Masculinity and mental health

STRATEGIES FOR IMPROVING HEALTH AND SOCIAL CARE

Swedish Association of Local Authorities and Regions

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Foreword

The quest for gender equality is founded on women's battle for equal rights and opportunities. However, gender equality work must necessarily also involve boys and men, and challenge the notions of masculinity that are a barrier to equality.

A gender equality strategy for changing restrictive and harmful masculinity norms can be of tremendous benefit to both women and men, and to society as a whole. It can bring about increased security, improved health, greater equality in relationships and less violence, as well as improved quality in education, healthcare, and social care. It can help to break up gender-segregation in the labour market and broaden the public service recruitment base.

This was the rationale for the agreement between SALAR and the Swedish government which led to an initiative on men and gender equality in 2016–2017.

The initiative started with a comprehensive survey of gender equality initiatives including men and masculinity norms in municipalities, county councils and regions, and has been conducted through extensive partnerships with representatives from public sector, research and civil society. In 2016 the deliverables included a number of films and regional conferences.

During 2017 the initiative has focused on gender equality in education, healthcare and parenting, as well as anti-violence initiatives. In each of these areas SALAR has produced films, reports and papers to outline possible routes to change.

This document contains proposals for strategies for developing the healthcare sector from a starting point of gender inequality and masculinity norms.

It is aimed at politicians, managers and strategists responsible for operational development, but also at other municipal and county council employees.

Our hope is that this material will reinforce ongoing gender equality efforts and inspire new initiatives, with the ultimate aim of women and men having equal power to shape society and their own lives.

Stockholm, March 2018

Vesna Jovic
Managing Director

Swedish Association of Local Authorities and Regions

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CHAPTER 1

Mental ill-health, gender inequality and masculinity

One of the aims of the national gender equality policy is that women and men, girls and boys should have equal opportunities for good health, and be offered health and social care on equal terms. One of the challenges in the effort to prevent and treat mental ill-health among boys and men are the masculinity norms that state that men should be strong and performance-oriented – norms that condition not only men's own attitudes to their emotional needs but also the provision of healthcare services.

By 2030 mental ill-health is expected to pose a major public health challenge, in Sweden as well as worldwide. The proportion of the population that report impaired mental wellbeing has increased in most groups over the last decade, both among women and men and in a range of age and educational groups. The biggest increase in mental ill-health is seen in adolescents and young adults.[1] Mental ill-health is more common among women than men in Sweden, and women also more frequently report problems with worry and anxiety (37 per cent of women versus 24 per cent of men). Research indicates that differences in women's and men's mental health correlate with sociocultural patterns in which expressions of mental ill-health are linked to gender.[2] Men with depression often display symptoms other than those expected by healthcare professionals, such as aggressive or disruptive behaviour or substance abuse. Likely consequences of this are that men's mental ill-health may remain undetected or that men are not given the right treatment.

Note. 1. Public Health Agency of Sweden (2016a).
Note. 2. Män och jämställdhet [Men and gender equality]. SOU:2014:6.

Mental ill-health may also cause self-destructive behaviour and lead to violence directed against oneself or others. There is a link between mental ill-health and intimate partner violence. Ultimately mental ill-health may lead to suicide, which is a significant public health problem – in Sweden and in the rest of the world. More than 1,100 individuals commit suicide in Sweden each year, more than 800 of whom are men.[3]

There are also clear links with gender and gender inequality in the area of young people and sexual health, in that gender-related expectations on young men and women affect the way they develop their sexuality and their relationships.[4] However, in recent years there has been increased awareness of men's needs in terms of support and advice on issues of sexuality and health, which can be seen as an important element in working with men towards gender equality and change.[5]

The work of women and their increased power resources have helped to make Sweden a relatively gender-equal country by international standards.[6] As a group women have gained ground and abandoned traditional gender patterns in several areas, not least in the job market. However, on the whole men have more power and remain privileged in a number of areas. Examples of this include the fact that men are paid more than women, that two out of three local council chairs are men, and that four out of five company directors are men. One expression of male power and dominance is that men are overrepresented as perpetrators of sexual harassment and violence against women and children, and of violence against other men.

Success factors for change

There is a need for more early and preventive interventions against mental ill-health in men and boys, before problems and issues with health or relationships have got out of hand. This paper contains examples and proposals for implementing change within service providers at local and regional level. There are a number of key success factors for this change process:

- To be able to target interventions, service providers and staff must have a thorough understanding of the differences between many women and men in the way mental ill-health is expressed.
- Service providers need to understand how masculinity norms restrict boys' ability and inclination to seek help and support when they are feeling unwell.

Note. 3. Socialstyrelsens Dödsorsaksregister [Swedish National Board of Health and Welfare Cause of Death Registry]: http://www.socialstyrelsen.se/register/dodsorsaksregistret

Note. 4. Public Health Agency of Sweden (2017a).

Note. 5. Män och jämställdhet [Men and gender equality]. SOU 2014:6.

Note. 6. European Institute for Gender Equality (2017).

- An important step towards change will be that more young and adult men take greater responsibility for their mental and sexual health. For such a change to be successful boys and men must be actively involved in the development process.
- The change process must be implemented at multiple levels and in multiple sectors, including working with parents and providing training for members of staff who encounter boys and men, and by creating space for educational and norm-critical conversations in and outside of school at pre-school, primary and secondary level.
- To give boys and men, girls and women the opportunity to develop good health and mutually fulfilling relationships, gender equality efforts within the public sector must also challenge masculinity and sexuality norms.

Harmful and restrictive masculinity norms

Masculinity norms are notions and ideas about men and masculinity that are shared by a large part of society. They state what is expected of men for them to be socially accepted and achieve status. All men and boys are not affected in the same way, but everyone relates in some way to these ideas of masculinity, referred to hereafter as *traditional* masculinity. These notions and ideals are very much alive to this day and are founded on ideas that men should be strong, performance-oriented, self-controlled and independent. In this way traditional masculinity is linked with characteristics that are associated with dominance and control. Men and boys who fail to live up to these ideals may risk various sanctions from those around them, which constitutes a crucial mechanism for preserving the norm.

Masculinity norms are defined in relation to femininity norms. These are contradictions or opposites of one another, with femininity being regarded as inferior to masculinity. Examples include strong–weak, performance-oriented–relationship-oriented, independent–dependent, and controlled–emotional.[7] Masculinity is not an innate trait; there is nothing essentially "male". Instead it involves associating certain characteristics, traits and expressions – that may be displayed by any person regardless of gender – with men and masculinity. In other words, men and boys are not the only ones who need to relate to masculinity norms. These norms are also linked to the notion of men and women as one another's opposites; that men should be "masculine", with all that this entails, and that women should be "feminine" with all that this entails. However, women also possess traits and attributes that are considered masculine under the norm, and likewise men possess feminine traits.

Note. 7. Hirdman (2003).

Breaking the norms may, however, often have adverse consequences for the individual in terms of loss of status, being questioned by peers, and suffering discrimination, harassment or abuse. This is not least evident when considering the living conditions for transgender people, a group that has been very hard hit by narrow conceptions of gender and as a consequence is particularly vulnerable in terms of mental ill-health.[8, 9]

Glossary

- Cisgender individual: An individual whose body, legal gender, and gender identity and expression match the norm of the gender they were assigned at birth. Another term for non-transgender people.
- Transgender individual: Umbrella term for people whose gender identity and/or gender expression does not match the norm of the legal gender they were assigned at birth.
- Binary: Something which has two elements, for example the classification of human beings by gender as either female or male.
- Non-binary: Umbrella term for a variety of gender identities that are outside the binary gender norm. Describes individuals who identify themselves between or beyond the binary classification of gender as female–male.

Source: Rätten till hälsa. Hur normer och strukturer inverkar på transpersoners upplevelser av sexuell hälsa [The right to health. How norms and structures affect transgender individuals' experiences of sexual health]. Public Health Agency of Sweden (2016b).

This text focuses on how men's and boys' mental health can be adversely affected by restrictive masculinity norms, and proposes strategies for changing such norms and thus helping to improve equality between women and men. The text is general and does not address in detail how cisgender and transgender individuals may be affected in different ways by masculinity norms, but there is every reason for raising awareness in this area within municipalities and regions, to help achieve equality in healthcare and improve the living conditions for both binary and non-binary transgender individuals.[10, 11]

Traditional norms that grant boys and men privileges may also increase their vulnerability. For example, eight out of ten victims of fatal drowning are men, and three times as many men as women die from alcohol-related conditions. The majority of victims of physical violence are boys or men.

Note. 8. Public Health Agency of Sweden (2015).
Note. 9. Public Health Agency of Sweden (2016b).
Note. 10. Transpersoner i Sverige [Transgender people in Sweden]. SOU 2017:92.
Note. 11. Swedish National Board of Health and Welfare (2015).

However, men and boys are not a single homogenous group; the variation in living conditions and opportunities is huge. Class, sexual orientation, skin colour, level of education, ethnicity, physical ability, age etc all reinforce hierarchies and positioning within the group of men and boys. Men and boys also relate differently to masculinity norms that convey power and privilege. This also reinforces power hierarchies within the male group. All men and boys are not willing or able to fit into these norms and ideals. Some men and boys also put up deliberate resistance.

In other words, the same traditional norms that convey privileges for boys and men may have disadvantages in terms of shallow relationships, ill health and a shorter life span, which may also be costly for society.[12] Doctor of psychology William Pollack has said that one of the most serious and harmful demands that traditional masculinity makes of boys is to suppress human emotions and expressions that are coded as feminine, such as care, empathy and expressions of sadness or vulnerability. Pollack refers to this demand as a gender straitjacket for boys.[13]

Men are less inclined to seek help or care than women, and they generally wait longer before doing so. A study from Västra Götaland Regional Council has shown that the greatest differences are seen in primary care.[14] A study from Stockholm County Council has shown that almost twice as many women as men are receiving some form of treatment for mental ill-health. According to this study this is unlikely to reflect any corresponding difference in actual health. Instead it proposes other reasons: "that the care provided is not appropriate for men; that men express ill health differently from women and for this reason do not fit into the healthcare system; that men feel more stigmatised by mental ill health than women.[15]" Lack of awareness of how men's mental ill health may present may result in healthcare professionals failing to spot potential underlying causes of, for example, drug or alcohol abuse.

The same pattern can be detected among boys and young men. They are less inclined than girls and young women to seek help and support when feeling unwell.[16] Boys and young men account for only 10–15 per cent of visits to youth health clinics: worst case, staff expectations of boys and young men may lead to few of them seeking help later in life as well.

Note. 12. Messner (2001).

Note. 13. Pollack (1998).

Note. 14. Osika Friberg, Krantz, Määttä & Järbrink (2015).

Note. 15. Centrum för epidemiologi och samhällsmedicin [Centre for Epidemiology and Community Medicine] (2017).

Note. 16. Börjesson & Rasmusson (2017).

Challenging norms benefits both individuals and society

Challenging and changing traditional masculinity norms in the fields of mental health and sexual health can have a number of health and equality benefits.

These benefits will be both financial and social, such as increased security and improved mental and sexual health among adolescents and adults irrespective of sexuality or gender identity. This would mean fewer assaults, less sexual harassment, fewer suicides, less violence among young people and reduced crime levels.

Creating opportunities for boys and men to seek help at an early stage and take responsibility for their health will reduce the risk of developing destructive or violent behaviours and mental illness both to the individuals and the people around them. It would also reduce the burden on many women who at the moment are taking the lion's share of the emotional responsibility in heterosexual relationships.

Changing ideas of masculinity and sexuality can also make healthcare services more accessible to vulnerable groups of boys and men who are disinclined to seek care when they need support and help. This may result in health improvements among LGBTQ persons, migrants and individuals living with honour culture norms, among others.

In the short term, providing boys and men with more space for identifying their needs and issues may take up more time; however, being actively involved may motivate them to take greater responsibility for their own change. This is also in line with the new Patient Act which came into power in 2015 and which aims to reinforce and clarify the patient's status and promote patient integrity, autonomy and participation.[17]

Norms affect men's inclination to seek help

Young women often seek knowledge and support at a relatively early stage. Girls are encouraged from an early age to talk about their thoughts and emotions.[18] Girls are expected to be able to express their emotional needs, which makes it easier for others to understand their needs. Girls are also encouraged to be sensitive to the emotions of others and to care for others. Boys and young men, on the other hand, are not encouraged in the same way to pay attention to their own emotional needs and those of others. This gets all the more evident when it comes to seeking help. Many adults, professionals as well as parents, do not expect boys to commit to relationships or be able to

Note. 17. Patient Act 2014: 821 (2017).
Note. 18. See Thomsson & Elvin-Novak (2012).

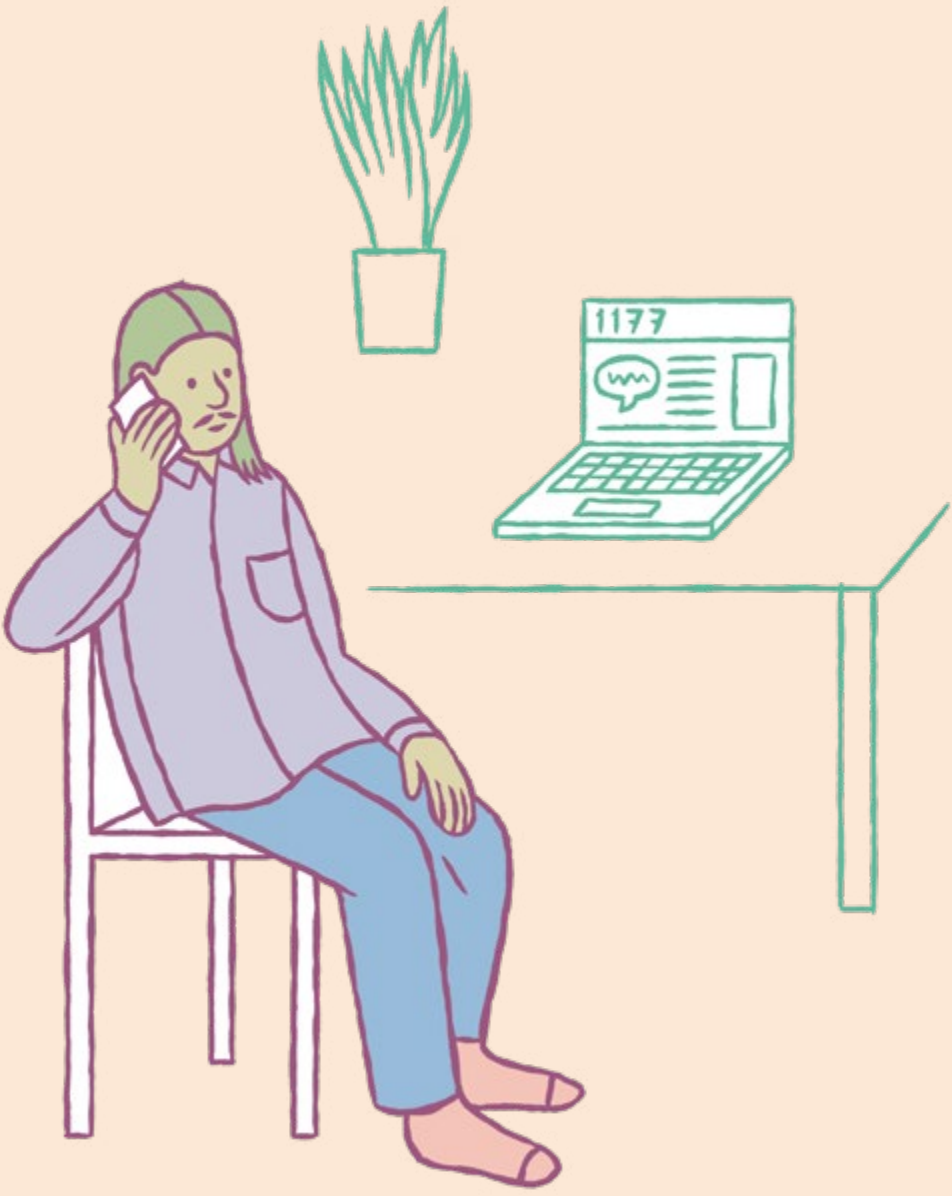
put their emotional needs into words, or take responsibility for their well-being.[19] The consequence may be that adults do not ask the same questions of boys as they do of girls, and also that adults do not listen when boys and men express their feelings, especially not feelings of vulnerability. Thus boys do not get the same amount of practice in verbalising their emotions or taking responsibility for their own needs and those of others.

One consequence of this is that many boys and men also are not used to recognising emotions such as anxiety or sadness at times of adversity or crisis. Emotions such as anger and hostility have traditionally been seen as acceptable and something boys are taught to express, whereas vulnerability and sadness are seen as weaknesses. For many men, emotions like these pose a threat to their "manliness". Seeking help therefore means risk of losing status, control and independence.[20]

Teaching a boy to suppress and conceal mental and emotional stress will most likely weaken his ability to cope with emergencies such as separations or deaths in adulthood.

Keeping quiet about mental, emotional or sexual issues thus becomes a way of appearing masculine. Seeking help may feel like, and be perceived as a loss of status.[21] This may prolong and deepen the individual's suffering and generate high costs for society. As men delay seeking help, treatments may end up less effective and more costly.[22]

Note. 19. See Oransky & Fisher (2009).
Note. 20. Möller-Leimkühler (2002).
Note. 21. Tyler & Williams (2013).
Note. 22. McVittie & McKinlay (2010), Osika Friberg et al. (2015).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CHAPTER 2

Young men talk about seeking help

Below are quotes from young men as they think about and reflect on the process of seeking and receiving help. The material comprises individual and focus group interviews with men aged between 20 and 30 years, conducted during 2015–2017 at the Young Men's Health Centre in Gothenburg.[23] The men approached the centre and the focus groups on their own initiative. They represent a variety of backgrounds and experiences and had sought help for different reasons, such as substance abuse, difficulties maintaining a relationship, anxiety, or self-harm.

The Young Men's Health Centre [Mottagningen för unga män – MUM]

The Young Men's Health Centre is open on certain days and evenings for people who define themselves as male. Services offered include testing for sexually transmitted diseases, and counselling. Because men often seek help later in life than women, MUM has an upper age limit of 30 years.

The fact that MUM is a centre for people who define themselves as male seems to have helped many in taking the first step. The name also suggests that the staff are aware of and understand the needs of young men. In recent years more young men have come to the centre with emotional difficulties and problems, and not just for getting tested.

The centre opened in 1999, in response to a clear need for a service provider that could capture the needs of young boys and men. In 2013 the centre was granted permanent funding through Gothenburg City Council and Västra Götaland Regional Council.

Note. 23. Bo Helsing, unpublished data. The material comprises interviews within three focus groups and eight individual interviews with men aged 20 to 30 years, conducted between 2015 and 2017 at the Young Men's Health Centre in Gothenburg.

Men's mental ill-health remains partly hidden

The focus groups showed that seeking help for mental ill-health was a taboo. It represented the opposite of being successful and self-sustaining. As one man put it, anyone having mental health problems and admitting it and who also seeks help is "really weak". Several respondents also reported that telling other men around them about having a counsellor was harder than, for example, talking about being tested for sexually transmitted diseases.

Because many men will not seek help, neither from healthcare professionals nor from friends or family, it is difficult to assess their actual state of health.[24] This means men's emotional problems will remain partly hidden in society. This perspective was reflected in the men's individual stories. Over a long period of time they had come to regard their ill health as the natural state of things. Seeking help had not been seen as an option. Emotional issues and tough experiences had been suppressed. Coping had become the normal state.

One young man said that he could hardly recall any period in his life when his family's difficult situation has not been on his mind:

"It becomes a habit or a natural state, a frame of reference and you have nothing to compare with. At some level you are still able to walk and breathe and hold down a job, so maybe there is no point in seeking help apparently."

The problems had not been perceived as problems before; they had become a part of life. One man said he felt sometimes well and sometimes unwell, and that he had managed his life on that basis.

"Well, in some way I haven't thought of it as a problem. That it's a problem you can get help for, it's more something you need to get through as a male."

Strategies for avoiding dealing with mental ill-health

The interviews provide numerous examples of the different strategies young men use for avoiding dealing with mental ill-health. These include delaying contacts with healthcare providers, diminishing the problems, or cutting oneself off to be able to cope with everyday life.

Note. 24. Möller-Leimkühler (2002).

Delaying contact involves not taking the situation seriously despite being aware of the problems. At times there may have been plans for dealing with the issue, or someone else may have told the person to seek help, but still it has been put off.

"There have probably been several occasions where I have thought this would be a good time. I have a lot I need to deal with, but I've told myself: 'later, sometime'."

Delaying may also be a deliberate strategy used for a period of time, because the timing in life is not right. One man coped until an opportunity presented itself.

"I thought, now I have to do it, I want to and I have the time now. I have finished my education and I can get to work on myself, kind of."

Diminishing means to make invisible, a way of trivialising the problems. It involves a fear that others will not consider the problems serious enough to warrant seeking help, or that there are those who are worse off.[25] It is also used as an excuse for not acknowledging one's own needs. There may also be a fear that others may think the person is just being attention-seeking. One young man revealed this by using the word "silly" about himself seeking help.

"Like, at some level I realise this is probably an issue that has affected me and is affecting me now, but I still feel incredibly silly talking about it because there are people who are worse off... You become a burden on those who need to take care of you, and you take up time from someone who is much sicker than you. Time is a huge problem and people are already putting in a lot of overtime, and then you turn up with your trivial problems."

Another form of diminishing that was described in the interviews and focus groups involved being evasive when other people ask how you are doing. Responding "it's not that bad" or "I'm going to get help" avoids further questions.

Note. 25. Tyler & Williams (2013).

"It becomes an every-day-of-life defence. You may avoid looking certain people in the eye, kind of. They can see something is the matter, but you don't want to open that particular box. Often you dodge it on a daily basis whenever someone asks, are you all right? And you say: Yeah, I'm fine."

Evasion can be summed up in the well-known metaphor "keeping the lid on".

"The fact that it has got so big now is because you haven't dealt with it sooner. That you've put the lid on it and ignored it. I suppose my way of surviving has been to play a part. To avoid having any feelings, and eventually you end up in this little box with two emotions. Happy and angry, sort of. I suppose that has been my strategy."

Evasion also seems to be about not being used to talk about one's emotional issues. This can result in shallow relationships.

"She said it was impossible to have a serious conversation with me without me trying to make a joke of it. It may be true. I may never have had any of those really deep conversations, and that makes it difficult to get close to someone. If you never talk about your emotions, and I was taught at an early age that that's not the done thing."

Isolation is another strategy that is linked to evasion. When it takes everything you have to "keep it together" until the end of the working day, there will be nothing left for seeing friends or doing things in the evening. Emotional problems cost energy, and there was an awareness among the young men that their performance was impaired – which in turn fed their self-criticism. Having to keep a straight face and dodge questions can cause social strain.

"I spend too much time thinking of how I'm perceived by everyone else, what I'm like and what I do. For this reason I daren't be around people. It feels as if I haven't got anything to say to people because I don't know what people want to talk about. I've become quieter."

Keeping the problems to yourself, under a "lid", detaches you from your own emotions. This will lead to difficulties not only with talking about your problems with others, but also with sharing other experiences. The consequence may be that you distance yourself from yourself.

"Whenever I talk about my problems it's as if I've been put inside a bubble or on a cloud. As if I'm talking about someone else down there, and I'm looking down. I distance myself hugely; I become almost callous, as if it's not about me when I'm talking about it."

Isolation may also involve taking concrete action, and increasingly avoiding social interaction. This can be done deliberately, or you may discover a pattern of doing it in yourself.

"I'm smart enough not to see other people at times when I'm hit by anxiety."

"What I noticed was happening to me was that I was cutting myself off. I avoided talking to people and I didn't take part in any activities. It affects my everyday life and it's quite sad when you're too angry to participate. That's what's affecting me the most: that I get angry and isolated."

Difficulty facing up to the problems

Being male and looking after your health does not clash with the masculinity norm where physical health is concerned, for example in connection with a sports injury. However, as regards seeking help for emotional problems, such as relationship and sexual issues, the norms are much more narrow.[26] That the young men in the focus group were affected in terms of self-esteem was evident from their descriptions of feeling inadequate. It is a challenge to admit to yourself that you have not been able to solve your problems. This means that to tell your male friends that you are having counselling will not be an obvious thing to do. There is a fear that this will be seen as a failure. It is a question of protecting yourself from looking needy[27], and being concerned that revealing your problems and issues may change the way other people see you. The fear is that you will be deemed inadequate, weak, incapable of looking after yourself, or be seen as someone who is ill.

"I'm afraid of what people will think, that I will be caught out somehow. I can imagine that anyone having counselling will be afraid of being seen as ill. In need of care, because that means you're not a strong person."

Note. 26. Tyler & Williams (2013).
Note. 27. Addis & Mahalik (2003).

There is a fear that others may perceive you as difficult, awkward, or a burden. This is not in line with the expectations of independence and autonomy.

"I said to myself that I must stop being difficult for a while, otherwise I will become like one of those awkward ones, sort of. I'm, like, not worthy of being allowed to feel bad. I suppose that it's something I have often feared, that people will think I'm being troublesome."

Fear of losing status

The young men who participated in the focus group interviews believed they had created a self-image of themselves as indestructible. Acknowledging and being open about your needs with yourself and others is something that is seen as weak or feminine. In their discussions they questioned these values, but at an emotional level these perceptions were very strong.

"I have made myself believe that coping on your own is a man thing. Not accepting help, just be responsible for your own problems and it becomes somehow self-fulfilling."

"That's something they teach you in pre-school, isn't it, that it doesn't hurt when you fall over, and on principle boys cannot bleed."

Many young men are not used to talking to other young men about feeling unwell, except when something has actually happened, for example when a relationship has ended. In such situations male friends may provide support, often by diverting attention or suggest activities such as seeing a game or going to the gym.

In the absence of a concrete explanation behind emotional issues or feelings of anxiety, turning to girlfriends and female acquaintances appears to be easier. In situations ridden with anxiety acting decisively can be a challenge, and it may be difficult to know how to handle the situation. The fear of losing status is present in these moments of vulnerability, which means many would rather turn to a woman close to them.

"I don't know why but somehow it's easier to be soft in front of girls, but it's hard to explain why. I feel, this may sound completely stupid, but with a girl I know that in a couple of days I'll be back to normal again and my position won't have changed in any way. I don't know what to say, I suppose it's a hell of a patriarchal way of thinking."

A possible consequence of boys and men not being taught to take responsibility for their own health may be that the responsibilities for health and relationships are assumed by women close to men, such as partners, siblings or colleagues.

"It's on a different level when you are at your very weakest. Because if my whole face is in shreds and I'm just sitting around crying, like, I'd rather have a woman near me actually, for some reason."

However, when the difficulties you are having involve problems in a relationship, bringing them up with your partner becomes more difficult. The inability to recognise and understand your own emotional issues creates limitations. Not being able to deal with the problems yourself is seen as a failure.

"One of the problems in our relationship is that I haven't turned to her and told her how I feel. I've been meaning to do it, but in the end I haven't done it for fear of letting her down or making her sad."


UMO.se

CHAPTER 3

Masculinity and sexuality

In the comprehensive report "Sexuality and health among young people in Sweden" published by the Public Health Agency of Sweden in 2017, the majority of respondents describe their sexual health and practices in positive terms.[28] However, a certain gender-related variation can be seen. Young men are slightly less satisfied with their sexual practices than young women.[29] The majority highlight the need for communication on sexual intercourse, but the importance of having a conversation is mentioned slightly more frequently by young women

Masculinity norms also have an impact on ideas of sexuality. Who and what is supposed to turn a man on, in what way men are expected to want to have sex and how you yourself would like to be as a sexual partner, are all closely linked with what is expected of a "real man". It is not just about the fact that our society is shaped by the heterosexual norm and that men and women are expected to be heterosexual. It is also about ideas that men should be proactive and randy, and turned on by women who are submissive and obsequious. The notion of men as potent and sexually self-assured plays a role in how young men deal with their sexuality.[30] Local context, close friends and other circumstances also influence young men's expectations and ideas of how to shape their own sexual practices.[31] Such notions and ideals can cause problems in close relationships and have a negative impact on mental well-being.

Expectations that men should be the initiators of sex can easily cause performance anxiety. Not being used to talking about issues of intimacy, vulnerability and sexuality, young men risk internalising these problems. The idea

Note. 28. Public Health Agency of Sweden (2017a).
Note. 29. Häggström-Nordin & Mattebo Eds (2016), Johansson (2005), Tikkanen et al. (2011).
Note. 30. Johansson (2005), Berg (2016), Häggström-Nordin & Mattebo (2016).
Note. 31. Tikkanen, Abelsson & Forsberg, (2011).

that men have to live up to the "potent and sexually self-assured man" stereotype can make it harder for young men to initiate conversations with friends or grown-ups about these expectations.[32] This idea is linked with masculinity norms that advocate independence, decisiveness and the "stronger alone" ideal.[33]

An interview study comprising ten heterosexual young men aged 16–24 years showed that the expectation that they would be the driver in sexual intercourse had become the norm to them.[34] The purpose of the study was to understand how consensual sexual intercourse can slide into becoming sexual assault and rape. The study participants were used to being the initiators and "drivers" of sexual intercourse. This meant that most of the time they could have sex in any way they themselves wanted. As the conversations progressed the men increasingly came to realise that their practice was to carry on with their advances and propositions until they heard a clear no. In other words, silence was interpreted as a yes. During the interviews the men in the study began to reflect self-critically on the extent to which they were actually sensitive to contrary signals from their partners.

The "potent, sexually self-assured man" ideal may also make it harder for young men to say no to having sex with a partner, and may cause young men to have sex against their will to avoid being seen as "dull" or "unmanly".[35] The image of men as always wanting sex may also make it harder to recognise and express feelings of discomfort. This may cause young men to overstep boundaries – their own or those of others – and not listen to their own or other people's needs. Lack of practice in putting emotions, thoughts and needs into words in the presence of other people may have an overall impact on young men's well-being and how they conduct themselves in close relationships.

Pornography, masculinity and sexuality

Pornography is something most young men and women come into contact with as teenagers.[36] The anonymous Q&A feature on UMO.se (online youth health service) receives a large number of queries relating to pornography.[37] These range from concerns about porn-related erectile dysfunction from watching too much porn, to feeling uneasy about the often abusive way in which women are portrayed in porn. A Swedish survey among young men in

Note. 32. See Randell (2016), Oransky & Fischer (2009).
Note. 33. Johansson (2005).
Note. 34. Berg (2016).
Note. 35. Berg (2016).
Note. 36. Häggström-Nordin & Mattebo (2016).
Note. 37. www.umo.se, National website on sex, health and relationships.

upper secondary school showed that many had come into contact with porn from as early as age twelve, and that almost 90 per cent had viewed pornography at some point.[38]

Anyone viewing pornographic depictions of heterosexual acts is expected to be aroused by scenarios in which men are capable of having sex whilst sustaining prolonged erections, and in which men are the main drivers and achieve multiple orgasms. Porn typically conveys an image of sex in which mutual intimacy and closeness are not taken for granted; instead the sexual intercourse is characterised by the man "helping himself" irrespective of consent. A considerable amount of porn also contains elements of violence and abuse of women. This means most boys and men from an early age will relate to the "potent, sexually self-assured man" ideal that is reflected in a lot of pornography. For many young men this may be a significant proportion of what they are taught about sex.

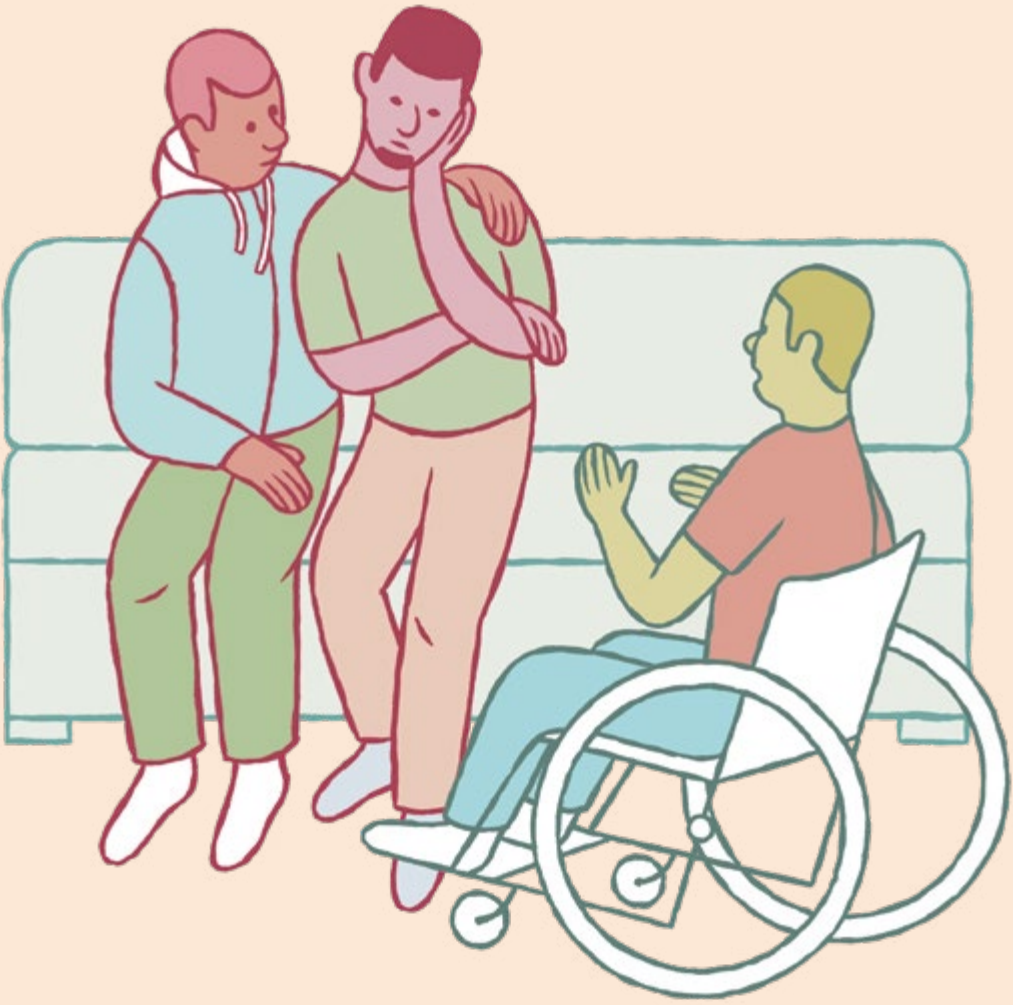
Attempts at challenging pornographic imagery are hampered by the fact that similar notions of men and sex are being reflected in television series, fiction films, and games. Meanwhile many young men do not talk to peers or grown-ups about their thoughts about sex. This means they do not get to practice their ability to express themselves about their own sexuality and feelings about uncertainty, arousal and intimacy, nor are they challenged with respect to the notions and ideas about masculinity that they have obtained from, for example, pornography.

Measures for promoting mental and sexual health

This is where society can play an important part, through schools, youth health clinics, and healthcare providers among others. By giving young men opportunity to talk about their expectations of sex, intimacy and closeness with adults who are able to challenge narrow ideas of gender and sexuality in an educational and respectful way, sexuality can become part of their own identity and boost their mental well-being.

To be successful, such activities must be founded on awareness of young men's living conditions, and the staff must have access to tools for challenging restrictive norms on gender and sexuality. A successful change process can contribute to improved sexual health and increased gender equality. It is also an important early intervention in the work against sexual abuse and intimate partner violence.

Note. 38. Mattebo & Häggström-Nordin (2016).



CHAPTER 4

Masculinity and suicide

Suicide is notably more common among men than women. It may be the clearest indicator of the different terms on which men and women seek help for mental ill-health.

In recent years more than 1,100 individuals have committed suicide in Sweden annually, of whom more than 800 were men. If we include deaths were it is uncertain whether the person intended to commit suicide – so-called uncertain suicides – the number goes up to approximately 1,500 per annum, of whom more than 1,000 were men.[39]

The consequences of suicides are hard to estimate; they cause suffering for everyone involved, as well as high costs to society. However, suicides can be prevented and avoided, and in Sweden this is work in progress.

That men are overrepresented in suicide statistics has been well known for a long time. This is a pattern that is repeated almost all over the world. That said, there are variations in the number of suicides among men, both over time and between countries. The same applies to gender variations. Despite this there is as yet nothing in current suicide prevention efforts to account for the fact that men more frequently commit suicide than women. Nor is there any coherent view among researchers on why men more often commit suicide, but the key research conclusions can be summarised thus:

- Men who are at increased risk of committing suicide do not seek help to the same extent as women. Neither from within their own networks nor from healthcare services.
- Those men at increased risk of committing suicide who do seek help from healthcare services or other providers are less likely to be identified as suicidal by healthcare professionals. For this reason they often do not receive the help they need.
- Men who commit suicide are more likely to use more decisive or drastic methods where the probability that the suicide will completed is higher.[40]

Note. 39. Karolinska Institute (2015).
Note. 40. Hadlaczky, Hökby & Wasserman (2014).

The different living conditions of boys and men are reflected also in the suicide statistics. Age, level of education, sexual orientation, and gender identity are all factors that may have an impact. Suicide is the most common cause of death among men aged 15–44 years. The largest proportion of suicides is committed by men in the age group 45–64 years (2015). Low education level and poor school performance are clear risk factors among men.[41] No such risk factors apply to women. The risk of suicide is also higher among LGBTQ individuals, regardless of biological sex. Prolonged and severe stress due to discrimination and heteronormative attitudes, known as minority stress, contributes to mental ill-health in this group and conditions such as depression, psychosis and alcohol abuse are more common.

A study published by the Swedish National Board of Health and Welfare found that LGBTQ people as a group are at increased risk of early death.[42]

The number of suicides varies between different parts of Sweden. Regional suicide rates vary year on year, but several rural counties are at the top of the league table. In 2015 the highest rates were reported in the counties of Gotland and Kalmar.[43] The suicide rate among the reindeer-herding Sami community is notably higher than in the general population.[44] In this group the suicide rate among men is 4- to 5-fold higher than among women.

Mental ill-health is a major risk factor for suicide

Suicide or suicide ideations are not in themselves signs of illness; instead they are just that, actions and thoughts. However, a large proportion of suicides are committed in a state of mental ill-health or illness. It is estimated that 90 per cent of suicides in Western societies are committed by individuals suffering from some form of mental illness.[45] Depression, bipolar disease, anxiety disorders, and psychoses are all common diagnoses that are associated with increased suicide risk, especially in the presence of alcohol or drug abuse. At the same time, far from everyone diagnosed with one of these conditions ever tries to commit suicide.

Many researchers and clinics subscribe to the view that a large proportion of suicides are committed in a state of clinical depression. Some are of the opinion that the proportion may be as high as 70–90 per cent of all suicides. For this reason, diagnosing and treating depression is something of a key issue in the efforts to prevent suicide.

Note. 41. Gunnell, Löfving, Gustafsson & Allebeck (2011).
Note. 42. Swedish National Board of Health and Welfare (2016).
Note. 43. Karolinska Institute (2017). Public Health Agency of Sweden (2017b).
Note. 44. Jacobsson (2014).
Note. 45. Arsenault-Lapierre, Kim & Turecki (2004).

The route to depression or other forms of mental illness and suicide can follow a number of different paths. Poverty, external stress, traumatic experiences or dramatic events, as well as suffering abuse, bullying or violence may all cause depression. Especially for individuals who lack a social safety net. Social exclusion, loneliness and different forms of loss – financial, emotional, or status-related – will also typically increase the risk of stress, social isolation and suicide.

There are no gender differences as to what promotes or maintains good mental health. However, it appears as if men and women differ in their vulnerability to different forms of loss in different situations in life.[46, 47] A Danish review of 800 suicides identified unemployment, retirement, loneliness, and being on sick leave as the principal risk factors for suicide among men.[48] It appears that losing the ability to earn a living and support your family and losing social status can trigger severe stress reactions among men, which is consistent with increased suicide rates among men at times of social change or during crises. In contrast, many women appear to have a protective ability to form and maintain health-enhancing social networks in times of crisis and transition, and take responsibility for their families and create a sense of control and meaning in life. Instead women appear more vulnerable to losing relationships and feeling unwanted in a social context.

There is evidence to show that there is a hereditary component to being vulnerable to stress and depression.[49] However, there is no evidence to suggest that such hereditary vulnerability is linked to biological sex.

Why is suicide more common among men?

As stated above, researchers largely agree that depression is an important risk factor for suicide. From this point of view it is paradoxical that while men are significantly less likely than women to be diagnosed with depression, they commit the majority of suicides.[50] This suggests there may be a large number of undiagnosed or untreated men with depression.

One likely reason for this is that men with depression do not seek help to the same extent as women with depression. Likewise, men are less likely to look for psychosocial support from people around them. The survey on living conditions published by Statistics Sweden shows that compared with women, men of all ages more often lack a close friend. Instead men are often more

Note. 46. Taylor, Morrell, Slaytor & Ford (1998).
Note. 47. Swami, Stanistreet & Payne (2008).
Note. 48. Qin, Agerbo, Westergard-Nielsen, Eriksson & Mortensen (2000).
Note. 49. Mann, Waternaux, Haas & Malone (1999).
Note. 50. Picinelli & Wilkinson (2000).

inclined to deal with stress by cutting themselves off, abusing alcohol, drugs or gambling, and suppressing their emotional pain and need for emotional support during periods of crisis.[51]

A further explanation is that men with depression who seek help are not identified as depressed by healthcare professionals.[52] This may be because men themselves do not verbalise their depression, or that they report symptoms that are not recognised as depression on conventional diagnostic scales.[53] Studies have shown that men with untreated depression less frequently report feeling low, and that they report fewer symptoms than women.[54] There are also indications that men often are incorrectly diagnosed with other conditions due to concomitant alcohol or drug abuse, or because of aggressive or disruptive behaviour that masks the underlying depression.[55] The example below from the county of Gotland does indeed show that depression appears to present differently in many men than in women, while at the same time diagnostic scales used by healthcare professionals are based on many women's presentation of depression. We also know that from a statistical point of view fewer men than women are referred for psychiatric care.[56]

All in all this indicates that traditional masculinity norms – which state that men should be performance-oriented, independent, successful, strong, and reject vulnerability – give rise to a range of destructive behavioural patterns and barriers for men who need help due to mental ill-health. These norms also determine in which situations men may be at increased risk of stress reactions and depression, and what type of symptoms men tend to present with. The same norms also affect the people around men who need help, including healthcare professionals and the methods they use. There is a risk that men's ill health will not be recognised by those around them, one consequence of which may include inadequate care.

Note. 51. Möller-Leimkühler (2003).
Note. 52. Angst, Gamma, Gastpar, Lépine, Mendlewicz & Tyree (2002).
Note. 53. Rutz, Walinder, von Knorring, Rihmer & Pihlgren (1997).
Note. 54. Picinelli & Wilkinson (2000).
Note. 55. Rutz, von Knorring, Pihlgren, Rihmer & Walinder (1995).
Note. 56. Hadlaczky et al. (2014).

The Gotland scale for assessing men's depression

During the 1980s the county of Gotland had the highest suicide rate in the country. In the mid-1980s an educational programme was developed for preventing, improving and monitoring the severe suicide and depression situation in Gotland. Primary care providers and specialist psychiatric services were involved. The outcome of the programme was that primary care practitioners got better at detecting and treating depressive conditions. The result was a significant decrease in the number of completed suicides and depression-related morbidity. However, this decrease affected almost exclusively depression-related suicides among women. The suicide rate among men remained unchanged at a high level.

To investigate the causes of this, a survey was carried out of all men who committed suicide in Gotland during the 1980s, led by Wolfgang Rutz who was a consultant specialist psychiatrist at the time. A pattern emerged: many of the men who had taken their own lives were not known to the healthcare services. They had been very unwell, not only in themselves but also in their relationships with friends and family. They had often been in contact with the police, tax authorities, drug treatment centres, etc. They had often been self-pitying, disruptive, blaming everything and everyone including themselves, sometimes becoming verbally or physically aggressive as well as being irritable, discontented, unbalanced, uneasy and having poor impulse control. Substance abuse and work addiction were part of the picture. In general they had not sought medical help, and those who had sought help had been dismissive of any treatment. They were often unaware that they were depressed. Another typical situation was a sudden change in personality at a distinct time point when men of otherwise normal interpersonal skills – fathers, colleagues, managers, or friends – would change beyond recognition to themselves and others in connection with a personal crisis such as divorce, unemployment, tax debt or similar.

Based on the survey a rating scale was developed for the purpose of identifying, preventing and treating this form of atypical depression. The instrument was named the Gotland Male Depression Scale (GMDS).

The Gotland Male Depression Scale

During the past month, have you or others noticed that your behaviour has changed in a way that you or others do not recognise in you, and if so, in what way?

(Not at all 0, To some extent 1, Very true 2, Extremely so 3)

1. Lower stress threshold/more easily stressed than usual
2. More aggressive and feeling empty
3. Feeling burned-out and empty
4. "Chronic" inexplicable fatigue
5. More irritable, restless, frustrated
6. Difficulty making simple everyday decisions
7. Sleeping difficulties, sleeping too much/too little/restlessly/difficulty falling asleep/waking up early
8. Feeling disquiet/anxious/uneasy, especially in the morning
9. Do you feel your behaviour has altered in such a way that neither you yourself nor others can recognise you/that you are difficult to deal with?
10. Have you felt or have others perceived you as gloomy, negative or in a state of hopelessness in which everything looks bleak?
11. Have you or others noticed an increased tendency towards self-pity, complaining or seeming "pathetic"?
12. In your biological family, are there any tendencies towards substance abuse, depression/dysphoria, attempted suicide, or being more inclined towards high-risk behaviour?
13. Overconsumption of alcohol or tablets to achieve a calming and relaxing effect. Hyperactivity or letting off steam by working hard and restlessly, jogging or other sports activities, under-/over-eating.

Scoring

0–13: No signs of depression.

14–26: Possible depression. Potential indication for specific treatment including psychopharmacological agents.

27–39: Clear signs of depression. Indication for specific treatment including psychopharmacological agents.

Source: Rutz, W. (2014).

The Gotland Male Depression Scale was presented to primary care practitioners in Gotland in the mid-1990s. The information was also disseminated in local media and via presentations to other healthcare providers and the general public. The public response was favourable, and many mainly women got in touch with the healthcare services to ask for help for male relatives, having clearly recognised the descriptions of male depression and suicidal tendencies in the Gotland scale. Several men were also indirectly motivated

to seek help via their employers. The outcome was that the number of suicides among men decreased in Gotland during the mid- to late 1990s.

The Gotland scale has since been scientifically validated – it has been shown to fit other populations than Gotland in the 1990s as well which suggests that similar traditional masculinity norms exist in many places. The scale has been translated into a number of languages and has had locally adapted successors in several countries. It is recommended as a model in EU and WHO suicide prevention efforts. The Gotland scale is also used as a tool for detecting "masked" depression among drug users, disruptive young men, and fathers with potential post-natal depression.[57]

It has not yet been widely disseminated in Sweden. Locally adapted versions have been introduced in the county of Jämtland and in Stockholm. In Gotland the model fell out of use after the team involved in the launch left the island, and there was a subsequent increase in the number of suicides. This shows the importance of ensuring that new ways of working are implemented and fully ramified across the organisation.

Strategies for reducing suicides among men

- Adopt the Gotland scale in primary care and psychiatric services as an adjunct to conventional diagnostic tools for depression, possibly with local or regional adaptations. Both are needed for capturing men's depression more effectively; some men present with signs of depression that are more in line with conventional symptoms, whereas other men with depression will be identified by the Gotland scale.
- Create a pool of suitable counsellors who are competent to see men who present with depression as identified by the Gotland scale – the Gotland experience shows that these contacts may be challenging and that not all professionals are up to this challenge.
- Use the media and means such as campaigns to communicate widely in the local community about men's depression and how to recognise the signs.
- Collaborate with the tax and debt enforcement authorities, police, drug treatment centres, workplaces, and representatives of civil society to make contact with men with depression. Join forces with employers, relatives and friends in efforts to.

Note. 57. Rutz (2014).

CHAPTER 5

Strategies for change

Restricting emotions and stigmatising vulnerability can make it more difficult for men and boys to seek help for mental health issues.

The ability to reflect on our wellbeing and our emotional issues involves self-confidence, self-esteem and a sense of self-worth. This ability arises when these powers are acknowledged in mutually-affirming relationships. A person who receives affirming and accepting reactions from others will be able to develop and maintain a positive and assured sense of self. Self-esteem is the ability to recognise your own needs and be confident of their worth. This will also develop the capacity for awareness of your own and others' integrity and self-respect.[58] It highlights further the importance of challenging masculinity norms that curtail the ability of boys to be in touch with their emotions.

Any process of change with a view to confronting and preventing mental ill-health among boys and men needs to involve multiple stakeholders and build on several complementary strategies. The aim should be to increase awareness of masculinity norms among service providers that deal with boys and men, as well as to motivate boys and men to participate in this change.

Increase awareness of masculinity norms

To be able to progress towards the goal of gender equality in health, municipalities and regions will need to increase their awareness of masculinity norms.

Recognising the impact of social norms on individuals and reflecting on how these are expressed within different types of service providers is essential for developing a professional approach. The frankness and ability of members of staff to listen without judgement will also affect young men's willingness to begin putting their mental well-being into words. It is about finding out how

Note. 58. Honneth (2003).

men react when they experience mental health issues and how they arrive at the decision to seek help.[59]

The sometimes subtle ways young men have of seeking help may be easily missed. For example, young men may attend adolescent health clinics for other reasons, for collecting free condoms on a weekly basis or having repeated tests, when what they really need is to talk about their wellbeing.

Encouraging men to take responsibility for their own health does not necessarily mean that healthcare professionals should do more explaining. Instead it involves asking the boy or man questions about what he would like to know to better care for his health.

Members of staff should also review and reflect on their own gender-related norms and expectations, as these often shine through in our encounters with others.

Many public stakeholders could and should be involved in making it easier for boys and men to seek help with mental health issues. Obviously through schools, including preschools, and also through primary care and specialist health services.

From a perspective of norm-awareness, service providers that deal with boys and men should be aware that men's accounts of themselves will always be coloured by expectations and norms, and thus they will state their needs in the terms that are currently available to them.

Healthcare professionals and other adults need to be sensitive to young men expressing their wellbeing in terms of their choosing. Seizing the opportunity will be important: listen, ask open-ended questions, and allow the person to reflect in the company of someone who has the time. Initially healthcare professionals may need to be flexible and prepared to adapt to the individual in front of them, but over time once the relationship and trust have been established, the timing and location for the talks can be more controlled.

Be aware of men's and boys' different living conditions

The struggle to live up to expectations of strength and independence and not appear weak or vulnerable is something many men have in common. However, norms interact with other social factors such as education, ethnicity, sexual orientation, gender identity, upbringing, age, personality, psychological conditions, physical ability, and appearance, and all this will influence the encounter between men and healthcare professionals. Members of staff should always start by asking unbiased questions to gain an understanding of each individual's living conditions. The fact that multiple factors play a role was evident in this quote from a young man in one of the focus groups at the Young Men's Health Centre:

Note. 59. Wenger (2011).

”As a queer person of colour I can’t go to my parents, or rather I can go to my parents, they accept everything, but they don’t understand my issues because they’re straight, and I can’t go to the standard xx Community because they are not all that LGBTQ-friendly, and I can’t turn to the white LGBTQ community because they know nothing about our cultural issues.”

Getting men motivated for change

Before men seek help they often check with someone in their social network. All the Young Men’s Health Centre interviewees shared this experience. This could be a partner, a sibling, a parent, or a close friend. Positive social network support for seeking help can provide strength and may be important.

A man seeking help who is supported by his network is given an indication that the treatment process will be supported by his friends and family, which is important for making positive progress. However, if he has no support it is important to talk to him about this. Someone who is lonely in combination with suffering from mental ill-health will be twice as vulnerable.

Asking questions about why and how the man made this decision at this moment in time will provide insight into what enables a young man to seek help. These insights are important factors for keeping the man motivated to continue treatment and take responsibility for change, which is key to achieving favourable health outcomes. Making it clear to the man that he is responsible will also make it clear that he needs to act. This is a way of handling the dilemma of being man enough to act and at the same time acknowledging that you need help with tackling your problems. Recognising your needs is to acknowledge your own worth. In one of the focus group interviews at the Young Men’s Health Centre, one young man outlined a scenario where the affirmation did not quite reach all the way.

”That you are a man and you are [having counselling], man, you’re so strong, but ’let’s not talk about it’. What it is, it’s no good feeling sad but being strong enough to go off and have counselling is good.

Then it’s all: ’Shit, you’re so strong, awesome’ and you sort of get bonus points. But you don’t really want to talk about it anymore because then you’ll get onto the reason why, right, and it’ll be: ”well, perhaps he wasn’t all that bloody successful then’.”

This process will continue in the encounter with the professional contact. If the man does not disclose important information on his life situation, the practitioner may struggle to make a correct assessment and begin appropriate interventions. Men's mental ill health may often be masked by other symptoms such as abuse in one form or other (gambling, alcohol, drugs, or porn) and other risk-taking behaviours. Against this background it is important to find out if there are other issues and to ask the question "Anything else?" as many men may find it difficult to bring up additional needs by themselves. By giving men time and asking questions, healthcare professionals can facilitate change and develop men's encounters with healthcare services.

WHO 5 Well Being Scale

Because men often have difficulties reporting depression and depressive feelings and symptoms, a more generalised scale, the WHO 5 Well Being Scale, may be useful for wider implementation in settings such as primary care centres and youth health clinics. This instrument does not ask about symptoms of depression, instead it asks questions about markers of well-being that men who struggle to verbalise their emotions can answer. It is brief and provides an early indication of a potential depression. This scale has been used successfully in large surveys.

Highlight role models

One way of challenging notions of strength and independence is to share stories of men who are vulnerable and who accept help.

Men in leading positions at local and regional level can help to promote more wholesome masculinity norms by acting as role models and publicly raise and pursue mental health issues. One such example is the Real Man campaign from Värmland County Council in which short films of ice hockey players talking about the importance of challenging masculinity norms were screened on large television screens mounted in the ceiling of the home arena of local team Färjestad.

Also, in connection with information campaigns and lectures, members of staff in schools, healthcare centres and leisure centres can tell stories of boys and men who have chosen to seek support and who have been helped by this (obviously in a way that does not jeopardise patient confidentiality). For example, it is important to talk about the fact that many young men feel bad about the amount of violence they are expected to deal with in their everyday

lives. Both sexual violence and violence more generally. It is important to talk about how violence has become normalised and the impact this is having on our wellbeing. By talking about young men's vulnerability, practitioners will be able to convey that they recognise and understand young men's experiences. This may also help to remove some of the stigma around seeking help as a young man.

Group counselling requires a sense of safety

Feeling safe is crucial for group counselling of boys and men. Safe rooms can be created by having a shared set of rules for the discussion, but also by having the discussions led by an adult who is prepared and non-judgemental. Talking in smaller groups can enable conversations in which existing masculinity and (hetero) sexuality norms may be challenged.

One challenge when working with young men in a group is that many of them will be busy with being accepted by the group, which may make stating an opinion and sticking to it more difficult.[60] Groups can easily become about prestige and one-upmanship when young men are asked to reflect together on things like sexual practices.[61] To create change through group counselling it is important to be aware of the "male bonding effect" – in other words, that intimacy in conversation is easily created through recognition. According to scientist Bob Pease, this is the biggest challenge in group counselling of boys and men.[62] Recognition can easily be based on prevailing masculinity norms, which will reinforce the norms rather than challenge them. According to Pease, one way of avoiding the male bonding effect is that the moderators prepare themselves for their role as leaders by undertaking memory work together with other moderators, about their own values and attitudes to being a man.

Apart from awareness of their own values, moderators must be patient, adopt an inquisitive and non-judgemental approach, and have plenty of time. For group counselling to successfully enable change, the conversations should happen over a period of time so that a safe group process may develop. The conversations may take place in schools, youth health clinics, or youth leisure centres.

Note. 60. See Petterson (2014).
Note. 61. See Pease (2003).
Note. 62. Ibid.

Lower the thresholds for seeking help

The fact that many boys and men restrict and divert attention away from their emotions and their vulnerability makes them poorly prepared for assuming responsibility for their own mental health. Masculinity norms affect boys in a profound way from the moment they are born. Parents, and service providers that deal with children and parents are thus key stakeholders in any strategy of change in this field. Parental support in the maternal and child services continuum of care, as well as pre-schools and schools are all important stakeholders.

To prevent children from losing their ability and capacity for expressing their emotions, children's emotional experiences must be acknowledged and affirmed (irrespective of gender). Emotions are experienced with our bodies and we can understand it when something makes us sad, happy, angry, scared etc. Restricting one's emotional life, for example by resisting or stigmatising some emotions or feelings, can lead to difficulties. Parts of the emotional life may become something alien that is perceived as unwelcome, sinister or unmanageable. In the longer term, emotional restrictions may contribute to mental ill-health, relationship issues and destructive behaviours, with violence and suicide as ultimate consequences.

Learning to seek help

"The hardest thing was finding out where to go. I had heard of others who were in touch with counsellors and that made me wonder how they had found them. Because I didn't know. It wasn't obvious to me how to go about it."

Knowing where and how to seek help is not obvious to all young men. In the field of healthcare this capability is covered by the term health literacy, that is, a form of basic reading, writing and interpretation skills. In the area of mental health this comprises the ability and skills to:

- recognise mental ill health and mental illness
- be aware of risk factors and causes
- be aware of what you can do yourself
- be aware of where to seek help
- be able to support others who are experiencing mental ill health
- know how and where to look for information on mental health and illness

Studies have shown that having these skills increases the individual's ability to recognise ill health at an early stage.[63]

Having confidence in your own ability to cope with stressful and emotionally demanding situations may also be important. This confidence will depend on the extent to which you feel you are able to handle difficulties and expectations from those around you. Someone who has lived for a prolonged period of time in a situation where they feel they have little chance of influencing their own life situation will have less confidence in their own ability, and this may create a sense of hopelessness.[64]

Taking promoting and preventing action can improve health literacy, but it should be done in a way that is norm-aware. An Australian study has revealed differences in the health literacy of boys and girls. The participants were asked to review two short films, including two descriptions of depression. The results showed that two thirds of the students identified the person with a girl's name as depressed, whereas the person with a boy's name was identified as depressed by one third of the students. The boys in the study found it harder to use emotional terms, and the investigators concluded that information and education should be gender sensitive.[65]

Outreach activities

The first impression made by a service provider will determine whether users will choose to come back. For example, youth health centres can develop the ways in which they invite boys and young men. Outreach activities such as visits to youth leisure centres, schools, or different types of sports arenas, may be another option for attracting more young men to youth health clinics. One solution may be a small bus where in promptu counselling could take place and samples be collected.

In 2014 Region Skåne became the first in the country to launch a mobile youth health centre on board a lorry. The mobile unit moves between the towns of Sjöbo, Svedala, Skurup and Höganäs, all areas where the population is insufficient to support a permanent clinic. Six members of staff are permanently stationed on board the lorry. The clinic is not much larger than an ordinary living room, but it comprises a complete youth clinic with equipment for collecting blood samples, testing out contraceptives, and providing psychosocial counselling. The mobile youth health centre visits each town on one day of the week.

Note. 63. Jorm (2000), Jorm (2012).
Note. 64. Det handlar om jämlik hälsa [It's about equality in health]. SOU 2016:55.
Note. 65. Burns & Rapee (2006).

Refer to information and support online

The online national youth health clinic, UMO.se, is a well-established platform for young people with concerns about sex, health and relationships. The website is a joint initiative by Sweden's local and regional councils. All materials published on the site have a norm-critical perspective. For example the material "Do guys have to behave in a certain way?" which invites reflection and offers interactivity on masculinity norms. Approximately one quarter of all site visits are made by boys or young men. Now there is also YOUMO with materials that have been translated into the five most frequent languages spoken by young new arrivals. Apart from UMO.se there are numerous online services that specifically target boys and young men, which provide opportunity for reflection on norms and health as well as information on where to get help.

Prevent mental ill-health through school-based programmes

Youth Awareness of Mental Health (YAM) is a five-hour school-based programme aimed at school students aged 14–16 years. It is a health-promoting and preventive measure which aims to improve mental health and reduce suicide acts among school students. Among other things the programme includes practising emotional skills in roleplay and improves the students' ability to recognise, verbalise and take action on signs of mental ill-health in themselves or their friends. The programme has proved effective in a large European study. The National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP) at the Karolinska Institute is responsible for the programme in Sweden.

It has yet to be shown in a study, but one hypothesis is that this programme could be particularly effective for boys by creating a counterforce to traditional masculinity norms that create stigma and silence around mental health issues. The programme may indeed be regarded as a part of a gender equality programme focusing on men, boys and masculinity norms.

Additional resources about boys, men and masculinity norms

In 2016 and 2017, the Swedish Association of Local Authorities and Regions (SALAR), with the support of the national government, conducted a special programme directed towards men, boys and masculinity issues.

This campaign has compiled and disseminated instructive examples, arranged conferences, seminars and workshops, and has produced a number of publications, reports and films – in consultation with politicians, high-level civil servants and employees of local authorities and regions, as well as with researchers and representatives of government agencies and civil society.

All this material is accessible on the SALAR website skl.se/jamstalldhet.

Publications

- Maskulinitet och jämställdhet – En introduktion till att förändra mansnormer [Masculinity and gender equality – An introduction to transforming male norms].
- Förändringsarbete med våldsutövande män – Strategier för kvalitetsutveckling [Changing violent men – Improving the quality of batterer interventions].
- Maskulinitet och psykisk hälsa – Strategier för förbättringsarbete i vård och omsorg [Masculinity and mental health – Strategies for improving health and social care].
- Maskulinitet och jämställd skola – Arbete för ökad trygghet och bättre studieresultat [Masculinity and the gender-equal school – Towards increased security and better school results].

- Maskulinitet och jämställt föräldraskap – Arbete för pappors ökade delaktighet [Masculinity and gender-equal parenting – Towards more active parenting for fathers].

Film series – Voices about masculinity

- En film om normer för killar och män. Maskulinitet – så funkar det [Masculinity – how it works].
- Män i förskolan. Förskolläraren Per Håkan Taavo i Luleå om ett yrke som passar alla oavsett kön [Men in preschool – Preschool teacher Per Håkan Taavo of Luleå about a profession that fits everyone, regardless of gender].
- Jämställt på vårdprogrammet. Om genusmedveten studie- och yrkesvägledning i Katrineholm [Gender-sensitive study and career guidance in Katrineholm].
- Arbete för ökad trygghet och bättre studieresultat. Om normkritiskt arbete på Järvenskolan Tallås i Katrineholm [Norm critical work for increased security and better school results].
- Män och våld. Om våldsförebyggande arbete på Hahrska gymnasiet i rVästerås [Men and violence – violence-prevention efforts at the Hahrska Upper Secondary School in Västerås].
- Män och normer. Om projektet Normstorm i Jönköping [Men and norms – a film on the Norm Storm project in Jönköping].
- Vårt vatten har gått. Om pappor i förlossningsvården [Our water broke – fathers in labour and delivery care].
- Män och barn. En film om att bli pappa [Men and children – a film about becoming a father].
- Jämställt föräldraskap. Om Region Skånes pappasamtal med nyblivna fäder [Gender-equal parenting – about the Skåne Region's counselling with new fathers].
- Män och hälsa. Hur vården kan nå unga män med psykisk ohälsa [Men and health – how healthcare can reach mentally ill young men].
- Att ha rätt till sina egna känslor. Hur vården kan nå unga män med psykisk ohälsa (lång version) [The right to your own feelings – how healthcare can reach mentally ill young men (long version)].
- Män och självmord. En film om suicidrisk, mansnormer och att söka hjälp [Men and suicide – a film about suicide risks, masculinity norms and seeking help].
- Killsamtal om sex och samlevnad. Om sex- och samlevnadsundervisning med killgrupper i Lund [Talking about sexuality and norms with young men – a film about Comprehensive Sexuality Education with the participation of a group of young men in Lund].

Articles on instructive examples at Jämställ.nu

- Sex- och samlevnadssamtal med unga nyanlända i Värmland [Discussions about sex and living together, with newly arrived immigrants in Värmland].
- Jämställt föräldraskap i Region Skåne [Gender-equal parenting in Skåne Region].
- Kriscentrum i mellersta Skåne, behandling för män i kris [Crisis centre in mid-Skåne, treatment for men in crisis].
- Normkritiskt arbete på Järvenskolan Tallås i Katrineholm [Efforts to critically examine norms at Järven School Tallås i Katrineholm].
- Malmö stad har flest manliga förskollärare i landet [The City of Malmö has the highest share of male preschool teachers in Sweden].

Conferences and seminars, documentation at skl.se

- Män och jämställdhet – konferens i december 2016 [Men and gender equality – Conference in December 2016].
- Fördel flicka? Seminarium om pojkar i skolan [Seminar about boys in school].
- Vårt vatten har gått! Seminarium om pappor som resurs i fölossnings-vården [Seminar about fathers as a resource during labour and delivery].
- Normer som dödar. Seminarium om män och suicidprevention [Seminar on men and suicide prevention]

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Masculinity and mental health

STRATEGIES FOR IMPROVING HEALTH AND SOCIAL CARE

One of the aims of the national gender equality policy is that women and men, girls and boys should have equal opportunities for good health, and be offered health and social care on equal terms. Achieving this goal will require local, regional and county councils to target development initiatives to boys, men, and issues of masculinity.

This paper contains proposals for strategies for development within mental and sexual health that are supported by gender equality efforts and focus on changing masculinity norms. With this publication, SALAR (the Swedish Association of Local Authorities and Regions) aims to increase awareness of how this change process may be achieved, and share some educational cases.

This publication has been developed within the framework of the joint initiative by SALAR and the Swedish government on men, masculinity and gender equality. Available on the SALAR website skl.se/jamstalldhet are additional papers, videos and other materials on this initiative.

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