mixed/multiple ethnic groups

White and Black Caribbean | White and Black African | White and Asian | Any other mixed/multiple ethnic background, please describe below

Asian/Asian British

Indian | Pakistani | Bangladeshi | Chinese | Another other Asian background, please describe below

Black/African/Caribbean/Black British

African	Caribbean	Any other Black/African/Caribbean background, please describe below

Other ethnic group

Arab	Any other ethnic group, please describe below

3. Relationship status

In a relationship	Single	Other	Prefer not to say

4. Employment status

Full-Time Employment	Part-Time Employment	Unemployed	Other (e.g. student)

5. Level of education

GCSE's	A-Level's (or equivalent)	Undergraduate	Postgraduate

6. Sexuality

Heterosexual or Straight	Gay	Bisexual	Other sexual orientation, please describe below	Prefer not to say

DERS (Gratz & Roemer, 2004)

Instructions: For each question, please mark the circle that best applies to you.

1. I am clear about my feelings

Almost never Sometimes About half of the time Most of the time Almost always

2. I pay attention to how I feel

Almost never Sometimes About half of the time Most of the time Almost always

3. I experience my emotions as overwhelming and out of control

Almost never Sometimes About half of the time Most of the time Almost always

4. I have no idea how I am feeling

Almost never Sometimes About half of the time Most of the time Almost always

5. I have difficulty making sense of my feelings

Almost never Sometimes About half of the time Most of the time Almost always

6. I am attentive to my feelings

Almost never Sometimes About half of the time Most of the time Almost always

7. I know exactly how I am feeling

Almost never Sometimes About half of the time Most of the time Almost always

8. I care about what I am feeling

Almost never Sometimes About half of the time Most of the time Almost always

9. I am confused about how I feel

Almost never Sometimes About half of the time Most of the time Almost always

10. When I'm upset, I acknowledge my emotions

Almost never Sometimes About half of the time Most of the time Almost always

11. When I'm upset, I become angry with myself for feeling that way

Almost never Sometimes About half of the time Most of the time Almost always

12. When I'm upset, I become embarrassed for feeling that way

Almost never Sometimes About half of the time Most of the time Almost always

13. When I'm upset, I have difficulty getting work done

Almost never Sometimes About half of the time Most of the time Almost always

14. When I'm upset, I become out of control

Almost never Sometimes About half of the time Most of the time Almost always

15. When I'm upset, I believe that I will remain that way for a long time

Almost never Sometimes About half of the time Most of the time Almost always

16. When I'm upset, I will end up feeling very depressed

Almost never Sometimes About half of the time Most of the time Almost always

17. When I'm upset, I believe that my feelings are valid and important

Almost never Sometimes About half of the time Most of the time Almost always

18. When I'm upset, I have difficulty focusing on other things

Almost never Sometimes About half of the time Most of the time Almost always

19. When I'm upset, I feel out of control

Almost never Sometimes About half of the time Most of the time Almost always

20. When I'm upset, I can still get things done

Almost never Sometimes About half of the time Most of the time Almost always

21. I feel ashamed at myself for feeling that way

Almost never Sometimes About half of the time Most of the time Almost always

22. When I'm upset, I know that I can find a way to eventually feel better

Almost never Sometimes About half of the time Most of the time Almost always

23. When I'm upset, I feel I am weak

Almost never Sometimes About half of the time Most of the time Almost always

24. When I'm upset, I feel like I can remain in control of my behaviours

Almost never Sometimes About half of the time Most of the time Almost always

25. When I'm upset, I feel guilty for feeling that way

Almost never Sometimes About half of the time Most of the time Almost always

26. When I'm upset, I have difficulty concentrating

Almost never Sometimes About half of the time Most of the time Almost always

27. When I'm upset, I have difficulty controlling my behaviours

Almost never Sometimes About half of the time Most of the time Almost always

28. When I'm upset, I believe there is nothing I can do to make myself feel better

Almost never Sometimes About half of the time Most of the time Almost always

29. When I'm upset, I become irritated at myself for feeling that way

Almost never Sometimes About half of the time Most of the time Almost always

30. When I'm upset, I start to feel very bad about myself

Almost never Sometimes About half of the time Most of the time Almost always

31. When I'm upset, I believe that wallowing in it is all I can do

Almost never Sometimes About half of the time Most of the time Almost always

32. When I'm upset, I lose control over my behaviour

Almost never Sometimes About half of the time Most of the time Almost always

33. When I'm upset, I have difficulty thinking about anything else

Almost never Sometimes About half of the time Most of the time Almost always

34. When I'm upset, I take time to figure out what I'm feeling

Almost never Sometimes About half of the time Most of the time Almost always

35. When I'm upset, it takes me a long time to feel better

Almost never Sometimes About half of the time Most of the time Almost always

36. When I'm upset, my emotions feel overwhelming

Almost never Sometimes About half of the time Most of the time Almost always

You're over halfway through! Thank you so much for your time; we really appreciate it :)

PHQ-8 (Kroenke, 2009)

Instructions: Please mark the circle that best describes you for each question. Over the last 2-weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

Not at all Several days More than half the days Nearly everyday

2. Feeling down, depressed, or hopeless

Not at all Several days More than half the days Nearly everday

3. Trouble falling or staying asleep, or sleeping too much

Not at all Several days More than half the days Nearly everyday

4. Feeling tired or having little energy

Not at all Several days More than half the days Nearly everyday

5. Poor appetite or overeating

Not at all Several days More than half the days Nearly everyday

6. Feeling bad about yourself - that you are a failure or have let yourself or your family down

Not at all Several days More than half the days Nearly everyday

7. Trouble concentrating on things, such as reading the newspaper or watching television

Not at all Several days More than half the days Nearly everyday

5. Moving or speaking so slow that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual

Not at all Several days More than half the days Nearly everyday

You're edging closer to the finish line. This is the last questionnaire, we promise! :) Thank you again for all of your support.

GRCS (O'Neil et al., 1986)

NB. This questionnaire has been found to be a valid and reliable measure of men's gender-role attitudes and behaviours through use in a number of published studies. Some of the questions may be difficult to answer, but please try to answer as openly as you can.

Instructions: For each question, please mark the circle that most closely represents the degree that you Agree or Disagree with the statement. There is no right or wrong answer to each statement; your reaction is what is asked for.

1. Moving up the career ladder is important to me

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

2. I have difficulty telling others I care about them

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

3. Verbally expressing my love to another man is difficult for me

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

4. I feel torn between my hectic work schedule and caring for my health

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

5. Making money is part of my idea of being a successful man

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

6. Strong emotions are difficult for me to understand

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

7. Affection with other men makes me tense

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

8. I sometimes define my personal value by my career success

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

9. Expressing feelings make me feel open to attack by other people

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

10. Expressing my emotions to other men is risky

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

11. My career, job, or school affects the quality of my leisure or family life

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

12. I evaluate other people's value by their level of achievement and success

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

13. Talking about my feelings during sexual relations is difficult for me

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

14. I worry about failing and how it affects my doing well as a man

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

15. I have difficulty expressing my emotional needs to my partner

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

16. Men who touch other men make me feel uncomfortable

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

17. Finding time to relax is difficult for me

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

18. Doing well all the time is important to me

Strongly disagree | Disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Agree | Strongly agree

19. I have difficulty expressing my tender feelings

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

20. Hugging other men is difficult for me

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

21. I often feel that I need to be in charge of those around me

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

22. Telling others of my strong feelings is not part of my sexual behaviour

Strongly disagree | Disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Agree | Strongly agree

23. Competing with others is the best way to succeed

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

24. Winning is a measure of my value and personal worth

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

25. I often have trouble finding words that describe how I am feeling

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

26. I am sometimes hesitant to show my affection to men because of how others might perceive me

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

27. My need to work or study keep me from my family or leisure more than I would like

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

28. I strive to be more successful than others

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

29. I do not like to show my emotions to other people

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

30. Telling my partner my feelings about him/her during sex is difficult for me

Strongly disagree | Disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Agree | Strongly agree

31. My work or school often disrupts other parts of my life (home, family, health, leisure).

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

32. I am often concerned about how others evaluate my performance at work or school

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

33. Being very personal with other men makes me feel uncomfortable

Strongly disagree | Somewhat disagree | Neither agree nor disagree | Somewhat agree | Strongly agree

34. Being smarter or physically stronger than other men is important to me

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree

35. Men who are overly friendly to me make me wonder about their sexual preference (men or women)

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

36. Overwork and stress caused by a need to achieve on the job or in school, affects/hurts my life

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

37. I like to feel superior to other people

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

Thank you so much for completing the survey! We hugely appreciate it. Your contributions will be invaluable for understanding more about this research topic and men's mental health.

Josh, Craig and Matthew

Appendix L: TDRP Interview Questions

Interview Questions

1. When you were a child, what messages did you receive about being a man?

    - Where do you recall those messages coming from?

      (e.g., peers, family, school, society, faith culture)

    - Now thinking specifically about when you were:
        - A child of primary school age, what messages did you receive?
        - A child of secondary school age, what messages did you receive?

2. To what extent does being a man shape how you see yourself?
3. Has the way you see yourself as a man changed over time?

    - Can you think of specific moments in your life when this has changed?

4. To what extent has being a man shaped how others have reacted to you?

I'd now like to ask you some questions about your experiences with mental ill health.

5. When you feel stressed, what do you do you notice about yourself?
6. What causes you to feel stressed?
7. How have you managed stress?
8. Finally, I'd like to ask you, what words that come to mind when you think about what it means to be a man?

Appendix M: TDRP Author Guidelines

Psychology of Men and Masculinities

2024 average time from submission to first editorial decision: **33 days**
Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.
View Guidelines for Reviewing Manuscripts (PDF, 151KB)

1. Submission
To submit to the Editorial Office of Y. Joel Wong, please submit manuscripts electronically through the Manuscript Submission Portal in Microsoft Word (.docx) or LaTex (.tex) as a zip file with an accompanied Portable Document Format (.pdf) of the manuscript file."
Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*). APA Style and Grammar Guidelines for the 7th edition are available.

General correspondence may be directed to
Y. Joel Wong, PhD
Indiana University Bloomington
Counseling and Educational Psychology
107 S. Indiana Avenue
Bloomington, IN
47405-7000

Email
Manuscripts for *Psychology of Men & Masculinities* may be regular-length submissions (7,500 words, not including references, tables, or figures) or brief reports (2,500 words, not including references, tables, or figures). **Please include your submission's word count on the title page.**

If Microsoft Word Track Changes was used in preparing the manuscript, please execute the "accept all changes" procedure, and remove all comments prior to submission.
Psychology of Men & Masculinities is now using a software system to screen submitted content for similarity with other published content. The system compares the initial version of each submitted manuscript against a database of 40+ million scholarly documents, as well as content appearing on the open web. This allows APA to check submissions for potential overlap with material previously published in scholarly journals (e.g., lifted or republished material).

If you are submitting a literature review, please read the Literature Review Guidelines.
Manuscripts for *Psychology of Men & Masculinities* may be regular-length submissions (7,500 words, not including references, tables, or figures) or brief reports (2,500 words, not

including references, tables, or figures). Please include your submission's word count on the title page.

Psychology of Men & Masculinities requires all manuscripts to comply with guidelines on equity, diversity, and inclusion (EDI). Read our EDI guidelines before submitting your manuscript.

Masked Review Policy

Psychology of Men & Masculinities uses a masked review process.

Each copy of a manuscript should include a separate title page with author names and affiliations, and these should not appear anywhere else on the manuscript. The first page of the manuscript should include only the title of the manuscript and the date it is submitted. Footnotes containing information pertaining to the authors' identity or affiliations should be removed.

Every effort should be made to see that the manuscript itself contains no clues to the authors' identity.

Please ensure that the final version for production includes a byline and full author note for typesetting.

2. Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*).
Review APA's Journal Manuscript Preparation Guidelines before submitting your article. Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In Online Supplemental Material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

3. Equity, Diversity, and Inclusion

Psychology of Men & Masculinities requires all manuscripts to comply with equity, diversity, and inclusion guidelines.

4. Participant description

Authors are encouraged to include a description of the study participants in the Method section of each empirical report, including (but not limited to) the following:

- Sex/Gender
- Race/Ethnicity
- Age

- Nativity or immigration history
- Socioeconomic status
- Any other relevant demographics (e.g., disability status; sexual orientation)

In the discussion section of the manuscript, authors are encouraged to discuss the diversity of their study samples and the generalizability of their findings.

5. Academic Writing and English Language Editing Services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several vendors that offer discounts to APA authors.

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6. Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the APA PsycArticles® database. Please see Supplementing Your Article With Online Material for more details.

7. Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

8. Public Significance Statements

Authors submitting manuscripts to *Psychology of Men & Masculinities* are required to provide 2–3 brief sentences regarding the public significance of the study or meta-analysis described in their paper. This description should be included within the manuscript on the abstract/keywords page, but in a separate paragraph from the abstract and keywords. It should be written in language that is easily understood by both professionals and members of the lay public.

When an accepted paper is published, these sentences will be boxed beneath the abstract for easy accessibility. All such descriptions will also be published as part of the Table of Contents, as well as on the journal's web page. This new policy is in keeping with efforts to increase dissemination and usage by larger and diverse audiences.

Examples of these 2–3 sentences include the following:

- "A brief cognitive–behavioral intervention for caregivers of children undergoing hematopoietic stem cell transplant reduced caregiver distress during the transplant hospitalization. Long-term effects on caregiver distress were found for more

anxious caregivers as well as caregivers of children who developed graft-versus-host disease after the transplant."

- "Inhibitory processes, particularly related to temporal attention, may play a critical role in response to exposure therapy for posttraumatic stress disorder (PTSD). The main finding that individuals with PTSD who made more clinical improvement showed faster improvement in inhibition over the course of exposure therapy supports the utility of novel therapeutic interventions that specifically target attentional inhibition and better patient-treatment matching."
- "When children participated in the enriched preschool program Head Start REDI, they were more likely to follow optimal developmental trajectories of social–emotional functioning through third grade. Ensuring that all children living in poverty have access to high-quality preschool may be one of the more effective means of reducing disparities in school readiness and increasing the likelihood of lifelong success."

To be maximally useful, these statements of public health significance should not simply be sentences lifted directly from the manuscript.

They are meant to be informative and useful to any reader. They should provide a bottom-line, take-home message that is accurate and easily understood. In addition, they should be able to be translated into media-appropriate statements for use in press releases and on social media.

Prior to final acceptance and publication, all public health significance statements will be carefully reviewed to make sure they meet these standards. Authors will be expected to revise statements as necessary.

9. Constraints on Generality

In a subsection of the discussion titled "Constraints on Generality," authors are encouraged to include a detailed discussion of the limits on generality (see Simons, Shoda, & Lindsay, 2017). In this section, authors should detail grounds for concluding that results are specific to characteristics of the participants and address limits on generality not only for participants but for materials, procedures, and context. They should also specify which methods the authors think could be varied without affecting the result and which should remain constant.

10. References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.
Examples of basic reference formats:

Journal Article

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored Book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an Edited Book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

11. Figures

Preferred formats for graphics files are TIFF and JPG, and preferred format for vector-based files is EPS. Graphics downloaded or saved from web pages are not acceptable for publication. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file. When possible, please place symbol legends below the figure instead of to the side.

Resolution

- All color line art and halftones: 300 DPI
- Black and white line tone and gray halftone images: 600 DPI

Line weights

- Adobe Photoshop images
    - Color (RGB, CMYK) images: 2 pixels
    - Grayscale images: 4 pixels
- Adobe Illustrator Images
    - Stroke weight: 0.5 points
    -

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., “the red (dark gray) bars represent”) as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- An additional $600 for the second figure
- An additional $450 for each subsequent figure

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Starting in August 2017, articles are eligible for open science badges recognizing publicly available data, materials, and/or preregistration plans and analyses. These badges are awarded on a self-disclosure basis.

At submission, authors must confirm that criteria have been fulfilled in a signed badge disclosure form (PDF, 33KB) that must be submitted as supplemental material. If all criteria are met as confirmed by the editor, the form will then be published with the article as supplemental material.

Authors should also note their eligibility for the badge(s) in the cover letter.
For all badges, items must be made available on an open-access repository with a persistent identifier in a format that is time-stamped, immutable, and permanent. For the preregistered badge, this is an institutional registration system.

Data and materials must be made available under an open license allowing others to copy, share, and use the data, with attribution and copyright as applicable.
Available badges are:



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All data necessary to reproduce the reported results that are digitally shareable are made publicly available. Information necessary for replication (e.g., codebooks or metadata) must be included.



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Preregistered:
At least one study's design has been preregistered with descriptions of (a) the research design and study materials, including the planned sample size; (b) the motivating research question or hypothesis; (c) the outcome variable(s); and (d) the predictor variables, including controls, covariates, and independent variables. Results must be fully disclosed. As long as they are distinguished from other results in the article, results from analyses that were not preregistered may be reported in the article.



Preregistered+Analysis Plan:
At least one study's design has been preregistered along with an analysis plan for the research — and results are recorded according to that plan.

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