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Examining the appeal and ascribed meanings of Complementary and Alternative Medicine (CAM) use by males: An interpretative phenomenological analysis

Kathryn V. Hogan
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Signature: K. V. HoganDate: 27 October 2014

Examining the Appeal and Ascribed Meanings of Complementary and Alternative Medicine
(CAM) use by Males: An Interpretative Phenomenological Analysis.

Kathryn V. Hogan

A report submitted in Partial Fulfilment of the Requirements for the Award of Bachelor of
Science (Psychology) Honours

Faculty of Health, Engineering and Science

Edith Cowan University

Submitted October, 2014

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Abstract

Men are commonly and consistently underrepresented in global depression rates, however figure predominantly in rates for substance abuse and suicide. It has been suggested that men's under-utilisation of mental health services accounts for the discrepancy between the genders and that hegemonic masculine stereotypes have created a barrier for males in seeking help for mood disorders. The use of Complementary and Alternative Medicines (CAM) has been expanding globally, with research showing in some instances of self-diagnosed depression and anxiety, CAM is being utilised more often than mainstream health care services. The present study explored the personal meanings of males who currently use CAM in Western Australia. The objective was to examine male motivations towards CAM use and their interpretations of men's health issues. Eight self-selected participants, from three procedure-based CAM (Yoga, Applied Kinesiology, Meditation), were interviewed using a semi-structured interview schedule. Interpretative Phenomenological Analysis was used to construct a framework for understanding the personal meanings of the participants' experiences. Four overarching themes were identified and discussed: (1) Male depression; Experience and expression, (2) Environmental influence, (3) CAM use to develop positive mental habits over time, and (4) CAM benefits of self-awareness, self-care and self-responsibility. CAM users report positive benefits in their thoughts, moods and behaviours, however feel restricted in talking about their positive experiences among some peer groups. Conclusions are made regarding the role societal expectations play on the expression of emotions for men. Limitations of this study and future directions are discussed.

Key words: Depression, Men, Complementary and Alternative Medicines (CAM)

Word Count - 10,835

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Dated: 27 October 2014

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Examining the Appeal and Ascribed Meanings of CAM use by Males: An Interpretative Phenomenological Analysis.

One of the most consistent and stable phenomena in psychological research, is the prevalence for women presenting with depression; namely depressed mood and a general loss of interest in pleasurable activities. The common adult ratio for which is two females to every one male, 2:1 (American Psychiatric Association [APA], 2000). This phenomenon has been consistently found across time and culture (Culbertson, 1997). However, research has shown that men, more than women, suffer from problems that can be closely related to depression, such as drug and alcohol abuse, personality disorders, and an alarmingly high rate of suicide (Cochran & Rabinowitz, 2000). When mental disorders as a whole are considered in large-scale epidemiological studies, the frequency of disorders between the genders becomes more evenly distributed (Cochran & Rabinowitz, 2000). This raises the question as to whether the disparity in depression rates is not more reflective of the influence of sociocultural factors upon men, as opposed to an actual lower rate of males experiencing depression. The sociocultural factors raising concern include: the impact of masculine gender role socialisation (Cochran & Rabinowitz, 2003), barriers to help-seeking behaviours and disclosure of symptoms (Gulliver, Griffiths, Christensen, & Brewer, 2012) and externalising behaviours, such as alcohol abuse, irritation and anger (Cochran & Rabinowitz, 2003). That is, behaviours falling short of diagnostic criteria for depression (DSM-IV-TR, 2000; Fields & Cochran, 2011). Masculine gender role socialisation, or hegemonic masculine ideology refers to the internalisation by males throughout their development of the cultural messages of what it is to be a man, for example: stoic, self-reliant, strong, and independent (Smith, Tran, & Thompson, 2008).

According to Australian census data, the popularity of complementary therapies, such as those practiced by naturopaths, chiropractors and acupuncturists, has been fast growing over the last few decades (Australian Bureau of Statistics, 2008). The World Health Organization (WHO) reports the use of traditional medicine, in terms of both herbal medicines and procedure-based therapies, has been expanding globally (WHO, 2000), with user estimates at 30-60% in Western societies (Sointu, 2011). Research has shown in some instances, specifically those of self-diagnosed anxiety and depression, that complementary and alternative medicines (CAM) are being used more often than conventional mental health services (Kessler et al., 2001). According to a recent study investigating Ajzen's theory of planned behaviour (Ajzen, 1985, as cited in Smith et al., 2008), an individual's attitude towards psychological help-seeking plays an important mediating role between hegemonic masculine ideology and the beneficial behaviour of seeking help for health-related issues (Smith et al., 2008). Recent CAM studies report CAM users feel empowered by their use of holistic therapies and that male CAM users interpret their CAM use in masculine-coded ways that are congruent with their gender roles, allowing for the embodiment of health care practices previously deemed feminine (Brenton & Elliott, 2013). With changing attitudes and the acceptance of genderless tenets around health behaviours, including self-responsibility and self-reinvention, appropriate help-seeking behaviours for men can become less stigmatised and may lead to improved mental health outcomes for this demographic.

There is a noticeable gap in health psychology literature, particularly qualitative research, around the phenomena of preventative health behaviour and health promotion behaviour (Smith, 2011). While the delivery of information targeting mental health literacy, particularly biological attributions to the condition of depression (Gulliver et al., 2012), have shown positive effects for improved attitudes towards help-seeking and are congruent with

the tendency for men to frame their CAM use in terms of science and rationality (Brenton & Elliott, 2013), changes in attitudes still do not necessarily equate to changes in behaviour (Gulliver et al., 2012). This highlights the need for further inquiry on the matter. Further gaps in the literature regarding the relationship between developmental ages and depression prove noteworthy (Culbertson, 1997), with gender differences becoming apparent around age thirteen (Nolen-Hoeksema, 2001) and having a significant relationship with adult depression, and changes in gender ratios also occurring in the ageing population. International involvement for psychological research into developmental influences, gender differences, cross-cultural commonalities and differences, and treatment strategies are cited as productive areas of research for this globally growing problem (Culbertson, 1997). The objective of the present research is to explore the experiences of males currently using CAM in Perth, Western Australia; their views and interpretations of their CAM use, men's health issues in general and subjective well-being. The specific purpose for conducting this research is to examine male motivations towards CAM use and consider whether these interpretations can be better understood in ways that can bridge the gap between the limitations of hegemonic masculine stereotypes and help-seeking / health promoting behaviours in men.

Men, Depression, Suicide

The present study refers to the mood disorder, depression, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000), for which the categories include major depressive disorder, dysthymic disorder and depressive disorder not otherwise specified. The criteria for a major depressive episode includes at least five of the following symptoms, having been present for a minimum of two weeks duration and representing a change in the individual's typical level of functioning; (with at least one of the symptoms being): (1) depressed mood or (2) loss of interest or

pleasure, and a further three symptoms such as weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, diminished ability to think, concentrate or indecisiveness, recurrent thought of death, suicidal ideation, suicidal planning or attempts (DSM-IV-TR, 2000). Depression has been associated with increased medical susceptibility, interference and conflict in personal relationships, days of lost productivity and suicide (Fields & Cochran, 2011).

Recent reports rank Major Depressive Disorder as the eleventh highest contributor to Global Burden of Disease (GBoD; WHO, 2010) and the number one leading cause of disability worldwide. Depression has an estimated effect on more than 350 million people globally (WHO, 2012). When looking at the Western Pacific Region, Major Depressive Disorder was recently ranked as the 4th highest contributor to BoD in the Australasia region (WHO, 2010). In the 2007 Australian Bureau of Statistics National Survey of Mental Health and Wellbeing, almost half (45% or 7.3 million) of Australians aged 16-85 years reported symptoms that would have met the criteria for diagnosis of a mental disorder at some point in their life, with one in five (3.2 million) reported having experienced symptoms of either anxiety, mood or substance use disorders in the twelve months prior to the survey (ABS, 2007). The Australian Psychological Society (APS) estimates the cost of depression upon the Australian economy to be approximately \$12.6 billion annually, with up to 6 million working days of lost productivity (Manicavasagar, 2012). It is estimated for every one person diagnosed with depression, three to five further individuals will be adversely affected (Black Dog Institute, 2012).

Despite depression being a treatable and potentially preventable disorder (Barrera, Torres, & Muñoz, 2007; Mammen & Faulkner, 2013), a recent review of help-seeking

interventions for mental disorders estimated “that only one quarter of adults with high levels of mental distress and one third of adults with diagnosable mental disorders seek professional help” (Gulliver et al., 2012, p. 81). Australian initiatives for community-based responses to growing rates of depression, such as the Beyondblue organisation (2014) and The Black Dog Institute (2014), estimate that one in eight men will experience depression and one in five men will have anxiety at some stage in their lives (Beyondblue, 2014). However, health care utilisation rates show fewer men than women seek help for psychological problems, alerting to a potential under-identification and under-treatment for men suffering depression (Cochran & Rabinowitz, 2003; Fields & Cochran, 2011). “There is an emerging consensus that the male gender role in our culture is problematic” (Cochran & Rabinowitz, 2000, p.x), with many studies referencing men’s stoicism, feelings of weakness and vulnerability and reluctance to talk about health issues as common barriers to help-seeking behaviours (Fields & Cochran, 2011, Wilhelm, 2009). Furthermore masculine-specific modes of experiencing and expressing depression may not correspond with criteria used to diagnose depression (Cochran & Rabinowitz, 2003). What is discovered is that men are being missed in diagnosis, and when they do present for treatment their symptoms are far more severe than those who are found sooner (Fields & Cochran, 2011).

Gender differences in depression form a vast amount of research studies examining causes, symptoms, coping strategies and treatments (Angst et al., 2002). Independent variables such as economic hardship (Borooah, 2009), interpersonal relationships (Cambron, Acitelli, & Pettit, 2009), and the impact of gendered learning on males’ willingness to self report (Berger et al., 2012; Mirowsky & Ross, 1995) have all been areas of interest, however no one variable has been able to account for the disparity amongst the sexes (Nolen-Hoeksema, 2001). Qualitative research with male experiences and interpretations in relation

to feelings of depression, colloquially termed ‘down in the dumps’ (Brownhill, Wilhelm, Barclay, & Schmied, 2005) conclude that it is in males’ expression, not experience of depression that differs from those of females. The constraints of ‘hegemonic masculinity’ stereotypes, a term used to describe societal norms defining expected behaviours of men (Valkonen & Hanninen, 2013), can contribute to limitations for expression for males experiencing emotional distress. For example, where hegemonic masculinity expects strength, confidence and rationality from males (Valkonen & Hanninen, 2013), stoicism in the face of tough times, and being the ‘bread winner’ for the family unit (Alston, 2010), men tend towards containing their emotional experience, often by numbing and escaping, rather than help-seeking and expression (Brownhill et. al., 2005). In choosing maladaptive behaviours, such as drug and alcohol use and gambling, male depression can be hidden and overlooked, resulting in a higher occurrence of aggression, violence and suicide (Brownhill et. al., 2005).

One of the most compelling indicators of hidden depression among males can be seen in the prevalence of men in suicide rates. There are approximately 2,200 suicides every year in Australia, of which 80% are by men; equating to an average of five men taking their lives every day (Beyondblue, 2014). High suicide rates for males have been associated with the ‘masculine crisis’, whereby men are taking their lives as a result of social challenges they face, primarily relating to their two key sites of interest and power; family and work (Canetto, 2012). Current theories suggest men who adopt traditional beliefs around masculinity are at a greater health risk than peers who do not and that men who struggle to live up to hegemonic ideals can experience feelings of shame and inadequacy, creating suicidal vulnerabilities. Furthermore, where hegemonic masculine ideals are viewed as the natural state of masculinity, divergent masculinities, such as being gay, bisexual or transgender, further create

a risk for suicide (Canetto, 2012). With up to 80% of suicides being reportedly preceded by a mood disorder (Manicavasagar, 2012), the issue of help-seeking barriers for men is of primary importance.

Current Solutions for Men and Depression

A number of studies have shown treatment outcomes for depression, including both psychotherapy and pharmacotherapy options, to be equally effective for both men and women (Fields & Cochran, 2011). While women are more frequently diagnosed with depression, there is an overrepresentation of men in clinical drug treatment trials (Cochran & Rabinowitz, 2000; Fields & Cochran, 2011), possibly because psychopharmacological treatments are generally considered less complicated for males than women, when biological and hormonal differences are taken into account. Despite this there is no solid evidence to suggest major differences in treatment responses from antidepressant medications between the genders, although certain classes may produce faster responses or more appropriately targeted responses for males and females (Fields & Cochran, 2011; Marsh & Deligiannidis, 2010). Furthermore, there is no compelling evidence to suggest pharmaceutical treatments are superior to alternative treatment methods, with a relatively large placebo response rate for patients in studies with control groups (Cochran, & Rabinowitz, 2000, p. 99). The downside of pharmacological treatments, for males specifically, is the common sexual side effects that can result from their use, including changes in libido, erectile dysfunction, anorgasmia, delayed ejaculation, painful orgasm, priapism and penile anaesthesia (Cochran & Rabinowitz, 2000). Taking into account studies that suggest male pathways to Major Depression include failures in finances, occupation and achievements (Kendler & Gardner, 2014), awareness of the detrimental sexual side effects may further deter men from seeking help for mood disorders.

As with medication interventions, psychotherapeutic treatments are an effective, albeit under-utilised intervention for men (Cochran & Rabinowitz, 2000). Level I, evidence-based psychological interventions for depression in adults include, cognitive behaviour therapy, interpersonal psychotherapy, brief psychodynamic psychotherapy and self-help (APS, 2010). While these treatments have proven effective, barriers for males accessing psychotherapy treatments remain. As previously outlined, barriers include gender role derived cognitive distortions of stoicism and emotional suppression. Further research and education is needed to (1) de-stigmatise depression and therapy for men, (2) develop gender appropriate / sensitive assessment measures and treatment programs for men, (3) encourage self-help and lifestyle change for recovery maintenance and relapse prevention (Cochran & Rabinowitz, 2000).

In a postal survey by Oliver, Pearson, Coe and Gunnell (2005), it was found that only 28% of people with high GHQ-12 scores (General Health Questionnaire; Goldberg, & Williams, 1991), representing a high likelihood of psychiatric illness, had sought help from their general practitioner. Most people were more likely to seek informal help from friends and relatives, rather than formal help from health professionals, including general practitioners (GP) and counsellors. Furthermore, males, young people and people living in affluent areas were the least likely to seek help (Oliver et al., 2005). The benefits of informal helping are unclear; however, there is evidence that good social support is a protective factor in both mental and physical health (Cohen, 2004). “Conclusions that health promotion interventions to encourage appropriate help seeking behaviours in young people, particularly men, may lead to improved mental health outcomes for this group of the population” (Oliver et al., 2005, p. 297).

Complementary and Alternative Medicines

Over the last few decades, the use of traditional medicine, defined as culturally indigenous skills and practices used to maintain health and prevent or treat physical and mental illnesses, has gained popularity and expanded globally (WHO, 2000). CAM can refer to both herbal medicines, and procedure-based therapies, such as acupuncture, yoga, manual therapies, and “other physical, mental, spiritual and mind-body therapies” (WHO, 2000, p. 9). Psychiatrists have recognised that mind-body techniques such as yoga, meditation and guided imagery can benefit clients by having a direct effect on how people deal with stress and depression (Gordon, 2008). Cited reasons for CAM use by consumers include a preference for self-treatment over clinical treatment and the perception that CAM use will be more effective and have fewer side effects than medication (Louie, 2014). One of the common aspects in procedure-based therapies, such as yoga, applied kinesiology and meditation, are relaxation techniques that offer mental health benefits via the hypothalamus-pituitary-adrenal (HPA) axis and the sympathetic nervous system (SNS). These bodily systems act as responders to psychological stressors and activate physiological stress responses, such as the release of cortisol and catecholamines, for coping in a ‘fight or flight’ reaction (Büssing et al., 2012; Ross & Thomas, 2010). These responses are effective and beneficial for short term stress, however repeated activation can result in hyper-vigilance and a dysregulation of the system, depleting the immune system’s ability to cope and leading to both mental and physical health problems (Louie, 2014). Furthermore, studies on mindfulness, the practice of remaining non-judgementally focused and present in the moment, have shown long-term changes in the brain, such as a decrease in the density of amygdala grey matter, which in turn reduced stress-signalling molecules and increased dopamine levels (Chan, Immink, & Hillier,

2012). The effect of which is increased relaxation and improved potential for control over mood, emotion and anxiety (Louie, 2014).

Studies have shown yoga to be effective in treating and improving psychological well-being for industrial workers (Bhat et al., 2012), men who are living with prostate cancer (Oliffe et al., 2009) and business managers (Ganpat & Nagendra, 2011). In the US, two recent systematic reviews of yoga for depression evaluated 13 randomised controlled trials (RCTs), with a total of 782 participants, aged 18 - 80 years with mild to moderate depression (Balasubramaniam, Telles, & Doraiswamy, 2012; D'Silva, Poscablo, Habousha, 2012). The use of yoga was compared to wait-list controls, counselling, education, exercise or usual care. Included in the review were eight moderate to high quality RCTs, with a total of 483 participants, that reported statistically significant reductions in depression symptoms in yoga groups compared to control groups. Overall reductions of symptoms were reported as being between 12% and 76%, with an average of 39% net reduction across all measures (Skowronek et al., 2014). Study limitations include a range of symptom severity, variable type and length of yoga, lack of participant blinding, wait-list rather than active-treatment controls and a lack of consistent long-term follow up data. The RCTs did not report any adverse effects of yoga and yoga is considered safe when taught by a competent instructor (Skowronek, Handler & Guthmann, 2014).

Applied Kinesiology was developed by a chiropractor, Dr. George J. Goodheart (AK; Goodheart, 1964, as cited by the American Cancer Society, 2014) and involves an assessment of the client's posture, gait, muscles strength and range of motion. AK practitioners claim a weak muscle response may be indicative of internal energy disruptions, including reduced blood flow, chemical imbalance or organ problems (American Cancer Society, 2014), and manual stimulation and relaxation techniques are then applied to restore muscle strength and

their underlying imbalances. Applied Kinesiology is often used by chiropractors, naturopaths, dieticians and other health care workers, however evidence-based research on AK is scarce. One systematic review of the literature on spinal palpatory procedures, similar to AK, as a diagnostic tool, showed no 'gold' standard reference for which to gauge their content validity upon. That being, an agreed upon reference point to gauge whether muscle testing techniques actually measure what they intend to measure (Najm et al., 2003). While some positive results were shown for its use as a diagnostic tool for pain, the variability in test types, terminology and research designs created limitations in the ability to compare and evaluate data (Najm et al., 2003). AK procedures are considered to be relatively safe, however given the prevalence of their use in diagnostic and therapeutic interventions, further studies that incorporate more rigour when investigating the efficacy and effectiveness of these procedures would allow for the establishment of reference benchmarks to enhance the evidence base behind them (Najm et al., 2003).

One of the commonalities found in the literature on CAM use, is the prevalence for women as participants. Again the issue of barriers for men to health care and health promotion are raised. Sointu (2011) reports the prevalence of women as both users and practitioners of CAM may relate to a feminised discourse of well-being as encouraging emotional expression and pampering, and in this lies a motivational explanation pulling women towards CAM and potentially pushing men away (Sointu, 2011). She suggests by gaining a deeper understanding of the appeal of CAM with reference to gendered identities, the therapeutic appeal and accomplishments of CAM can be better explored and a shift towards de-feminising engagement in health promoting behaviours and decreasing the marginality of males in the arena of holistic health can be made.

A common pitfall that is noted when reviewing the literature on CAM research was the relatively small database of articles. Over a five year period, CAM articles represented just under 0.7% of the medical literature on Medline (Wider & Boddy, 2009). Furthermore, the evidence base for the efficacy of CAM interventions on depression and anxiety remains poor, with a significant lack of methodologically rigorous studies available within the field (Van der Watt, Laugharne, & Janca, 2008). No randomised controlled trial studies were found for Applied Kinesiology, and although evidence for the benefits of acupuncture and mindfulness-based meditation is becoming stronger, again those studies had methodological limitations (Louie, 2014). Two valid arguments when examining the benefits of yoga as represented in RCTs and cross-sectional surveys of yoga practitioners, include (1) the element of self-selection in which only healthy individuals choose to practice yoga (Ross et al., 2013), and (2) a review of published systematic reviews found over 70 % of the clinical trials had been conducted in India, which, due to differences in yoga practice and cultural meaning, limits their generalizability to Western populations (Innes et al., 2005, as cited in Satin, Linden, & Millman, 2013).

Despite these issues, CAM use continues to grow globally in popularity. Reasons for this growing popularity are cited as Western societies embodiment of postmodern cultural shifts, whereby individual choice, personal responsibility and self-management are becoming key in health and wellbeing (Brenton & Elliott, 2013). Researchers are reporting CAM users feel empowered by their use of holistic therapies (Brenton & Elliott, 2013). With the acceptance of genderless tenets around health behaviours, such as self-responsibility and self-reinvention, researchers have shown men can interpret their CAM use in masculine-coded ways, and embody health care practices previously deemed feminine (Brenton & Elliott, 2013). This is of such importance when considering the impact of hegemonic masculine

gender roles, those of being tough and stoic in the face of adversary and illness, has been cited as a primary reason for males only utilising health care facilities when the case is 'serious' (Brenton & Elliott, 2013). Even when the case is serious, as in the case of cancer and human immunodeficiency virus (HIV) patients, research shows greater male skepticism for alternative therapies, suggesting a conditioned influence of societal expectations, whereby people are being held accountable for their membership to a gender category (Brenton & Elliott, 2013).

Research Purpose and Objectives

The purpose of the present research was to explore the personal experiences and ascribed meanings of males who currently use CAM in Western Australia. The objective was to examine the appeal of CAM and male motivations towards CAM use. The specific aim for conducting this research is to examine male motivations towards CAM use and consider whether male interpretations of CAM can be better understood in ways that can bridge the gap between hegemonic masculine stereotypes and help-seeking / health promoting behaviours.

The main research questions were:

1. What factors lead male participants to engage in CAM?
2. In what ways have men's experiences with CAM affected other areas of their lives?
3. What are the barriers or stigmas men have experienced in engaging in CAM?

Method

Research Design

The present study takes a qualitative method approach as a means to give a voice to CAM service-users and allow for the richness and diversity of human experience to be expressed and interpreted (Peters, 2014). Under the epistemological umbrella of social

constructionism, the theoretical framework of Interpretative Phenomenological Analysis (IPA; Smith, 1996a, 1996b, as cited in Smith et al., 1999) has been utilised, with adherence to its three principle tenets: (1) The research is phenomenological, meaning it is concerned with understanding the lived experience of a particular phenomenon; (2) The research engages a double hermeneutic approach, whereby the participant offers their interpretations of personal experiences and the researcher systematically seeks to further interpret and analyse these accounts; and (3) The research is idiographic in its commitment to in-depth analysis of each individual case study (Smith, Jarman, & Osborn, 1999; Smith, 2011).

Participants

A purposive sample of eight self-selected participants took part in the study. Initially CAM centres around Perth were contacted to request permission to hang an information flyer in their centre or to forward an invitation email to their clientele contact list. Three CAM providers responded positively, including: High Aspirations Dru Yoga Centre, the O'Neill Kinesiology Graduates Facebook Page in Perth and Mazzella Kinesiology. The criteria for inclusion in the study was that participants were required to be male, aged 18 and above, and in regular attendance of one form of CAM. Eight volunteers responded to the researcher via email, in response to the flyers and the emailed invitations. Of the eight participants, four regularly attended Applied Kinesiology sessions, three attended a men's yoga class and one attended meditation and reiki sessions. Two participants were aged between 20 - 25 years, four participants were aged between 40 - 50 years and two participants were aged between 60 - 70 years of age. All participants were Caucasian and resided in the Perth metropolitan areas and Bunbury region (175 kilometres south of Perth City) in Western Australia. Participant characteristics are outlined in Table 1. The names of all participants have been removed to protect their anonymity. Participants received a \$20 JB-Hi gift voucher for participating. This

study was approved by the Edith Cowan University (ECU) ethics committee and informed consent was obtained prior to conducting the interviews.

Table 1
Participant Characteristics

Participant No.	Age (yrs)	CAM type	Marital Status	Employment	Children	Reason for CAM use
P1	40 - 50	Applied Kinesiology, Bowen therapy, Remedial Massage	Divorced	Self Employed	3	Interest in health industry
P2	20 - 25	Applied Kinesiology	Partner	Student	0	Brain Integration, memory
P3	20 - 25	Applied Kinesiology	Single	Employed	0	Anxiety
P4	45 - 55	Applied Kinesiology	Married	Employed	3	Stress release
P5	40 - 50	Meditation, Reiki	Married	Employed	0	Relaxation
P6	40 - 50	Meditation, Yoga	Married	Employed	2	Health and Wellbeing
P7	60 - 70	Yoga	Widowed	Retired	6	Health and Wellbeing
P8	60 - 70	Yoga	Married	Semi Retired	3	Pain in back

Note: *N*: 8.

Procedure

Semi structured interviews were conducted during July and August 2014. Locations were negotiated between participants and the researcher and included the participants' place of business, the local library and an army barracks. Interviews lasted between 30 minutes and 75 minutes. In the first part of the interviews, participants were encouraged to share the form of CAM they participated in, what brought them to use the CAM and what was involved while attending their chosen form of CAM. In the second part of the interview, participants were encouraged to share the benefits they experienced from CAM in their lives, experiences when they have felt stressed or depressed, their experiences as a man in society and any

stigma they perceived as a man attending CAM. Participants were encouraged to share both their personal experiences and their opinions about men in general, including within their peer groups within Western Australia. Interviews were audio recorded and transcribed verbatim by the researcher.

Analysis

The interviewed transcripts were analysed using the principles of Interpretative Phenomenological Analysis (IPA; Smith, 1996, as cited in Smith et al., 1999). The first transcript was read and general themes were entered onto a spreadsheet designated for themes occurring in the narratives. The next transcript was then read, adding relevant data to the general themes already identified in the spreadsheet, and adding new themes not presently represented onto the spreadsheet. This process was repeated for all transcripts. Special attention was paid to personal experiences of depression, stigmas associated with being a male and attitudes towards and benefits of CAM use. Idiographic similarities and contrasts were a primary focus. The transcripts were then re-analysed using the spreadsheet to cluster themes with shared meanings and build an overarching theme list. In accordance with Smith's (2011) criteria for acceptable IPA quality guide, for a sample of eight participants, extracts from at least three participants were required to show evidence for an overarching theme. For the four overarching themes identified and reported in this research, the clustered themes and the participants who contributed to them can be found in Table 2. A reflexive journal was kept from June 2014, when initial contacts with CAM providers were made, through until October 2014, when writing was completed. The journal allowed for self-reflection throughout the process, along with a full audit trail to enhance methodological and theoretical rigour (Liamputtong & Ezzy, 2005). Coding reliability was checked by the research supervisor during the writing process, to ensure any researcher bias was

acknowledged in the reporting and themes were developed from participant feedback rather than predetermined categories.

Findings and Interpretations

The main themes that are identified and discussed in this study, along with their overarching theme category and the participants who contributed to that theme, can be found in Table 2. The four overarching themes discussed are: (1) Male depression; Experience and expression, (2) Environmental influence, (3) CAM use to develop positive mental habits over time, (4) CAM benefits of self-awareness, self-care and self-responsibility.

Table 2
Main themes and participants contributing to each

Overarching Theme	Theme	Participants Contributing
Male depression; Experience and expression	Personal experience with depression	P1, P2, P3, P4, P6, P7
	Personal experience with anxiety, stress	P3, P4, P5, P6, P8
	Behaviours attributed to depression	P1, P2, P5, P6
	Factors contributing to depression	P1, P3, P4, P5, P7, P8
Environmental influence	References to hegemonic masculine ideology	P1, P2, P4, P5, P6, P7, P8
	Societal Impact	P1, P2, P4, P5, P6, P7, P8
	Barriers for help-seeking for men	P1, P2, P4, P6, P7
	Negative peer group perceptions	P2, P5, P6, P7
	Positive peer group perceptions	P1, P2, P3, P5, P7, P8
CAM use to develop positive mental habits over time	Benefits of CAM improve with time / practice	P2, P3, P6, P7
	Crisis versus habit	P1, P4, P7, P8
CAM benefits of self-awareness, self-care and self-responsibility	Self-awareness	P2, P3, P4, P6, P7
	Self-care - Mind/Body Connection	P1, P6, P7, P8

Self-responsibility - try something new	P2, P4, P5, P6
Self-responsibility - Diet	P1, P2, P3, P4, P5, P6

Note: $N = 8$.

Male depression; Experience and expression

Personal experience with depression and anxiety:

While none of the present sample have a current medical diagnosis for depression or anxiety, it was interesting to note that every participant described personal experiences of commonly accepted symptoms of depression, anxiety and stress, according to criteria outlined by the DSM-IV-TR (APA, 1994). An example for depressed mood was noted when a participant said, *“I’m so sad most of the time”*. An example for the loss of interest or pleasure was seen when a participant said, *“most of the times I find that when you’re depressed you tend to isolate yourself”*. One participant spoke of experiences of fatigue or loss of energy, saying, *“I’d just sit in the chair all day long, and then I’d think, I can’t do this tomorrow and then I’d do the same thing tomorrow”*, which he linked with feelings of worthlessness or guilt, saying, *“And then you’ve got the guilt that goes with it. You feel guilty because you think that you should be doing more”*. Anxiety was illustrated by participants with comments such as, *“I just have random bursts of like fear”*, and *“I felt myself at times getting quite frustrated, annoyed, upset with myself and others”* representing irritability, a common symptom of stress.

Behaviours attributed to depression:

Participants identified certain behaviours as being indicative of the experience of depression in themselves and others. These included substance abuse, irritability and anger, and making poor choices in other areas of life, such as diet. One participant likened using junk food to the behaviour of taking drugs, describing food as a coping mechanism for

emotional unhappiness. Whilst one of the younger participants identified alcohol use as a common part of Australian culture, he referenced a discernible difference between those who use alcohol and drugs in a recreational fashion and those who take substances as a means to escape from mental or emotional issues. He said,

I know at least three friends that are not only psychologically damaged from issues from before, but it has been exacerbated by the use of drugs. And it was more or less trying to get them to stay sober to deal with the issues, but it was easier to buy some weed, to buy a pill or buy a tab or something, just get high, than to deal with it - It's much easier, it doesn't require any effort.

Another participant interpreted alcohol use as a coping mechanism, saying, “*He gets drunk every night, so obviously drinking his way back from some sort of fears*”. Substance abuse is generally treated separately from mental disorders, however co-morbidity rates show that substance abuse is commonly found to co-occur with mental disorders (Gordon & Holmwood, 2008) and may provide an early-warning indication of someone who is struggling to cope (Beyondblue, 2014). As mentioned by one participant, “*you may see some subtle changes in their behaviour, they may start to drink more, smoke more, to try and compensate for that arising emotion that they're feeling*”. Behavioural changes may play an important role in recognising hidden depression among men, and as one participant mentioned, it is important for partners and employers to not only recognise behavioural changes, but to create an environment where seeking help is acceptable. As an example “*if people know the information, then they are informed and can make informed decisions. If they are then supported by their wife or the employers to go off and get help, then they're more likely to engage in that.*”

Factors contributing to depression:

When investigating the factors contributing to male depression, issues surrounding the core values of work and family, outlined in the ‘masculine crisis’ as the key social challenges men face (Canetto, 2012), seemed to hold true in the present interviews. One participant defined work as, “*work used to be work hard, work long and then go home and maybe have a beer and catch up with your kids and family. That’s what the value for work for men often means*”. Another participant spoke of stresses relating to providing for the family and the uncertainty of changing jobs,

I think not being able to fulfil your role as a provider... for your family; if you’re worried financially... I knew there were going to be times when I was going to be anxious and depressed about changing jobs and looking for new work ... you just have to be on the ball all the time in that situation, looking for work, contacting employers and up-skilling.

Other participants cited the breakdown of their marriage, “*after my relationship split up, then all of a sudden I’d lost my home, I’d lost... my family broke up and then I lost 80% of my income all in one go*”, or the death of loved ones,

But also in that same year, my mother passed away and my younger brother passed away and I think my uncle as well too, so it was just a hit, every couple of months there was a major crisis... it’s been a really traumatic time over the past few years because of those incidents.

These events can be recognised as antecedent vulnerabilities for depression. One participant’s quote summed up the impact financial pressures can place on men, and leads into the second overarching theme; environmental influence:

That's what concerns me still, is there are a lot of people out there who work, because they don't know any different, and they work because of expectations and societal norms and their own core beliefs and values, but don't realise they're actually in the process of neglecting the most important thing, their health.

Environmental influence

References to hegemonic masculine ideology and societal impact:

Bearing in mind current theories suggesting males who adhere to and fail to live up to hegemonic masculine ideologies can be seen as being at a higher risk of suicide (Canetto, 2012), it was interesting to note every participant in this research readily identified colloquial terms that represented the influence of hegemonic masculine ideals in and around their lives. This can be seen across all ages, with one participant from the oldest cohort saying, *“what's the male prototype? You're big, you're strong, you're invincible, nothing worries you, you can drink heaps, you can do this, you can stay up all night”*, and one participant from the youngest cohort saying,

If you try to understand the alpha male... victory at all costs... It's like everything just gets lost in 'I have to win, I have to win'... The alpha male reaction is kind of like 'just do it', 'you're not trying hard enough'.

Another participant pointed out that male gender role stereotypes are not necessarily perpetuated as an intentional imputation, but rather are present in environmental messages and are being received by males throughout the stages of their development:

“Don't be a wuss. Be a man” and you say it to little tackers and what do they hear, well they've got to be tough and they've got to do this, and it's... I'd be disappointed if I ever said that to a little kid, I don't think I would, it might slip out, but it's societies' perception.

Furthermore, another participant referred to the environmental absorption of behaviours not only throughout development but in male dominated workplaces, such as the Fly-in, Fly-out (FIFO) mining industry, saying, *“And you watch people vicariously, so you learn their behaviours, so you think, their behaviour is normal, so it becomes normalised, doesn't it.”*

The male dominated FIFO industry has come to the media's attention recently regarding the negative effects isolation, boredom and relationship breakdowns can have on employees (Deceglie, 2014). However, research has not found significant evidence of poor mental health among miners, with the personal choice to work and financial gains providing a protective factor (Hagemann, 2014). Further inquiries into the issue of mental health in FIFO workers are currently being made by the Western Australian Legislative Assembly (Hagemann, 2014).

Barriers for help-seeking for men:

Participants spoke about the barriers they have experienced or witnessed with other males, in terms of seeking help for mental issues or trying something new, like yoga, meditation or kinesiology. One of the most fundamental barriers was the reluctance to see a general practitioner, with one participant saying, *“Because I think it's hard enough for a guy to go to the doctor, let alone go get a massage or something“* and another saying, *“Some men feel foolish and fearful at going to a male doctor, let alone a female one”*. Participants spoke about the stigmas associated with seeking help and trying something new. One participant identified weakness and vulnerability in admitting to needing help, *“It's kind of seen, almost as a point of weakness, admitting to, you know, feeling sad and stuff like that”*, and another spoke about the uncertainty of trying something new like CAM,

I guess because it's... firstly because it is dealing with a mental issue, that it's stigmatised amongst males, it's not seen as the thing to do, and secondly that

Kinesiology is a relatively newish complimentary therapy. It's very different and we're of a society where very different things are scary.

One participant, who works in the mental health industry, said: “[men] *still wait until the femur is hanging off by the last tendon often before seeking help*”. He said the men he sees in his practice have generally been asked to go for help because they've gotten to the stage where their partners or employers have noticed changes in their behaviour or work performance and “*they've acknowledged that they can no longer cope with a problem ... they feel overwhelmed*”. This reluctance to seek help until, as this participant mentioned, “*something more sinister has manifested... and it's no longer just stress but they realise now that they can't do the things they used to do, like function*”, is concerning, as found in Fields and Cochran's (2011) research, that when men do present for treatment, their symptoms are far more severe than those who are found sooner.

When asked what the reasons were for participants to begin using CAM, motivations to work on specific areas relating to their thoughts or emotions were cited by a number of participants. For example, one participant spoke about using CAM to improve cognitive functioning while studying, saying,

I'm currently using kinesiology with assisting my studies ... Mainly focusing on brain integration, which is just with processing information, short term, long term memory ... it's all about breaking down that initial stress so you can really absorb the information really quickly.

Another participant spoke about using CAM to cope with issues of anxiety, saying, “*Because I just have random bursts of like fear and it's just like, where is this coming from? I have no idea. And I just, I don't think this should be happening*”. A number of participants identified their reason for beginning CAM use as simply being encouraged to try something new by a

friend or a partner. One participant said, “*Tim [name changed to protect anonymity] does yoga with me. He is the one who put us onto it. He came to us last year and said look guys I'm doing this yoga thing*”. Another participant said,

I think men's partners; the females, the wives, the girlfriends, actually have a big role to play here, because if they then purport this as something positive, but then more importantly convey it as something that's unisex, then I think that that's going to influence, potentially, have more influence on his decision to try at least. Happy life - happy wife.

Negative peer group perceptions:

Although these participants identified that a brief positive mention of CAM or an encouragement by a friend or partner had lead them to try CAM for themselves, participants from all three cohorts identified different instances and types of peer groups where they did not feel they would readily bring up a conversation about their CAM use. For example, one participant said that he openly and easily discusses CAM with his friends, because he feels they are of a certain type of character, (i.e. artistic, who are likely to be open-minded to CAM). However, the same participant would not bring up CAM with his work peers, describing those types of males as more “Boganistic”, saying, “*Well like one of the guys I work with races drag cars. So he's a bogan through and through, he wears stubbies, the whole lot. So try and speak to him about natural therapies... he'll laugh at me*”. One of the participants from the older cohort also mentioned, “*if I mentioned that I was a practitioner of yoga or whatever... you'd get some odd looks*”. He described most of his peers as being in their 60s and that they tend to be mainly “*locked into their way of thinking*” and “*unlikely to change their thinking or mind sets*”. So while he said he does not deliberately avoid

discussing CAM with them, he feels that the conversation generally remains at a more superficial level, for example topics related to sports.

One of the younger participants from the youngest cohort said, that with some of his peers, whom he referred to as “*the new age kind of guys*”, that they will ask each other if “*they’re alright?*” when they know someone is having a “*shit time*”. However he also identified that majority of his peers are engineering students who have been taught to think scientifically, for example, “*if it can’t be touched, measured or seen, it can’t exist*”. This participant said he felt if he were to talk about CAM with these friends, they would “*chalk it up to placebo effect*” and whilst as a student of science himself, he feels that the possibility of placebo effect is valid, his personal experience is that “*whether it’s a placebo effect or not, I feel better for it*”. This raises an interesting point, whereby the lack of scientific evidence may be creating a barrier for men, who tend toward rationality and scientific thinking, to try something new and undefined such as CAM. As Sointu (2011) suggested, feminine discourses of CAM as encouraging emotional expression and pampering may be an underlying explanation pushing men away, and perhaps as the psychological world begins to investigate CAM scientifically, greater evidence may enable greater usage. As mentioned, the delivery of information on mental health literacy that is focused on science and rationality has shown positive effects for improved attitude towards help-seeking in males (Brenton & Elliott, 2013; Gulliver et al., 2012). This was reflected in the interviews with the younger participants, as they noted that most people do not know what Kinesiology is, and that while they personally feel better for using Kinesiology and plan to continue to use it, they do feel that the explanations that are given may need to be “*more refined for people to accept it as a practice*”.

Caution when discussing CAM around certain peer groups in participant's lives, appears to relate to the stigma associated with CAM use as being converse to hegemonic masculine ideologies. While the men in this study feel personally congruent with their engagement in CAM and identified positive benefits that CAM use contributes to their lives, they still feel some restriction as to who they can speak openly to about their experiences. One participant spoke about a friend with whom when faced with any kind of emotional discussion, for example even asking, "*are you ok?*", would dance around the question, change the topic or respond with anger, saying "*get out, I don't want to talk to you*". The participant perceived his friend's reaction as stemming from a notion of avoidance, whereby "*he didn't want to talk about it because... I think that he felt that by engaging in that.. he would also prolong that undesirable feeling.*" This may reflect an example of how hegemonic masculine ideologies, that notion of "*Man up; Don't be a pussy*", may play a limiting role on men's willingness to open up and discuss problems, even with close friends or family. As one participant said that generally, "*blokes are more likely to pick up car magazines than they are yoga magazines, because it supports the egotistic, male dominate male image*", so it would require an intervention coming "*from the top*", (i.e. education, or workplace policies), "*to allow people to engage in things they haven't done, they don't know and to finally have a taste of it*".

Positive peer group perceptions:

While the benefits of informal helping are unclear, there is evidence that good social support is a protective factor in both mental and physical health (Cohen, 2004). A number of participants spoke about the positive effect having a group of good male friends has been for them. One participant reflected,

I've got some good friends so ... we meet every couple of weeks and we sit down and we talk, probably not many men do this, we talk about what's going on in our lives, we might talk about finance or philosophy, or you know whatever, we're just very open with each other, and I think it's a really good thing.

Another participant said that when he opened up and spoke about his anxiety with work peers, he actually found it to be a relief, and rather than experiencing any form of stigma or “any form of feeling sorry for someone, it's like, alright, we get it, let's move on. Let's acknowledge that, but let's not dwell into it”, which he found to be a positive response. Furthermore, one participant identified a benefit in talking with his CAM practitioner, saying, “I generally like to talk about it... it just kind of offers some weird, some kind of strange reflection that I think you do kind of get from like a psychologist”.

These identifications of a positive effect in being able to talk about personal problems with friends, family or a CAM practitioner, appear to support present education incentives, such as those by the Beyondblue and The Black Dog Institute, to increase mental health awareness for men, de-stigmatise help-seeking behaviours and encourage open discussions with others. One of the participants, who has experience working with mental health and the organisation, Beyondblue, said:

You know that old saying, the cliché, that men just don't cry... the reality is of course that most of our suicides in Australia are from men, so you know, we haven't got it right. It just shows you how powerful our perceptions of how men should behave, is still very damaging to society... in order to change that amount, you need to be around 'someone', or 'some bodies' who have a different attitude to life. You start floating words like 'yoga' and 'meditation' and 'massage', or the word even 'relaxation' around, because then it gets men to realise they don't have to be these

stoic, rigid, hard working machines, there is time when they can put down tools and stop and smell the air and give themselves permission to go off and have a massage or do some yoga or meditation.

CAM use to develop positive mental habits over time

Benefits of CAM improve with time / practice:

The third theme identified through this study, was the gradual, yet ingrained benefits that regular CAM use can develop over time. As one of the participants noted,

It's not immediate. It may be many weeks of kinesiology sessions. It's never going to be this like... 'congratulations you've done it' (clapping hands). It just happens. I feel that's better, because there's no pressure that there's going to be this big pay off at the end of it.

One client described his regular yoga practice as a way to “neurologically retrain the brain”. He described a “grounding” experience during yoga sessions, citing the practice of yoga, with its focus on the breath and on different body movements, as allowing his mind to spend more time living in the present and less time thinking about the past or worrying about the future. He commented,

I've noticed it's not natural to spend a great awareness about what's happening in the here and now, and so with that comes a sense of quietness, peace, almost serenity, it's quite an amazing experience...the more you practice this, the more that you can make the connection into the 'now' experience.

The description of these personal experiences align with the reviewed research suggesting the benefits of relaxation and mindfulness practices, produce long-term changes in the brain, in terms of reducing hyper vigilant stress-signally molecules and increasing dopamine levels (Chan et al., 2012). This participant noted that with increased practice, you are able to

connect with *“a sense of quietness and things start to become more slower; the mind and the body. It’s gravitational, you want more of it, you feel a pull”*. Furthermore, he noted that the extension of that feeling increases with more regular practice, so now after a number of years practising, he found he not only feels *“less disturbed or irritated or aggravated by things that used to concern me once”*, but also feels his capacity to care and love has increased. These claims clearly warrant further investigation, in line with current research highlighting the effect of improved potential for control over mood, emotion and anxiety (Louie, 2014).

Crisis versus habit:

An issue with using CAM during a crisis versus developing a habitual coping mechanism over time to be accessed in times of crisis, was raised by a number of participants. One participant cited his reason for trying CAM was a response to a stressful time he was experiencing, he said, *“isn’t it funny, when you have times of stress or whatever that’s when you are going to try stuff out”*. Another participant noted that people often try something like CAM when they are in a crisis, however once they feel better, they do not maintain that practice and hence are vulnerable to fall into poor coping strategies, or experiences of depression or anxiety. Another participant said, that when he was faced with a number of traumatic circumstances, specifically the loss of a number of close family members, including his wife, that he *“could’ve quite easily gone into a depressed state, but I didn’t”*. He went on to say,

I felt really lost to some extent, but you know you have to sort of deal with those things, and I’m quite sure that the things that I’ve learnt and through mediation and reading and so forth and I also have a lot of support with friends... But I’m quite sure that what I’ve done, in terms of the practices I’ve talked about, have been beneficial.

He concluded by saying that he believed one could not access meditation in a crisis. He believed that by already knowing where to go or how to get what he needed, allowed him to cope with those times of crisis, *“So because I was there, I know what meditation can do., so yeah, I basically used it as a support thing.”* This suggests that education for CAM use may be most influential if it focuses on CAM use as a preventative measure for health promotion, that a person can incorporate into their weekly activities to reduce stress and protect against mental illness and burnout.

CAM benefits of self-awareness, self-care and self-responsibility

The final theme refers to the benefits of CAM use that were predominantly identified by participants, and relate to a better sense of self-awareness and a feeling of self-responsibility when it came to issues of self-care. As was discussed in Brenton and Elliott’s (2013) study, if education initiatives work towards changing attitudes in society, by focusing on genderless tenets, such as self-responsibility and self-reinvention, then improvements in mental health outcomes for males can be made. As one participant mentioned, he feels it is important for people to take more responsibility for finding out what is wrong with them and not rely so heavily on only one source of information. He said, *“the conventional medical model works sometimes, but there may also be something else you can try”*. He believes people should *“keep searching... Research what’s wrong with you, what are you eating, what are you doing and stuff like that”*.

Self-awareness:

The benefit of better self-awareness was discussed by participants in a number of different ways. Firstly, one participant spoke about enjoying the explanations that were provided during a yoga session, regarding what impact different stretches were having on different parts of the body, for example, *“You know sometimes she’ll say you’re exercising*

your kidneys, and I go "ok" I didn't know that was going on... So that sort of thing, I think is beneficial". Another participant reported feeling calmer, more relaxed and yet realising it's not just about relaxing, but also, *"it's about, self-awareness and self-control. An option to live more fully in the now, as opposed to being caught up in unhelpful thoughts and feelings"*. A third participant mentioned that after a Kinesiology session, he felt, *"mentally lighter... I felt I had clarity of thought, and I felt that what I was really worrying about didn't warrant it because you already have a strategy for it anyway, so what were you worried about"*. Finally, one participant described that in having a better awareness, he was able to cope with the loss of his partner, by *"being able to see things for what they are...you go through the grieving process and that's a genuine thing, you have to honour that, recognise that, respect that... but then there is also, you do sort of move on"*. One participant said,

by engaging in these therapies it allows you to unwind, it allows you to balance the mind and more importantly if you practice it regularly, you're also going to protect the body from becoming stressed in the first place, because of the change in attitude and awareness and acceptance.

It is interesting to note from participants' responses, that the different forms of CAM produced a similar effect on the body, that is a feeling of relaxation and on the mind, that is greater clarity of thoughts and a sense of awareness. This notion of a connection between the mind and the body, was a topic that was raised throughout the interviews.

Self-care - Mind body connection:

A number of the men spoke about using CAM for physical reasons, such as chronic pain and back issues, and that the benefits for the mind were in addition to the benefits they had hoped to achieve for the pain in their body, for example one participant mentioned, *"if I'm not happy or I'm a bit depressed about something, I use Kinesiology as well as*

chiropractic, but that's more [of a] physical, than a mental thing, although it does contribute to my mental well-being as well". One participant linked his physical pain with an emotional or mental aspect, saying, *"when I was at work, I didn't have a lot of stressful days, but occasionally I would have one, and when I did, my back would go out virtually straight away, and I'd stew over it"*. Another participant spoke about using Kinesiology to work on his lower back pain and having his practitioner relate his back pain to an attitude of *"not being good enough"*. He went on to say, at that time in his life, he had just left his full time employment to work towards setting up his own small business, and that the emotion of *"not feeling good enough"* felt very relevant to the life experiences he was facing at that time. The connection of thoughts, emotion and the physical body may warrant further investigation. Studies have shown physical activity can reduce stress (Satin et al., 2013) and that a reduction of stress can improve the immune system by returning the body's flight or fight regulatory system to a calm state, rather than a hyper-vigilant state, as is the case in high stress and long-term stress situations (Louie, 2014). An example of this principle was when one participant described his experiences with yoga and the effect it has on his body,

A stressed body is a tight body. A tight body is a tense body... and that tension in the muscular skeletal structure, also relates (emulates) itself to the mind... that generally you'll have both components that are tight; the mind's tight and busy, and the body is tight... so by going to these classes, the yoga, allows you to find that balance, to release the physical attributes around the stress, the tightness, and that allows then allows the mind to start to unwind and freewheel doesn't it. So it's powerful isn't it.

Self responsibility - trying new things and diet:

"It has been argued that because only a minority of people seek professional help, self-help skills are of great importance and that self and informal care should be supported

and developed for some problems” (Oliver et al., 2005, p. 301). Following on from the second theme relating to participants’ perceptions that some character types may be more open-minded to CAM use, while others may be less receptive, the issue of men opening up to trying new things, is one that may require further attention. One participant said that because scientific proof is lacking, their friends tend to “*shun it*”, that even though it can not be proven or disproven, “*they’ll go by a default and say well it’s not real because that’s the safer option*”. Another participant reflected that while he perceives males may be inquisitive when they hear of a practice that may possibly bring about some “*positive change or benefit*”, they are also likely to be quite dubious and that “*being receptive to taking this up... reflects a certain attitude as well, an attitude around alternative medicine as a bloke*”. This perception highlights the need for further research into CAM and for further education of alternative therapies in our society. By de-stigmatising CAM use, better attitudes towards trying something new can be promoted, in line with Azjen’s theory of planned behaviour (Ajzen, 1985). As one participant said, “*you don’t know what you don’t know*”, and furthermore,

I think there’s room for these things in a lot of men’s lives, particularly men who are under a lot of stress or demands in their job. It’s a great sort of therapy or interventions that can be quite easily amended to peoples’ lives... even the busy lives and I think it is far better choice to adopt sooner rather than later and end up looking down the barrel of an antidepressant or an anti-anxiety drug.

In accepting responsibility for one’s physical and mental health, one participant identified that CAM can be seen as an additional factor to mainstream medicine, for example,

I realise that when you listen to your body, you know what you need and sometimes that pill or that medicine is not going to help, it may help, but you may need

something additional, that's something else, that's maybe non traditional, or complementary to it and that seems to make it work.

While another participant identified that attending CAM should not be seen as the miracle cure, but rather as one of many aspect of lifestyle that contribute to health and well-being, including, diet, smoking and sleep, as identified as important considerations when examining differences in health between individuals (Satin et al., 2013). An example of this from the present study was,

When I went to [Kinesiologist], there was a lot of talk about depression on my part, but it's um, something that I think would take a lot more than Kinesiology to sort of help and I know I mainly blame that on my diet... because you can't go to Kinesiology and expect everything to be better.

And another who said, *"I look back and wish I had of eaten a lot healthier, because as I'm getting older, health issues arise, where you need food and diet, which is an essential part of being healthy. It really is"*.

Conclusion

Research shows a potential under identification and treatment for men suffering from depression (Fields, & Cochran, 2011). An emerging consensus highlights that hegemonic masculine gender roles may be problematic for males, limiting healthy help-seeking behaviours and leading to a larger incidence of externalising behaviours including substance abuse, aggression and suicide (Cochran, & Rabinowitz, 2000). The rise of CAM in Western societies may offer an informal, less-stigmatised option for men suffering mood disorders. By promoting genderless tenets of self-responsibility and self-care, CAM users report feeling empowered by their use of holistic therapies and this may encourage men's embodiment of health care practices previously deemed feminine (Brenton & Elliott, 2013). The present

study sought to explore and interpret the personal experiences and expositions of men who currently utilise a form of CAM in Perth, Western Australia. The specific aim for conducting this research was to examine male motivations towards CAM use and consider whether male interpretations of CAM can be better understood in ways that can bridge the gap between hegemonic masculine stereotypes and help-seeking / health-promoting behaviours.

The answers to the main research questions for this study were found as follows: First, the primary factor that leads participants to engage in CAM was an encouragement to try something new by a partner, family member or a friend. Second, regardless of which CAM type was attended, participants in this study cited the benefits of CAM use in their lives as feeling more relaxed, having more clarity in their thinking, feeling better able to accomplish what they wanted and feeling better able to cope with crisis when they arose. Third, all participants readily recognised the influence of hegemonic masculine ideologies in their environments and the impact they have on males' engagement with CAM. Terms such as "*man up*" and "*don't be a pussy*" were commonly referenced in response to men seeking help for stress related problems. Moreover, a general reluctance to see a doctor and the associated perceived weakness that may denote was cited as the main barrier for men to attend CAM. Participants felt that CAM use was a beneficial option for men and some suggested by having a better understanding of CAM from a scientific and rational point of view, men's interest in CAM may increase. Participants also felt that men would benefit from taking a more active role in their own health care, researching more than one aspect of health care, including diet and alternative therapies, which may enhance or complement mainstream primary health care.

One of the limitations of this study, as with past research on the use of CAM (Ross et al., 2013), was the element of self-selection, whereby the participants were all generally

healthy individuals who had chosen to attend CAM from their own volition. Future research may benefit from adopting a mixed-methods design and selecting novice participants to attend CAM as part of randomised controlled trials (RCTs). RCTs with novice participants would enhance the validity of CAM research. Furthermore, the issue of education and changing attitudes is important. Studies have shown that education based on biological explanations have a better effect on men (Gulliver et al., 2012). Further research into what types of education and information men are receptive to, and what factors influence males to change their attitudes and as an extension of that, change their behaviours, would provide valuable insights for this at-risk demographic. Given the high rates of suicide and substance abuse by men, men's mental health issues are an important area of concern for psychologists and the community. Further research to develop education initiatives that de-stigmatise depression and therapy for men are warranted. As is the development of gender appropriate assessment measures and treatment programs for men, along with community based initiatives that encourage self-help and lifestyle changes (Cochran & Rabinowitz, 2000).

Overall the findings of this research suggest CAM use has a positive effect on the males who currently use them. The benefits of using CAM regularly have been described by participants as a healthy way to reduce day-to-day stress; CAM use empowers them as they take responsibility for their own health and feel they have better clarity and awareness of their thoughts, emotions and health. However, participants did report some restriction in the groups of male peers they felt comfortable discussing their CAM use with. This may highlight the importance of community-based education initiatives to develop an environment that supports men and minimises the negative influences of hegemonic masculine stereotypes. By developing an attitude of acceptance for the genderless tenets of health behaviours, such as self-responsibility and appropriate help-seeking behaviours for

men, improvements for mental health outcomes for this demographic may be made. While this study has focused on men and depression, it is not the intention of this researcher to ignore or minimise the large numbers of women suffering from depression.

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Appendix B

Participants Information Letter



JOONDALUP CAMPUS

270 Joondalup Drive,
Joondalup
Western Australia 6027
Telephone 134 328
Facsimile: (08) 9300 1257
CRICOS 00279B

ABN 54 361 485 361

Title of Research Project:

Examining the appeal and ascribed meanings of CAM use by males: An Interpretative Phenomenological Analysis.

Dear participant,

Thank you for taking the time to read about my study. My name is Kathryn Hogan and I am conducting this research as a requirement for my Bachelor of Science (Psychology) Honours degree at Edith Cowan University.

The aim of this study is to investigate why people use complimentary and alternative medicines (CAM), and the experiences they have had with them. I am specifically looking for male CAM users, as it is an industry that currently holds a prevalence for females, as both users and practitioners, and I am interested in learning more about why men use CAM and what they think about their CAM experiences. This project has been approved by the ECU Human Research Ethics Committee.

For the purpose of this study, I am looking for volunteers to be involved in a one-time face to face interview, which is expected to take 30-60 minutes. The interview will be audio-taped, and I will also be taking written notes. The interview will consist of a number of open ended questions, and participants will be invited to contribute as much as they would like about their experiences, thoughts and feelings about CAM, health and wellbeing. As a thank you, participants will receive a \$20 JB hi-fi voucher.

The transcription of the audio tapes will form the data I will be examining. I will be writing my findings in a journal article which will be graded as my final mark and may be published in a psychology forum. The information participants provide, will be referred to anonymously in the written article, with interviews being coded as 'Respondent A'; 'Respondent B' and so forth. Participants may be contacted via email after the interview for clarification on their responses if required.

Participation in this study is completely voluntary. You are under no obligation to answer any question with which you are not comfortable, and you may withdraw your consent and remove your data without explanation or penalty up until August 31st 2014. Please be aware, that after this date, removal of the data will no longer be possible, as it will have already been anonymously coded into the report. A written consent form will be presented to volunteers and a signature of agreement will be required in order to participate.

After transcription, the recordings will be erased. A copy of the transcriptions will be kept by myself and my supervisor, and the university may keep a copy in long

Appendix B

term confidential storage which may be accessed for future research projects. You will be offered the option to give consent to future studies. You may request a copy of your own interview transcription if you would like to keep a copy.

If you would like to participate in this research study, please contact Kathryn on kvhogan@our.ecu.edu.au.

If you have any questions or require any further information about the research project, please contact myself, Kathryn on 0402 307 823, or my supervisor, Dr. Madalena Grobbelaar on 6304 5902, m.grobbelaar@ecu.edu.au.

If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact:

Research Ethics Officer

Edith Cowan University

270 Joondalup Drive

JOONDALUP WA 6027

Phone: (08) 6304 2170

Email: research.ethics@ecu.edu.au

Thank you for your interest in this project.

Kathryn Hogan

kvhogan@our.ecu.edu.au

Appendix C

Participants Consent Form



JOONDALUP CAMPUS
 270 Joondalup Drive,
 Joondalup
 Western Australia 6027
 Telephone 134 328
 Facsimile: (08) 9300 1257
 CRICOS 00279B
 ABN 54 361 485 361

Title of Research Project:

Investigating the Appeal and Interpretation of CAM for Males Users: An Interpretative Phenomenological Analysis.

Contact Details

Primary Researcher:

Kathryn Hogan

Mobile: 0402 307 823

kvhogan@our.ecu.edu.au

Supervisor:

Dr. Madalena Grobbelaar

Ph. 6304 5902

m.grobbelaar@ecu.edu.au

I have read through a copy of the Information Letter explaining this research project. I have been given the opportunity to ask questions, and my questions have been answered satisfactorily. I am aware that I may contact the research team at any time, should I have any further questions.

In accordance with the Information Letter, I am aware that my participation in this research will take the form of a 30-60 minute, audio-taped interview, with the possibility of follow up email correspondence to confirm or clarify my interview data if required.

I understand that the information I provide will be kept confidential and I will not be identified in any way. I am aware that the results of this research project may be published in reports, conference papers and journals.

I understand that I am under no obligation to answer any question I do not wish to answer, and that up until the specified date, August 31st 2014, I am able to withdraw my consent and information without explanation or penalty. I confirm that I am over the age of 18 years and I voluntarily agree to participate in this study.

I consent to my participation in an interview : **YES** **NO**

I consent to the interview being recorded : **YES** **NO**

I consent to the use of this information for future research studies:
 YES **NO**

Participant: Researcher:

Signature: Signature:

Date: Date:

Appendix D

Interview Schedule:

1. Can you tell me about the type of CAM you use and how you became involved with using it?
2. In what ways do you feel using CAM impacts or effects yourself and your life?
 1. Do you find that CAM use is beneficial for mood, thoughts, and / or emotions?
3. Can you describe what happens during a typical session of CAM?
4. Have you experienced a time in your life when you felt like you were depressed?
 1. What were the circumstance that contributed to your feeling depressed?
 2. What did you do about it?
 3. How do you feel you recovered from it?
5. What do you think are some of the common factors that contribute to male depression?
6. Do you think there is a stigma associated with men seeking help for mood disturbances?
7. Do you think there is a stigma attached with men who use CAM?
8. Do you think CAM would be beneficial for more men to participate in?
9. Is there anything else you would like to say about CAM or mens health?