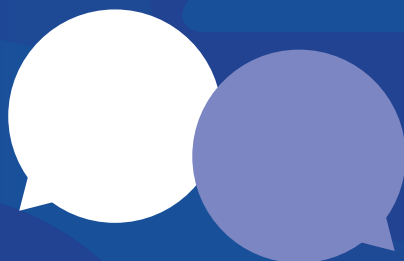


MIND YOUR LANGUAGE HOW MEN TALK ABOUT MENTAL HEALTH

Report written by Chris Stein
January 2018



MEN'S HEALTH FORUM

The Men's Health Forum is the independent voice for the health and wellbeing of men and boys in England, Scotland and Wales.

- > **OUR MISSION:** to improve the health of men and boys.
- > **OUR AMBITION:** that all men and boys – particularly those in the most disadvantaged areas and communities – will have the information, services and treatments they need to live healthier, longer and more fulfilling lives.
- > **OUR WORK:** we carry out research, raise awareness, work to change health policy, share and encourage good practice, work with other charities and provide health information to men off and online.

One man in five dies before the age of 65.
TOGETHER we can change that.

Mind Your Language
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MIND YOUR LANGUAGE HOW MEN TALK ABOUT MENTAL HEALTH

INTRODUCTION	4
MEN AND SERVICES	6
DESKTOP REVIEW	8
NEW QUALITATIVE RESEARCH	11
GOOGLE ADWORDS ANALYSIS	25
RECOMMENDATIONS	29
APPENDIX	30
REFERENCES	31

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INTRODUCTION

This report is intended for decision-makers, service providers and practitioners whose work impacts on men's mental health.

The report, which refers to both qualitative and quantitative data sets, provides:

- > **Desktop Review** - a rapid review of literature on the topic of language and men's mental health
- > **New Qualitative Research** - findings from eight focus groups with boys and men from a diverse range of backgrounds, and
- > **Ad Analysis** - an analysis of language in the Men's Health Forum's Google AdWord campaigns

In sharing these findings, the Men's Health Forum hopes to impact positively on the mental health of men by developing professionals' understanding of the language men use when talking about their mental health.

Men engage less with mental health services than women. Men account for just 35% of all referrals to Improving Access to Psychological Therapies (IAPT) the programme sponsored by the National Health Service to increase access to talking therapies.¹

They also talk differently about mental health. In their analysis of the impact of the Time to Change campaign on public knowledge of and attitudes to people with mental health problems, Henderson et al (2013)² found that while men's attitudes and behaviours had changed over the period, those changes were mainly in their contact with women. That is to say, men reported they were more likely to confide in women about their challenges with their mental health than in other men. This suggests that stigma amongst men continues to be a barrier to improving men's mental health.

Work in other areas shows that using correct language improves engagement.³ There are many sources inviting us to be mindful of our language, but little published in the way of recommendations of terms and phrases one might use, especially in a UK context. There are tensions in the language used relating to mental health. Some advocate using the language that is used by men (and by implication might attract them and/or make more sense to them) while others argue that language that is accurate and relates directly to mental health conditions ought to be used to build understanding and reduce stigma. You could see the former as the social model, the latter as the medical one.

The purpose of this report is to provide quantitative and qualitative information about the language men use in talking about mental health with a view to provide recommendations for how services might best reach out to and engage with men in order to improve their mental health.

For clarification, the scope of this report relates to engaging men, not retaining them in a service or supporting them to complete an intervention.



MEN AND SERVICES

Men engage less with mental health services than women and talk differently about mental health too. During the first 3 quarters of 2015, men were only 35% of those accessing psychological therapies.

In a 2016 survey by Opinion Leader for the Men's Health Forum⁴, the majority of men surveyed said that they would take time off work to get medical help for physical symptoms such as blood in stools or urine, unexpected lumps or chest pain, yet fewer than one in five said they would do the same for anxiety (19%) or feeling low (15%).

Further data from the Opinion Leader research showed that 34% would be embarrassed or ashamed to take time off work for mental health concerns such as anxiety or depression compared to 13% for a physical injury. The rate was even higher amongst men with existing mental health concerns (46%). Some 38% would be concerned that their employer would think badly of them if they took time off work for a mental health concern – compared to 26% for a physical injury - and again this was higher amongst men with existing mental health concerns (52%). This data suggests an elevated level of stigma amongst men in taking time off work for mental health concerns within an ongoing culture of more-generalised stigma and a reluctance to make use of services.

The picture of men's mental health looks even more different from that of women when the following is considered:

- > 73% of adults who 'go missing' are men⁵;
- > 87% of rough sleepers are men⁶;
- > men commit 86% of violent crime and are twice as likely to be victims of violent crime.⁷

Perhaps the most arresting statistic is that of suicide rates, where men represented 76% of all suicides in 2016.⁸

This suggests that men choose methods other than engaging in conversation with either significant others or services when they are experiencing periods of challenges. This conclusion is reinforced by a survey conducted by YouGov for the Mental Health Foundation (2016)⁹ in which it was reported that 28% of men had not sought medical help for the last mental health problem they had experienced compared to 19% of women. A third of women (33%) who disclosed a mental health problem to a friend or loved one did so within a month, compared to only a quarter of men (25%). Indeed, over a third of men (35%) waited more than 2 years or never disclosed a mental health problem to a friend or family member, compared to a quarter of women (25%).

Robertson and Baker (2016)¹⁰ suggest that potentially part of the issue for under-diagnosis of male depression lies with the language used in the diagnostic tools. They cite examples where phrases such as 'feeling unloved' or 'butterflies in the stomach' are used and hypothesise that such language may better represent female depression than male.

Martin et al (2013)¹¹ developed the Gotland Scale that accounts for alternative behaviours, such as aggression, substance misuse and anger, alongside more traditional behaviours, such as feeling tired, to generate a conceivably more accurate measure of depression in men. When applied, rates of depression in men were shown to be higher than previously thought and indeed roughly the same as in women (30.6% of men and 33.3% of women).



DESKTOP REVIEW

Given that men engage less with services and appear to behave differently in response to mental health challenges and to use different words to describe those challenges, what research exists into the language used by men and the services trying to engage with them?

An investigative network of seven academics and researchers was contacted for guidance towards research papers and to understand their tacit knowledge on the topic. The network comprised experts in men's health and mental health. From the network there was little in the way of robust academic research that defined words and phrases endorsed by men for engaging men with mental health services. Some papers made reference to the need to be mindful of language when working with men around their mental health, but they did not go into more depth to propose specific terms or ways of speaking or writing.

James Leadbitter, artist, activist and diagnosed with borderline personality disorder, articulates the power of language concisely when he says 'language is how we codify things. If we shift language then we shift perceptions'.¹²

Johal et al (2012) identified language as a barrier to engaging men in social projects. They recommend organisations consider 'tailor[ing] marketing to target men specifically, taking into consideration language and graphics.' Robertson et al (2014) documented the impact of using language that resonates with men to engage them to address their mental health. Robertson says that in order to create 'an environment in which men feel more comfortable exploring their problems', the initial marketing of the service had to 'include discussing the unique symptoms of masculine depression, and use of language more compatible with traditional masculine gender roles'.

However, conversation and contact with professionals suggests that some professionals and agencies believe that it is important to use clinical terminology when talking or writing about mental health. The general rationale for this appears to be that by using accurate, medical terms knowledge around mental health is built and stigma reduced. But researcher from the McPin Foundation noted that although it is a topic that arises frequently in discussions during development of commissioned projects, there appears to be no solid consensus in relation to using clinical terminology. Robertson et al (2014)¹³ notes that services must consider the 'benefits and costs of using mental health language'. The discrepancy in service uptake by men noted earlier suggests that this is not yet happening. Would professionals prefer that men used medically-approved terms but eschewed their services or used more colloquial expressions but turned up?

One of the investigative network, Professor Damien Ridge of Westminster University, believed that the term 'stress' was one that research on the Atlas wellbeing service¹⁴, co-developed by Ridge and colleagues had validated for attracting a greater male audience. The marketing materials for the service make unambiguous reference to stress and how it manifests in the body. In their analysis of the Atlas programme, Cheshire et al (2016)¹⁵ argue that 'high levels of self-labelled 'depression' are found in both men and women when they are asked in lay terms about depression, and men report work stress more frequently than women. Studies such as these suggest complex factors are influencing male distress, as well as the way that professionals interpret the issue.'

Shand et al (2015)¹⁶ identified terminology that could be used for tailoring interventions to meet men's specific needs. They surveyed 251 Australian men aged over 18 years who had made a suicide attempt 6–18 months prior to completing the survey. The objective was to better understand the language used by men to describe their depression and suicidality (likelihood of

completing suicide), the warning signs, the barriers to accessing support and what is needed to interrupt a suicide attempt. The words and phrases most commonly endorsed by the participants were 'useless or worthless', 'I've had enough', 'hopeless', 'pointless' and 'over it' in reference to feeling suicidal (for further information see table 1 in Shand et al, 2015). In reference to feeling depressed, the most frequently endorsed words or terms were: 'stressed', 'tired', 'not going too well' and 'down in the dumps'. While it is highly likely that there are cultural specificities in regards to the above terms, the paper represented the most robust findings from our desktop research. It certainly suggests that colloquial terms are those used by men themselves. The findings were used to inform the development and delivery of focus group sessions discussed below.

The Investigative Network

- > **Peter Baker** - Director, Global Action on Men's Health and Associate of the Men's Health Forum
- > **Dr Neil Coulson** - Associate Professor of Health Psychology, University of Nottingham
- > **Professor Damien Ridge** - Professor of Health Studies, University of Westminster
- > **Professor Steve Robertson** - Co-Director of The Centre for Men's Health, Leeds Beckett University
- > **Dr Rose Thompson** - McPin Foundation
- > **David Wilkins** - Associate of the Men's Health Forum



NEW QUALITATIVE RESEARCH

METHOD

Using a convenience sampling approach, eight focus groups of men were convened. The number of males in each group ranged from five to 38, with ages ranging from 13 to mid-70's. The men were drawn from diverse socio-economic backgrounds, across a range of job roles and industries and included unemployed, employed and retired men.¹⁷ To complement the focus groups, two one-to-one semi-structured interviews were undertaken.

The aim of the focus groups and interviews was to build an understanding of the language men use in relation to speaking about mental health.

The focus groups were convened using two key strategies, which are described below. These strategies served to ensure participation and engagement by the men in the discursive task.

The first strategy saw men being invited to respond to words and phrases presented to them. They were also asked to consider what caused them to feel stressed or low and what they might do in response to those feelings to improve their well-being. Groups were also invited to present their understanding of what well-being meant to them (and alternative language where it was felt well-being was not a desirable word to use).

The second engagement technique was to present sub-groups with a series of 15 words and phrases on cards and ask them to structure the cards into a hierarchal pyramid with the word at the top reflecting the word or phrase they most identified with. Groups were given cards reflecting language they would use or would want used in reference to themselves in an instance where

they had just begun to notice they were not as well as they could be or language that reflected what they might do when they noticed they were not as well as they could be. Within the group of cards, there were four 'blanks' allowing the group to insert their own terms. The exercise also included the need to reject five terms. Following the exercise, the groups would present their pyramid and the discussion would be facilitated to probe further understanding.

Thirdly, the groups were presented with marketing materials from various organisations and asked to comment on the strengths and weaknesses of the publications. They were also presented with images representing men, potentially in a state of distress, and were asked to comment on the strengths and weaknesses of the images.

The groups were always briefed on the purpose of the group and told that the write-up would fully respect anonymity.

The groups convened were as follows:

- > Bupa, Claims Advisors, Manchester
- > Bupa, Project Managers, Staines
- > CAN Mezzanine, various job functions, Southwark, London
- > Skanska, varied job functions, Farringdon, London
- > Barnet Fire Station, Firemen, North London
- > Surbiton Fire Station, Firemen, West London
- > Amerbeley Youth Project, young people, Maida Vale, London
- > Walking Football Group, Walton-on-Thames, Surrey

Two practitioner interviews were conducted. The first was with the mental health lead from Working With Men, Leslie Mitchell. The second was with Neil Emsley a volunteer with Samaritans with 15 years experience.

KEY FOCUS GROUP FINDINGS

As can be imagined, there was significant variance in the feedback from the participants across the different settings, but equally there were some broad themes that emerged.

Many within the groups expressed the need to be mindful of language, reflecting the academic findings, and it was felt this was especially so in a digital setting. It was recognised that in a digital context organisations had a small window of opportunity for attracting people to their service and that language was often the key focal point for driving uptake.

'Stress'

There was a consensus within groups and across them that stress is a word that can be used effectively for engaging men to talk about their mental health. As a concept, stress represented a state that 'sits on top of you' (Surbiton Fire Station) but could be 'pushed back' (Bupa, Manchester). It was defined as 'being out of control' (Skanska) at a high level. Stress manifests itself through a series of apparently opposing symptoms: too much sleep/not enough sleep; eating too much/ loss of appetite. Other manifestations included excessive drinking, smoking and substance misuse. It could be seen through bouts of anger and isolation.

While stress as a word was validated, different groups emphasised different causes of stress. Skanska, where the group was generally older, spoke more about financial stress and not being ready for retirement, as well as stress emanating from teenage children. There was also a sensitivity to the challenges faced by young people today as a result of the 24 hour lifestyle foisted upon them by technology. The negative impact of technology on the mental health of young people was also mentioned by the group at Surbiton, with one member saying that social media brings a lot of responsibility and that many children and young people were not able to manage that responsibility in the right way. The group from CAN

Mezzanine spoke more about workplace stress and work-life balance where people felt 'overloaded' and 'overwhelmed', words that acted as synonyms to stress.

The group from Surbiton Fire Station made the point that 'different people have different tolerance levels for stress' going on to say it was a term that could not be used accurately to indicate mental health problems, 'though it could be used as a term for opening a discussion.'

Various groups made the point that stress was not necessarily a wholly bad thing and could lead to productive cycles. (Academically, the term eustress is sometimes used for positive stress and contrasted with distress.) A participant at the Staines group stated 'Positive stress gives me motivation, goals and drives me on'. At Barnet Fire Station there was a lively discussion about what good stress is and how it differs from motivation. Interestingly, there was a consensus that negative stress impacts the body as well as the mind, with senses being impacted in different ways for different people, perhaps indicating there is better awareness of what negative stress is and how it manifests.

Synonyms of stress used by the groups included 'overloaded' and 'overwhelmed'. These terms were used to describe a state where a person was 'out of control', 'having more to do than they could cope with'.

'Stressed Out'

Over the course of the focus groups a differentiation between 'stress' and 'stressed out' began to emerge. Some reflected that the word 'out' is 'like a tipping point' (Surbiton Fire Station). This was corroborated by the older men's group from the Walking Football session where a participant stated 'You wouldn't want anyone saying, 'You're stressed out!' It sounds like you can't cope'. The same concept was reflected by the group of young people at the Amberley Youth Club, where the subgroup participating in the hierarchical exercise also stated that the word 'out' took the sense of the term to a different level of concern.

Not everyone shared this opinion, however. A participant at the Surbiton Fire Station stated he used the term almost frivolously in saying things such as 'the kids are stressing me out' and 'work is stressing me out'. Equally, during the hierarchical word exercise, one of the groups from the Walking Football session rejected the term 'stressed out' on the basis that it was the same as 'stress'.

The context plays a large role in the meaning attributed to a term as the above demonstrates. A participant at the Walking Football session, previously diagnosed with depression, said 'when I opened up to a close friend [about his state at the time] their response was 'You're stressed out' but I felt that was ok because of the context: I'd opened up to them and, despite speaking calmly and with purpose, I was crying as I spoke'.

'Mental Health'

The term 'mental health', a popular blanket term used by the media, professionals and academics alike, was, by the majority, seen as a negative word, indicating a failure to cope. A minority - perhaps more accurately - reflected that we all have mental health and that it represents a spectrum of existence, positive and negative. This debate clearly illustrated the disjunction between more 'medical' terms and how they are understood colloquially.

In Manchester, a reflection was that 'mental health' was often pitched as a problem in society and underfunded by the NHS. In Skanska, two people shared their experience of stress boiling over into mental health problems. In one case, the system at large failed to address the presenting issue, leading to the person experiencing depression. In the other, an individual shared their experience of being placed on medication and the negative impact of that.

There was a widespread feeling that the term was steeped in stigma. 'People think you are mental', said a Skanska participant. The group from Staines reflected how mental health is generally portrayed in the media, 'The media talks about mental health as a medical thing, a problem'. Also, that 'Mental health is seen as dangerous'.

Across the groups, there was also a sense that while mental health was a term shrouded in stigma, changes had been made that make it more acceptable for men and wider society to talk about mental health than in previous eras. The Walking Football group took this notion a step further by saying that 'people's expectations of their own mental health have changed'. This is significant as it suggests that where expectations change, cultural norms are likely to align.

'Anger'

This was widely seen as a word that would be acceptable for men to respond to and speak about further. This was particularly the case among young people. It was the emotion that was deemed easiest to express because it was easy to identify and was linked to being a man. When asked why it was an easier emotion to express, one participant stated 'because you can be physical', i.e. pace around, shout, or potentially punch something. There was a feeling that these expressions of emotion were more closely aligned to their sense of being male as well as to society's view of being male.

During the session at CAN Mezzanine, the feedback on the term anger brought more variety. Anger is something that can be 'seen' in society through swearing, clenching fist and pacing, for example, but that the responses to it might not always be proportionate depending on who was expressing anger. A similar view was expressed by the group from Barnet Fire Station where it was suggested that when we are angry it can result in very visible behaviour such as shouting, ranting and invasion of personal space. It was felt that women will more likely resort to being quiet and ignoring people. One person noted that 'anger needs to be released, like stress' and physical activity is an effective way of doing so. Another person said 'anger can spill out when a person drinks because inhibitions are lowered', thereby noting a behaviour that can have a compounding negative impact.

There was a discussion also about cultural tolerance levels for expressions of anger, in which behaviour that might pass as acceptable in one culture might be seen as unacceptable in another. The UK's culture of reticence and reserve was seen to have a lower level of tolerance to anger.

'Feeling Down'

Feeling down was seen as a preferable term to depressed. The latter was classified as more closely aligned to a mental health term, with the associated stigma. Interestingly, one of the sub-groups at the Walking Football session identified this as a term that they would feel comfortable others using to describe themselves if they were not as well as they could be and that they would comfortably use to describe another person. This term was identified independently through making use of a blank card.

'Well-being'

There was a wide variance in how this term is perceived. 'Well-being' as a term was often thought of as being over-used and over-applied, without being clearly defined. At Barnet Fire Station, one person pointed to a poster for counselling and well-being services saying it used to be referred to as counselling and welfare so there was a sense that well-being was a buzzword more than anything of substance, though they were not against the principle of well-being. Some at Skanska said the term was 'woolly' 'doesn't really mean anything' and is 'overused'.

While the sense of 'well-being' needing greater contextualisation was expressed in other focus groups also, there was also an equal voice seeing the term as representing a 'series of good habits', 'suggest[ing] investment in yourself' and as a 'responsibility' [Staines]. The Walking Football session corroborated this, where one participant stated it means 'Looking after yourself'.

PYRAMID EXERCISE

Walton on Thames Walking Football Group

While the discussion-based groups provided insights into the language used by men relating to mental health, arguably the pyramid exercises provided more depth. In part, this may be because the groups had the opportunity to add their own language into the exercise, providing new, unforeseen insights.

The Walking Football group saw 38 men aged between their mid-50s to mid-70s engaged in a two hour pyramid session. The group was structured into four sub-groups. Two groups were given a set of words relating directly to mental health ('term' groups), while two other groups were given sets of words relating to behaviours a person may engage in when they first realised they were not as well as they could be ('behaviour' groups).

Each group was given 15 minutes to take the list of words and invited to do the following:

- > Remove 5 words that are unacceptable or not applicable
- > Structure the remaining 10 words into a pyramid of 4 levels
- > Decide whether to make use of the blank cards to add words or phrases the group felt were left out

On page 20 are examples of the pyramid constructed by the groups. Image 1 relates to language around behaviours enacted while Image 2 shows words the group would feel comfortable using or hearing used towards them in talking about mental health.

Of the two 'term' groups, the following terms were rejected by both groups:

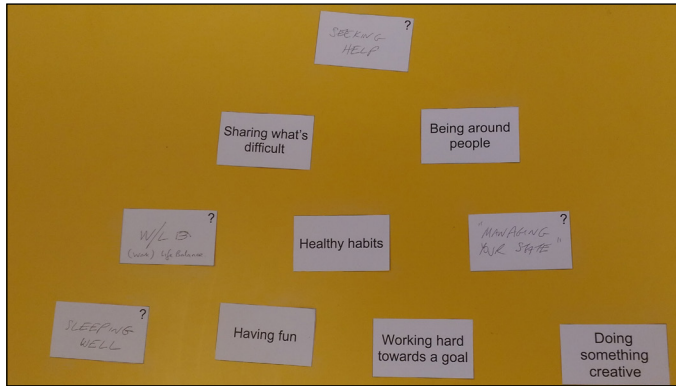
- > Mental - 'People don't say that anymore', indicating a change in the language used around mental health
- > Psycho - 'That's really negative'

- > Angry - 'It could be for any reason'
- > A bit weird - 'I wouldn't want someone to say that about me'
- > Emotional - 'It's too girly'; 'Emotions aren't the same as mental health'

Terms that were added included:

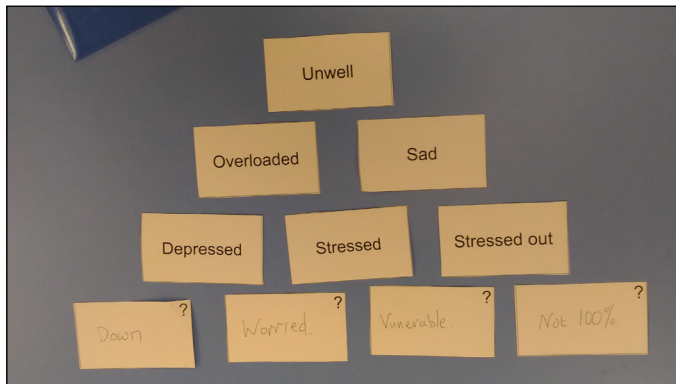
- > Not 100%
- > Down - Corroborating findings from the Australian research
- > Worried - 'It's better than anxious'
- > Vulnerable
- > Lonely - 'That's a good one because you can be lonely in a crowded room. That's not a good place to be.'
- > Pressure - 'It's something happening to you and it might just be too much'

After each sub-group separately engaged in the pyramid exercise, the full group came together around each table in turn where the sub-group presented their pyramid to the others. During this discussion phase, there were recurring themes expressed by the group. Beyond the matter of terms and phrases, the group stated consistently that it was about how mental health interventions were delivered, by whom and when. As an example, the term 'depressed' could be an acceptable but depended upon how it was presented to the individual not feeling well: a person could say 'you look depressed' and depending upon tone and body language it could mean different things. The group acknowledged that much had changed since their childhood in the field of mental health, how it is spoken about in society and in people's expectations of their own mental health.

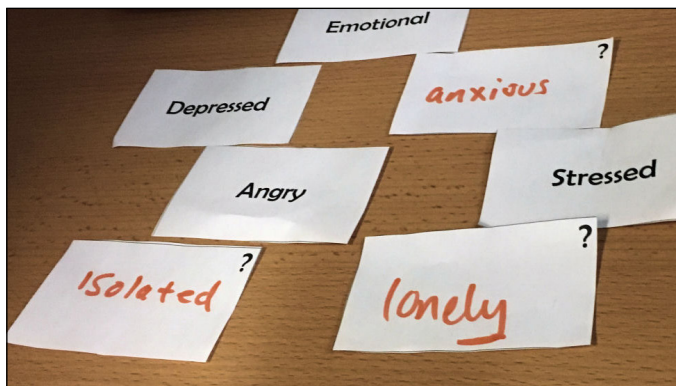


Pyramid images

Walton on Thames
Pyramid 1: the added terms are Seeking Help, W/L B (work-life balance), Managing Your State and Sleeping Well.



Walton on Thames
Pyramid 2: the added terms are Down, Worried, Vulnerable and Not 100%.



Amberley Pyramid

The Amberley Youth Project

Young males aged between 13 and 16 were engaged in a focus group on mental health at the Amberley Project managed by Working with Men. The insights from this focus group of, effectively, boys were extremely interesting and often in contrast to those from the focus groups with men.

The pyramid exercise was used to help shape discussion. On page 20 is an image of the pyramid relating to words and phrases about mental health.

The group of five, mostly from lower-income Arabic backgrounds, rejected 'overloaded' very quickly with one person from the group asking what it meant. (This could indicate a language issue or suggest that the term resonated more with men from a different socio-economic background or possibly a different age group.)

The group suggested that 'depressed' was a preferable term to 'sad', the latter word was rejected. Again this was in contrast with the adult focus groups where the word 'depressed' was rejected in favour of 'feeling down' or 'low'.

'Emotional' topped their pyramid. This surprised me and I asked them if they would make a statement such as 'I am feeling emotional', which they confirmed they would. This was a stark contrast to the Walking Football group where the consensus was that 'emotional' was too 'girly' and sat in contrast to my assumptions about the language young people might use to discuss mental health.

All of the above and the inclusion of the words 'anxious' and 'isolated' in the Amberley pyramid suggest that perhaps more clinical terms for mental health have become accepted by young people. Of course, these findings would need to be tested across a much wider group of young people in order to develop any recommendations.

PRACTITIONER INTERVIEWS

In addition to the focus groups, the Men's Health Forum interviewed two practitioners, the first from a charity working with boys and young men and the second from Samaritans.

Interview 1: Leslie Mitchell, Mental Health Lead for Working with Men.

The purpose of the interview was to gain insights into Leslie's understanding of the words and terminology that he used to engage boys and young men that he worked with, as well as insights into language patterns he noticed among young people.

The project that Leslie runs is called the 'Life Development Programme'. The aim is to support young men aged 13 - 25 with their social and emotional development through the use of short- and medium-term solution-focussed therapy. The target audience is young people at risk of, or showing signs of, poor mental health. Some of the young people he engages have mental health diagnoses.

The programme was called 'The Life Development Programme' as the term 'mental health' was steeped in stigma, presenting barriers to accessing support. Leslie spoke about specific cultural barriers faced in engaging with mental health services giving the example of a Muslim client whose parent was seeking support from an Imam in a Mosque because they felt more comfortable in that setting. It was his sense that young people who were white were more accepting of more targeted interventions such as CAMHS. He felt ethnicity was seen as a potential barrier for some young people with Black British young people facing specific barriers to accessing services. (This sentiment broadly correlates to what is known about service uptake among ethnic minorities.¹⁸)

Leslie said that he used the term 'emotional regulation' when working with young people to open discussions around mental health. He said this was a term that was

acceptable to young people who he noted would use the term 'I'm feeling emotional' to identify a changed emotional state. This statement correlates with the findings from the focus group at the Amberley Youth Club. It was also a term that Leslie found worked equally well in engaging families. In a previous role with Working with Men Leslie delivered the 'Boys Development Programme', which included a topic entitled 'Emotions'. Leslie noted that in this setting (group work, delivered in schools) emotions was an acceptable term.

'Angry' was a term frequently used and Leslie stated that this would often indicate internal and external challenges. Leslie said this is a term that is easy to access because of its association with machismo saying 'It is much easier for a young man to say they are angry than express other emotions. Anger fits well with our cultural perceptions of youth and particularly young men'. All of the aforementioned correlated closely to the findings from the session at the Amberley Youth Club.

Interestingly, Leslie felt that 'depressed', a term that is widely used, was acceptable. This stands in contrast to men who broadly stated that this is a term for which an alternative was needed, such as 'feeling low'.

Interview 2: Neil, Samaritans Listening Volunteer

Neil has volunteered for Samaritans for 15 years. He began while employed and is now retired. Neil said there were qualities developed in his professional career such as patience, understanding and empathy that translated well to the Samaritans. He provides support by phone, email, text and face-to-face. He does not have experience in any other 'mental health' setting.

Neil said that the majority of telephone calls received were from women and from people who did not mention mental health as such at all. Neil felt that some callers may say they have mental health problems but do not while others who did not express any mental health problems may have been experiencing them.

BEAT STRESS



Neil's experience was that people contact Samaritans when they are potentially experiencing a moment of acute distress. He said that the aim is to keep a caller engaged for as long as it is felt necessary to support them away from that acute moment.

The context of the support given by a Samaritans volunteer has to be kept in mind. When a person calls Samaritans the volunteer does not know the caller, has no sense of what they might present with, may not hear clearly (mobile phone connections are not as clear as they might be) and there may be language barriers. Some of these challenges might also exist in face-to-face settings but there is the advantage that sharing physical space allows for other forms of communication to take place.

Neil spoke about the need to be aware of tone, pace and volume in terms of addressing a caller. He said that one aim was to support callers to understand why they called. To this end, a volunteer could not 'sound authoritative, must be kind and inviting, and must allow the caller to feel in control of the conversation'. While these principles might not relate directly to language, they do reflect what some men were saying during the focus groups about the importance of delivery. In the focus groups, some people were reporting that even in instances where the actual words being used might be considered challenging - for example when a person said to a friend experiencing distress that he looked stressed out - if the right approach is taken, a positive challenge can yield results.

Neil felt that in his experience men were more likely to struggle to find the vocabulary to describe their feelings. At times this led to a repetition of the situation rather than expansion on or deepening of the feeling. Neil felt that male prisoners were the least likely to be able to say how they felt. An example of the language used was 'I feel gutted'. 'As a volunteer, I offer further vocabulary through summarising their presentation, however they rarely use it [the additional vocabulary]'. There is a need to exercise caution and not to over generalise from one interview but the insight is still highly valuable.

AD ANALYSIS

The Men's Health Forum has used two Google AdWords accounts, one paid for by the Google Ad Grants programme and one funded directly.

Both Google AdWords accounts were used to advertise the Men's Health Forum's Beat Stress service that connects people looking for support around mental health with professionals through webchat and emails. However, they were used in different ways. The Google Ad Grants funded account was used 24 hours a day, 7 days a week to direct people searching for support to the email service arm of Beat Stress. The paid-for Google AdWords account (funded by a grant from the Bupa UK Foundation) was used on Wednesdays between 7pm and 10pm to direct people to the webchat instant messaging service.

Analysing the accounts gives a clear picture of what terms people search for online and what they engage with. An advantage to using this data, as opposed to a survey, is that the data represents people's actual behaviour instead of their own interpretation of their behaviour.

The Google Ad Grant account, in particular, has given the Men's Health Forum an opportunity to structure 'tests' to monitor the impact of language change in advertisements. Such tests include how the service staff are referred to. Among the staff team are people from a range of professional backgrounds including psychologists, counsellors and mental health nurses. Focus groups indicated a preference for not referring to staff in clinical terms such as these so ads were created to test this preference to see if there was a difference between what people say publicly but search for privately.

While the accounts give an insight into language patterns, it should be noted there are some biases in the delivery of the ads to account for.

The first bias is the people are searching for support online. These individuals have access to the internet, have an awareness of mental health, of the challenges faced either personally (or by someone close to them) and they have acknowledged there is a need for support. They have then searched online, found the advertisements for Beat Stress and have decided to engage with this service over others. In other words, these searchers are not opening a discussion about mental health, they are some distance down the road. Such a group is far from representative.

The second bias is in the way ads are supplied to those searching the internet. When a search is entered into a search engine, it triggers a bidding process that makes an analysis of both the maximum bid and the quality of the advertisements created by various organisations bidding for customers. The search engines' algorithms will then determine which advertisements are displayed before the searcher and therefore which language is seen by the searcher. Having said that, during January and February 2017 the advertisements promoting Beat Stress were seen by 218,166 individuals - a sound sample size.

Despite these biases, analysis of Google Adwords, in particular the structured ad tests, gives an insight into what searchers for support actually engage with and what they click.

The data below is divided in the following ways:

- > Search queries - the terms people use to search online
- > Keywords - terms in the advertisements that people engaged with
- > Descriptors - terms used to describe the service staff and the differences in engagement rates
- > Directed language - what happens when you tell men the service is for men?

Each of the above data sets were then analysed against the following criteria:

- > Clicks - the number of times an advertisement was clicked on by a person searching online
- > Click Through Rate - a measure of the efficiency of an advertisement and keywords determined by the number of people who see an advertisement versus the number who click on it
- > Conversions - a measure of the the effectiveness of an advertisement to produce a defined behaviour

See Appendix for the data sets referred to below.

From the focus groups some general hypotheses regarding the correct language to use for engaging men emerged:

- > Refrain from using clinical terms
- > Refer to the service staff in general terms such as Stress Team, but do not use professional staff titles such as Mental Health Experts
- > Use socially acceptable language for opening discussions with men about their mental health

These hypotheses were adopted (the evident nuances in the language preferences of particular focus groups notwithstanding).

In analysing the Google AdWords content for search queries, it was found that those searching on more clinical terms such as 'suicidal thoughts', 'anxiety and depression help' and 'controlling stress and anger' were more likely to go through to the endpoint of the service (ie a webchat with a staff member.)

Similarly, the keywords in the advertisements that produced the greatest number of webchats conversions were more clinical terms. 'Mental health depression', 'suicide help' and 'anxiety stress' accounted for the three most fruitful (in terms of conversions to webchats) keywords used.

The use of clinical terms suggests more certainty over what is being searched for so it is perhaps no surprise

that such searches are more likely to convert all the way. It doesn't mean that these terms will resonate with those who don't know exactly what they're searching for or even what challenge their search is to address.

A test was conducted to see the impact on engagement and conversions of explicitly stating the service was for men. Ten advertisements were structured (see appendix). The core content was kept the same but, in five of the advertisements, it was explicitly stated, in the headline, that the service was for men. (All ten ads included the URL: menshealthforum.org.uk.) In only one instance was there not a perceptible advantage in stating the service was for men. The exception was where the staff descriptor indicated a 'Beat Stress Team' or a generic term as opposed to a clinical term. In all other instances, identifying the service as being for men, produced increased rates of engagement and conversions.

The final test was to see if there was an impact on engagement and conversion resulting from the terminology used to describe the staff member. The team of five staff members included counsellors, psychologists, therapists and mental health professionals. In every instance where a professional term was used (counsellor, therapist, psychologist and mental health expert) both engagement and conversions were higher and more effective.

While further research would need to be conducted to better understand the above contrasts, it could be suggested that there is a significant difference between the private and the public person. In private and online people are searching for specific forms of support and the validation that they will receive support from a professional, while in public people are stating they want to reduce a sense of stigma associated to certain terminology. Equally it is possible that these are two stages of the same process and that removal of stigma using colloquial terms makes possible subsequent informed help-seeking using more clinical ones.



RECOMMENDATIONS

This report is an initial investigation into the language men use to open discussion about their mental health. Further research is required in this space, particularly in regards to language related to positive mental health.

With that in mind, following are recommendations for supporting the engagement of men to discuss their mental health.

There is no 'one size fits all' word or phrase for engaging men to talk about mental health - 'stress' probably comes nearest.

Consider the precise group you want to reach. We have talked to men from different backgrounds to gain insight into the language they use for talking about mental health and into the nuances that emerge between groups. As an example, 'emotional' was a term roundly rejected by older men but endorsed by boys and young men in London. These nuances indicate the importance of talking to the particular group you are trying to engage with.

Broadly speaking 'stress', 'stressed out', 'overwhelmed' and 'overloaded' were endorsed by older men while 'emotional', 'depressed' and 'anxious' were endorsed by boys and young men

If your objective is engagement, **use the terms men use rather than those in vogue at any given time in professional or academic circles**, you can refine understanding later.

There was a difference between the language employed effectively by engaged users on the internet in private and that suggested for attracting the non-engaged in public focus groups. This may reflect the difference between the engaged and the non-engaged around mental health or it may reflect the difference between

what people say in public and do in private. It may be a bit of both. Further research is needed. These differences may translate into support delivery also, but this was outside the scope of this report.

After identifying words and phrases through discussion with your target group, **design tests to understand the impact of the language used in practice.** Be clear on what it is that you want to measure, why and how. These insights will allow for an iterative approach to the design of marketing materials and ultimately produce increased uptake of services.

When promoting services for men, tell them it is for them. There would appear to be a positive impact in telling a group who are unsure whether traditional services are for them that your service definitely is.

Be aware of where promotional materials are going to be seen. The location may impact the level of perceived stigma in engaging with the materials and this may impact the language used in them - the words that someone may click on in private online may be very different from those on the cover of a leaflet they're prepared to pick up in public.

APPENDIX

The Appendix relating to the ad analysis on page 25 is available online along with a PDF of this report at: www.menshealthforum.org.uk/language_report

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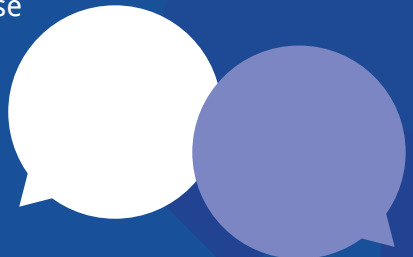
Thanks to Florian Simeth (Burnout & Stress) and David Goehring (Heart Line) for posting in the Creative Commons (CC2BY licence). Other photos by the Men's Health Forum.

MIND YOUR LANGUAGE

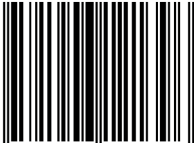
HOW MEN TALK ABOUT MENTAL HEALTH

Male mental health is in crisis. Men make up just a third of referrals to NHS talking therapy services yet account for three-quarters of suicides. Something doesn't add up.

How can services be made more relevant to men? Is part of the problem the language they use? How do men really talk about mental health? This reports draws on existing data and new research to begin to answer these key questions and take the first step towards identifying good practice.



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