

Masculinity and Mental Health Treatment Initiation for Former Political Prisoners in Yangon, Myanmar – A Qualitative Investigation

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Abstract

Background Men are less likely to seek care for mental health problems globally. This finding is more pronounced in low- and middle-income countries, where poor healthcare infrastructure, differences in illness conceptualization, and stigma impact treatment seeking. To improve the likelihood of successful engagement of men in psychotherapy, it is necessary to identify factors that influence treatment adherence, and to better understand men's attitudes surrounding decisions to seek and initiate care. The purpose of this investigation was to explore themes of masculinity, treatment seeking, and differences between men who accepted and declined therapy in an urban low-income context.

Methods We conducted a qualitative, interview-based investigation with 30 former political prisoners in Yangon, Myanmar who were eligible to receive mental health counseling provided by the Assistance Association for Political Prisoners. Men were initially screened using a composite questionnaire with items related to depression, anxiety, and posttraumatic stress symptom severity. After screening, if potential clients were identified as having probable mental health problems, they were asked if they would like to participate in a multi-session cognitive behavioral therapy program. Semi-structured, open-ended interviews were conducted with 15 participants who accepted and 15 participants who declined therapy. Interviews were transcribed and translated by local partners and thematically coded by the authors. We used thematic analysis to identify and explore differences in treatment-seeking attitudes between men who accepted and men who declined the intervention.

Results Men described that being a community leader, self-reliance, morality, and honesty were defining characteristics of masculinity. A focus on self-correction often led to men declining psychotherapy. A general lack of familiarity with psychological therapy, and how it differed from locally available treatments (e.g. astrologists) was connected to stigma regarding mental health treatment.

Conclusions Masculinity was described in similar terms by both groups of participants. The interpretation of masculine qualities within the context of help-seeking (e.g. self-reliance as refusing help from others versus listening to others and applying that guidance) were driving factors behind men's decision to enter psychotherapy.

Background

An estimated 75% of people in need of mental health services in low- and middle-income countries (LMICs) do not receive treatment (1). While the burden of mental health problems is borne largely by LMICs (1, 2), treatment infrastructure for such problems is largely underdeveloped in these contexts (3, 4). To address this treatment gap, research has focused on culturally adapting evidence-based interventions and training lay workforces to provide mental health services in non-specialist settings (e.g., primary care) (5, 6).

Despite similar prevalence of general mental health problems for men and women in both low- and high-income countries (7), men are less likely to use formal treatment for mood and anxiety disorders (8).

Studies conducted in high-income settings have indicated that men are less likely to hold favorable attitudes towards care (9), and are more likely still to drop out of interventions for post-traumatic stress (PTS) (10) and depression (11, 12).

A previous systematic review and meta-analysis of mental health-related stigma and help-seeking found that the interplay of societal norms, attitudes towards care, and individual differences was a driving force behind help seeking behaviors for men (13). While these attitudinal barriers to men's engagement with mental health services have been identified in high-income contexts, the extent to which these factors are important in LMICs has received little attention. In such contexts, psychological distress among men has been associated with an increased likelihood of living in poverty, abusing alcohol, and perpetrating gender-based violence (14, 15). The little research that has focused on men affected by armed conflict has largely focused on former combatants (16), and not among other men in the community in need of services. In a recent systematic review of 29 trials of mental health treatments in LMICs, four focused specifically on men – largely ex-combatants – and five included 50% or more men in the sample (17). Extant literature from high- and low-income contexts, (18–22), including multiple trials (23–26), have reported engaging and retaining men in psychotherapy. Some reported significant treatment effects only for women (25, 27). Cultural adaptations of evidence-based treatments (28, 29) and diagnostic practices (30) have shown to successfully improve mental health in various socio-cultural settings (6, 31), however, male gender identity does not appear to have been considered in such adaptations(6).

We sought to gather information the perspectives of a group of former political prisoners regarding the decision to accept or decline mental health treatment. We were interested in understanding this decision within former political prisoners' views on masculinity, and to explore treatment seeking and attitudinal differences between men who accepted and declined psychotherapy in an urban setting within a low-income country – Yangon, Myanmar. Formative investigations that identify mutable individual characteristics of the population of interest, as well as features of the treatments themselves, are critical to the development of treatment protocols that are better suited for engaging and retaining men.

Methods

Setting

Burma or Myanmar is a union of seven ethnic states that correspond to historical minority-held territories, and seven divisions that are populated mostly by the largest ethnic group, the Bamar. It has a population of 51 million people, with roughly 70% living and working in rural areas, and 30% living below the national poverty line (32). Theravada Buddhism, the state religion since 1961, has been prominent across Burmese cultures for centuries, and influences facets of society from education to folklore (33). Two central components of Theravada Buddhist doctrine include the Five Precepts and the Eightfold Path. The Five Precepts, are five moral doctrines involving abstinence from: harming living things, sexual promiscuity, stealing, lying, and substance abuse. The Eightfold Path, one of the Four Noble Truths, encompasses the core doctrine of Buddhist practice for escaping suffering and the cycle of rebirth. It

consists of eight guidelines (e.g. Right Thought or Right Speech) that serve as a means by which followers can cultivate moral and intellectual virtue through mindful living, and ultimately, escape from the cycle (34).

The History and Context of Political Imprisonment

Following Burmese independence in 1947, the country has been subject to persistent open conflict between the central Burmese government and ethnic armies in Shan, Karen, Kachin, and other states continues to date (35). Beginning in the early 1950's, novel economic programs led to a steady increase in economic progress, and near the end of the decade Burma was the fastest growing economy in the world (33). However, in 1962 a military coup led to new policies of isolationism and ethnonationalism, triggering catastrophic economic collapse. Within a generation what was once forecasted to be one of the first industrialized nations in the region became the world's poorest country (33).

By the mid 1980's, popular dissatisfaction with the government had reached its apex. In a 1987 radio address, Prime Minister Ne Win mandated the abandonment of several denominations of currency to more astrologically significant values at the advice of a fortune teller (35). Within two weeks, nearly 80% of Burmese legal tender would be valueless. The timing of the devaluation was such that Burmese university students would be rendered penniless days before their yearly tuition fees were due, inciting riots at the Rangoon Institute of Technology. This event led to a year of student revolts and university shutdowns, culminating in the 1988 August 8th Revolution. Students from the University of Rangoon staged political protests that shut down Yangon, with movements spreading to other major cities. By September 1988, protests were quelled by armed riot police, many of whom opened fire on the crowds. Casualty estimates are impossible to accurately measure, but some non-governmental organizations (NGOs) posit that more than one thousand people were killed in Yangon alone in only a few days (35). Students who participated in the dissemination or production of pro-democracy materials – or who were rumored to – were charged with sedition and incarcerated.

The effects of the crackdown spiraled outward to the rest of Burma, as students joined ethnic militias in minority-held states. Others, fearing continued violence and political persecution, fled to neighboring Thailand and other countries. Many who stayed in-country were jailed as political prisoners. Decades later, after redrafting the national constitution in 2008 and transitioning to partial civilian rule, the Burmese government still does not acknowledge that it has or has ever had political prisoners. Following additional protests in the 90's and 2000's, a second generation of political prisoners was created as the Burmese central government continued to arrest university students for participating in pro-democratic rallies. Since the National League for Democracy won major elections in 2012, 35 political prisoners have been convicted, 56 are in jail awaiting trial, and 235 are awaiting trial on bail (36).

Mental health infrastructure

Exposure to traumatic events, adversity, associated joblessness, poor economic conditions, and a permanent criminal record for political dissent present highly distressing challenges for former political prisoners in Yangon. Formal mental health treatment is handled primarily by Yangon Hospital, and

typically relies on poorly monitored psychotropic medication or outdated and harmful inpatient practices (e.g. isolation or confinement) (37). Mental health and psychosocial support (MHPSS) programs, and counseling in general, are often considered novel and do not have widespread support or recognition. Community-level measures are typically limited to familial/social support, and local astrologists who rely on the traditional Burmese Zodiac to provide solutions to common problems and advice for stress management. In recent years, community-based organizations (CBOs) have collaborated with non-governmental organizations (NGOs) and universities to disseminate, implement, and evaluate mental health programs for traumatized populations in both urban Yangon and more rural areas (37).

Procedures and ethics

The interviews for this study, conducted between July and September, 2018, took place within Yangon proper and in nearby Thanlyin township at Thabarwa Meditation Center and Hospital - a yeikthar, or monastery and education center, providing basic medical and housing services for homeless clients. Ethical approval was provided by the Johns Hopkins University Institutional Review Board prior to data collection. A local community advisory board comprised of mental health professionals from a clinic serving Burmese refugees in Mae Sot, Thailand also approved of the interview and recruitment materials in June 2018.

Interviews were conducted by three interviewers (one female, two male) employed by the Assistance Association for Political Prisoners (AAPP), a local NGO. Interviewers were trained as trainers in the Common Elements Treatment Approach (CETA) (38), as part of a continuing partnership with Johns Hopkins University (39). All three interviewers in this study were TOT's at the Yangon AAPP headquarters who received weekly supervision in CETA from staff at Johns Hopkins University as well as didactic training in evaluation and diagnosis. All three interviewers are former political prisoners themselves. Transcription of the recorded interviews was provided by three AAPP CETA counselors fluent in Burmese. The interviewers and transcribers attended a two-day, qualitative research methods training at the AAPP office. The training covered basic principles of in-depth interviews (e.g. probing questions), as well as an introduction to the study aims and interviewing materials.

Interview Procedures

The interviews themselves followed a semi-structured rubric with open-ended questioning. The original IRB-approved interview materials are provided as supplementary materials in Appendix A. Interviews lasted between 30 and 60 minutes. To discuss participant recruitment strategies, assess interview fidelity, and discuss interview themes, the primary author facilitated weekly group supervision meetings with all three AAPP counselor/interviewers. In these sessions, the interviewers described one or two of the interviews they had conducted in the past week, the content of those interviews, what questions from the interview were well-received and which did not yield rich responses from their clients. These conversations shaped subsequent interviews, as questions were added or removed from the semi-structured prompts depending on interviewer feedback. After transcription by AAPP staff, the subsequent

anonymized transcriptions were translated into English by two non-AAPP graduate-level professionals in Yangon.

Participants

Interviews were conducted with 30 adult men (age \geq 18 years) as part of standard client recruitment for AAPP's mental health assistance program (MHAP). Participant ages ranged from 24 years to 72 years. All men interviewed were former political prisoners who spent between six and 25 years incarcerated for sedition against the Burmese government. A majority of participants were incarcerated in the late 1980's as part of the 8888 uprising, while several younger men had been apprehended for speaking out against the military regime in the early 2000's.

While the political prisoner community network in Yangon is extremely protective, AAPP is well-regarded and maintains a relatively high profile in Yangon. They frequently advertise and promote their MHAP program through social media and public events. Many respondents subsequently self-referred based on AAPP's reputation and word of mouth. Others were friends, neighbors or former inmates imprisoned with the interview staff. No formal sampling framework was used, as the interviews immediately followed screening for MHAP inclusion criteria.

While most clients were recruited from residential neighborhoods in Yangon proper, several ($n = 8$) were recruited from the Natural Meditation Center (Thabarwa Yeikthar). The yeikthar serves as an urgent care center, hospice, and homeless shelter for men and women unable to afford housing or medical care. Respondents from this center were often suffering from highly stigmatized chronic disease (e.g. HIV) or debilitating conditions (e.g. stroke-induced partial paralysis) resulting in familial abandonment or isolation.

Informed consent to participate in these interviews was obtained immediately following client screening. All potential MHAP clients were screened using the same questionnaire, initially developed for a randomized controlled trial of CETA with Burmese refugees in Mae Sot, Thailand (39). This locally-validated screener contained 15 items related to depression and 30 related to PTS symptoms derived from the Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (40) criteria for each respective mental health problem. Items were developed and incorporated after extensive community-based participatory research to ensure more valid measurement of psychological distress within this context (41).

Respondents reported symptom frequencies for the past month, from 0 ("none of the time") to 3 ("almost always"). The inclusion criteria for each disorder are listed in Table 1. Participants met criteria for depression if either Criterion A or B was met, and 3 or more of the symptoms from Criterion C were endorsed with a "2" or "3" rating on the Likert scale. A participant meets criteria for PTS if they meet any two of the criteria. Immediately following this assessment, participants were asked if they would like to participate in the MHAP program. To explore potential attitudinal differences between men who accepted

and declined therapy, interviews were conducted with both participants who accepted treatment (n = 15) and participants who declined (n = 15).

Analysis

Data collection and analyses procedures were rooted in two qualitative methodologies – constructivist grounded theory (42) and more general thematic analysis (43). Grounded theory-based approaches are well-suited to developing theoretical frameworks that explore a specific phenomenon (i.e. accepting or declining treatment), and to provide a broader sense of factors that motivate or shape that phenomenon (e.g. masculinity, barriers to care, perceptions of treatment, etc.). Theoretical sampling and in vivo coding could not be adhered to strictly given time, translation, and resource constraints. However, clients and counselors were consulted regularly for insight into improvements in recruitment and data interpretation procedures. Initial coding of some interviews and identifying thematic content was conducted while the first author was in-country when possible, with feedback from the interview staff regarding emergent themes. These themes in turn modified the interview process and data collection.

Given the difficulty of translating multiple interviews with precision in a short amount of time, the primary coding for a majority of the interviews was conducted after the first author returned from Burma. For thematic analysis, the transcripts were coded, organized, and analyzed using Nvivo version 12 (44). The overarching thematic codes, derived with help from the interview staff (authors KSW, HA, KNCS), served as an initial guide for data interpretation. After first reading an interview, the first author coded each transcript line-by-line to explore subthemes and examples, and to further develop the initial broad codes, e.g. conceptualizations of masculinity within the sample. These codes were confirmed or reconciled with help from interviewer KSW and HA. After coding interviews, themes regarding the differences between men who accepted and declined therapy were developed primarily by DL through active collaboration with KSW, WT, & JB.

Results

Men who accepted and declined therapy described thematically similar norms and expectations with regard to masculinity. As such, the results begin with description of masculinity as defined by the full sample of interviewees, followed by a comparison of themes between groups (i.e. men who accepted and men who declined).

Masculinity

Honesty and Morality were the most commonly cited core characteristics of masculinity among interviewees (n = 21; 70%). Descriptions of morality and honesty were commonly based on the Buddhist Five Precepts. “An Honest Man” was the title most men strived for among their peers. While honesty was related to speaking truthfully it was also related to living in a forthright and plain manner, e.g. as described by a X-year old participant as someone who is “righteous, [who does things] without discrimination...He must be able to decide fairly, and speak up if [something] is good or bad. He shouldn't

nod for a bad thing if it is good; he needs to justify. He must speak the right thing without cheating. Even his inner mind must be righteous.”

Righteousness and having a “a good moral spirit” were predicated on following the Five Precepts, often verbatim. There were particularly strong feelings against the use and abuse of alcohol and drugs, despite the simultaneous frequent mention of drinking with friends and getting drunk as a coping mechanism for psychological distress. One participant mentions nearly four of the precepts – abstinence from alcohol, stealing, lying and harming living creatures - in a single response, stating that “to be a gentleman, one must have good morality. For example, he must not lie or steal. He must be humane, and have a spirit of volunteering...In addition, he must not drink...” Only one participant mentioned “not mixing with women,” because they “should do their own business.”

While the Five Precepts are not inherently gendered, men commented on the belief that “[Burmese people] have the concept that men are better and more noble than women,” even though the moral “checklists are not supposed to be ‘this is for men’ or ‘this one for women.’” However, based on these responses, it seems that Burmese men believe there is a greater expectation to be models of morality and that they are the ones to uphold these Precepts.

Breadwinning emerged as a core feature of Burmese masculinity (n = 10; 33%). One interviewee succinctly explained, “A man is someone who needs to support income for his family...When their wife is making money, I don’t consider that kind of person as a man.” Spending time away from one’s family while incarcerated added an extra dimension of urgency for some participants. As one participant explained:

As I was away from my family for a very long time [while in prison], I have the feeling that I have the responsibility to take care of my family as much as possible. When I got back [home], I saw that my family’s living was not in good condition, so I had to try so hard to fill that blank.

While being the primary economic support in a household is a common feature of traditional masculinity (45), there appears to be added pressure to provide economically among these respondents given their status as former political prisoners.

For half the participants (n = 15), being the primary earner in a household was intrinsically linked to the idea of leadership within a community for men – the twofold ability to provide thoughtful, measured solutions to difficult problems, as well as to be recognized person of status/importance. Leadership was defined as “doing things bravely in front of other people,” and taking “responsibility and accountability.” Leaders are responsible for addressing prominent issues and advancing an agenda, and not moving “crabwise,” as one participant described it. “There are some in the neighborhood who are neither leading from the front nor following behind, but moving crabwise,” he said. “He should lead from the front if there is something urgent and take to it right away.” As one participant stated, “just like the Myanmar saying, ‘a big tree is home for a thousand birds.’” This sentiment – that men should serve as reliable pillars within a

community and family – is furthered by the belief that leadership is a necessary facet of masculinity among many of the men interviewed.

Indeed, one's ability to actualize and perform duties related to community needs was directly related to the quality of his character, such that indolent or non-active men were seen as morally deficient. As one 66-year old participant explained:

If the person uses [his past] knowledge and experiences for the welfare of his family and his community, he will be a useful person. If the person does not or is not able to use them, that person will be useless and maybe he will have a negative effect on the community.

This judgement regarding one's value as measured by his utility is a key feature of the theme of self-reliance – men are expected to individually resolve their problems and disputes without outside help. Sixty percent (n = 18) of men interviewed described this as a priority. Issues of mental health are no exception, as one participant noted: "When the problem is dealing with mental health, it needs to be fixed by yourself first. After you have fixed it yourself, you can create good works in your environment." Another respondent summarized the process of internal change as a process of mental fortitude and will. "I have just such a kind of tough mind. I think it's all related to mentality. Willingness: when you are not able to walk on your own, you need willingness to be able to walk."

With regard to self-reliance, several respondents noted that men have strong minds, and that there is a tension between the stubbornness borne out of this strength and a pressure for men to appear in control and not to "explode," or outwardly demonstrate an inappropriate level of anger or sadness "I don't think they will accept [mental health services]. Some [men] are really stubborn. I try to persuade them to concentrate on other things instead of exploding their anger, but they don't listen," one man who refused counseling said. According to another respondent, "men suffer more than women [because] they are strong-minded in nature. So they more easily lose their temper, and explode more violently. They might feel sad, and more depressed than women." Intense emotions should be suppressed by men's "strong-minded nature" and stubbornness, and men subsequently "go nuts" or "explode."

Guilt or shame stemming from accepting others' help of self-reliant was enough for some men to keep from seeking help. "I'm not the type to depend on others," one respondent who accepted therapy said, "I want to stand on my own two feet. I feel guilty relying on the support of others." There was a common refrain among men interviewed that everyone "has their own problems." The same respondent went on to clarify that each man "has the feeling that 'we must' whether we want to or not. We also know that we have fewer choices and we must work."

Accepting and Declining Therapy

Men who Declined

Across all 30 interviews, men were asked to describe their reasons for accepting or declining therapy. Men often declined because they felt they were dealing with their problems reasonably well on their own and

did not believe psychotherapy would be helpful. Men's descriptions of plans to manage stressors were often tautological, vague, and terse – "I address...everyday tasks by solving [them]. If I need to write, I write. If I need to discuss, I discuss. If I need to attend a meeting, I attend. That's all." Another participant simply said, "When the problem is dealing with mental health, it needs to be fixed by yourself first...If you do good things, you will be good. If you do bad things, you will be bad. That's it." The belief that men are expected to solve their problems on their own was summarized by one respondent who declined therapy, who said:

Men mostly don't take psychological treatments – they believe too far in the tradition that men are heads of the family, and whatever they do is right. That's why they don't easily accept if they have mental or physical problems and moreover, they don't evaluate themselves, and they are hard to change.

These quotations suggests that mental health concerns are equated with poor morals, in that men who unable to handle mental problems have probably done something immoral that led to such a negative outcome.

Others believed that Burmese people were concerned with not "giv[ing] their problems to others", as this may increase suffering in their community. "I have my own problems, and everyone has their own problems," said one respondent, a taxi driver. "Physically, we might struggle to control our anger and fight with others. Mentally, what we have suffered only concerns our own minds." This sentiment, that what happens in the mind is the burden of the individual underscores the conflict between self-reliance and treatment seeking –to what extent could the involvement of an unfamiliar third party be beneficial? "That's why I refuse counseling," one respondent said, "I don't really want to change myself with the help of others. That's my belief. I'll change myself. When you get counseling, you have to follow their advice." Counseling was seen by several men who declined therapy as an imperious practice that undermines a potential client's autonomy.

Not having time for therapy, or needing to work was also a frequent reason for declining participation. There was a sense that an hour spent in treatment was an hour better spent working - "I can make 15,000–20,000 kyat during this time...A man has to give priority to making money, so I must refuse counseling." Another respondent mentioned that he was personally interested in receiving counseling, but "I can't give time for [it], although you are willing to provide it." Some were also wary of taking time off work for something that amounted to "30 minutes or an hour to meet up with each other, open up all our sufferings, make small talk, and relieve our feelings. After that we go on our way and work." Finding even an hour to commit to therapy was decidedly difficult, as unpredictable economic and employment situations render scheduling impossible – "You know my situation, right? Everything is unstable for me."

Many men mentioned a lack of familiarity with counseling as another reason for refusing. Men "don't know what a counselor is, or what counseling services are. They think that counselors are just like anybody else because they don't wear uniforms like lawyers or soldiers. Counselors are nothing – most of our citizens think like that." The role of a mental health counselor, or of counseling in general is unclear, even after an introduction to the CETA program.

The role of a counselor was viewed as overlapping with local astrologists – experts in the Burmese Zodiac who are often consulted to manage stress from family and work problems. “We have our own superstitions, whether they’re real or not,” one man said. “[People] go to a fortune teller (nat sayar) or astrologist. We get help from those kinds of things.” Another participant added that astrologists are “quite good at making someone relieve their stress, and help concentrate on other things.” He added that there is still a need for “scientific and realistic mental treatment in Myanmar.” Astrologists are chiefly consulted by women and girls, according to the respondents. It is conceivable that lack of familiarity with counseling, little understanding of the differences between counseling and astrology, and the assumption that similar community services are primarily for women contributed to men’s abstention from the intervention offered.

Men who Accepted

Men who accepted the intervention cited a self-correction priority in addressing mental health problems, but with the additional belief that input from a third-party would allow for personal development and a greater likelihood of improved well-being. “I have noticed myself and I don’t know what is happening to me,” one participant mentioned. “I’m over 70 years old and I need some support.” Interest in improving well-being and more general internal curiosity were the most commonly mentioned reasons for entering treatment among men interviewed. Men’s motivation to engage in psychological therapy was commonly couched in the desire to be self-reliant. Men who accepted therapy believed that it was an opportunity to receive guidance that would enable them to be more self-reliant and useful. One participant stated he “can tell what is on my mind and...the things happening in my surroundings...Counseling is a higher psychology that I can’t reach. It digs down to a deeper question, and if I can get there, I can get much more knowledge. I will be motivated, and be able to raise my life from this experience.” While the desire to appear self-sufficient was cited as a reason not to go into therapy among men who declined, it was also the driving reason behind accepting therapy.

Several participants spoke about their hopes for treatment in terms of symptom reduction (e.g. “I hope to get some advice on how I should think and behave to relieve my feelings”), improving “motivation” (e.g. ... I can be psychologically motivated by counseling...), and most commonly a belief that improving one’s mental health would help the individual better serve his community. Men who accepted therapy believed that through being vulnerable, one would “start to think of doing merit for the community.” Like self-reliance, serving others was both a reason to accept and decline the intervention. While both men who accepted and men who declined therapy stated that everyone in their community was facing the same kinds of problems (e.g. economic, work-related, family stress, etc.), men who accepted the intervention qualified that statement by adding that men “need to be dutiful” to their community, and that through therapy men can “benefit [their] community.” The desire for deeper understanding of thoughts and feelings, and curiosity about these internal processes, seem to fundamentally change how existing conceptualizations of masculinity shaped one’s decision to enter treatment.

Men from the yeikthar all suffered from complications from other stigmatizing conditions such as HIV, partial paralysis, or missing limbs. One HIV-positive, yeikthar-based interviewee stated that he accepted

services from AAPP because they were the first providers to not approach him “wearing a mask.” He went on to clarify, “When we go and get our medicine at the clinic, people come wearing mask because they don’t want to be infected.” Given the general lack of familiarity with stigmatized conditions, it may be the case that experiencing receiving care for one stigmatized condition lead participants to be more likely to accept care for another one that is similarly underrecognized by most people in Burma.

Discussion

The purpose of this qualitative study was to explore conceptualizations of masculinity as it relates to motivations for accepting or declining treatment within a sample of men in a low-income, urban context. We conducted interviews with 30 former political prisoners based in the Yangon region of Myanmar in collaboration with a Burmese NGO conducting mental health interventions in the area.

All men interviewed were fairly consistent in their depiction of a masculine ideal embodied by honest and morality, breadwinning, leadership, and self-reliance. Men who accepted and declined both described the importance of self-reliance and community service, yet men who accepted treatment saw the opportunity to work with a third party as a way to become more self-reliant rather than as a hindrance to that process. Men who declined believed that counseling was akin to being forced to follow someone’s advice, whereas men who accepted believed they would ultimately be gaining new coping skills through professional guidance that would assist them in becoming more self-reliant and serve their communities better. Men who accepted may have had more experience with stigmatized conditions, as they frequently suffered from them, and as such may have been more interested in treatment.

Masculine identity and the extent to which men endorse specific masculine traits can vary contextually, particularly in treatment seeking contexts (46). In this study, masculinity as described in both groups seemed capable of helping or hindering the likelihood of entering treatment. That point of inflection has been explored within the context of masculinity in theoretical frameworks that rely largely on data from the developed world (e.g. a prototype/willingness model; (47).

Respondents’ answers provided a prototype for the ‘ideal man’ and could be used to inform how mental health services are subsequently described and defined to people in need. Given the general lack of familiarity with mental health problems and MHPSS programming, service providers may be in a position to develop a more robust approach to introducing and recruiting for MHPSS programming that more accurately reflects what men expect at the point of initial contact or during outreach. Describing mental health interventions in less prescriptive terms - e.g. avoiding terms that categorize a potential male participant as ill, broken, etc. – and focusing more on how collaborating with a service provider might improve community standing or self-reliance may in turn improve treatment engagement among men.

The current study raises additional questions related to the potential benefits of incorporating men’s conceptualizations of masculinity into MHPSS programming, and how that might inform working descriptions of a given intervention. Among the sample interviewed, an example might be framing CETA as an opportunity to help participants become better providers for their family through problem solving,

help them be seen as more reliable fixtures of their community, and use cognitive skills to solve their own problems in a meaningful way. Future research might include community-based participatory research with men in LMICs that explores both conceptualization of masculinity and acceptability of mental health treatments. Program materials for existing or novel interventions (e.g. recruitment flyers, consent forms, or therapy principles) could be developed to more closely match the specific language used by men in the community when describing goals for wellbeing, and assessed for differences in acceptance and attrition among men.

This study was limited in that the interviewers responsible for primary data collection were all trained mental health professionals. This is a potential source of bias, as they are all actively supportive of the intervention being used, and may have more readily encouraged participants to engage in mental health services, or led to less honest responses from the participants. Interviews were conducted after a client refused or accepted the intervention however, and no clients reversed their position during the course of a follow-up interview or immediately following one. Many of the men who accepted mental health treatment were receiving services for other medical problems at the time, or had exposure to other mental health programs. All eight men interviewed at the yeikthar accepted CETA, and the other seven men were receiving care or services from local clinics or CBO's. As such, the group of men who accepted are functionally a clinical sample, which presents another potential source of bias. The findings reported among this group may speak more to differences in willingness to accept services. While there were also decliners receiving medical care for other conditions, additional research could clarify the role of willingness to participate in health care programs, and how it interacts with masculinity in novel cultural contexts.

Conclusions

Men are unlikely to use mental health services though they experience a significant burden of mental health problems, particularly in the developing world. This article explores the relationship between masculinity and mental health treatment seeking among former political prisoners in Yangon, Myanmar. While masculinity was described in consistent terms between groups, there is a notable difference in interpretation of masculine norms when comparing men who accepted and men who declined therapy. This qualitative investigation highlights the need for deeper understanding of what might influence that decision-making process, and how men's conceptualization of masculine characteristics can help or hinder the likelihood of treatment seeking. Future research may benefit from examining and possibly reconceptualizing how men are approached, recruited for, and informed about MHPSS programs. Incorporating men's perspectives on values and beliefs with mental health treatment materials may improve the likelihood of both treatment engagement and retention in mental health treatment. Specifically, research that incorporates men's own perspectives on positive masculine values with descriptions of mental health programming and evaluation strategies warrants further consideration.

Abbreviations

AAPP Assistance Association for Political Prisoners

CBO Community Based Organization

CETA Common Elements Treatment Approach

LMIC Low- and Middle-Income Countries

MHAP Mental Health Assistance Program

MHPSS Mental Health and Psychosocial Services

PTS Posttraumatic Stress

TOT Trainer-of-trainers

Declarations

Ethics Approval and Consent to Participate

Ethical approval was provided by the Johns Hopkins University Bloomberg School of Public Health's Institutional Review Board (IRB No 000008538). Local ethical review was formally provided by the Community Ethics Advisory Board at Mae Tao Clinic in Mae Sot, Thailand– a health center specializing in care for Burmese asylum seekers and refugees that provides ethical oversight for AAPP's research activities. Written informed consent was obtained prior to mental health screening, and again prior to patient interviews. All consent forms were approved prior to data collection by both Johns Hopkins University's IRB as well the Community Ethics Advisory Board at Mae Tao Clinic.

Consent for Publication

Not Applicable

Availability of Data And Materials

The original transcripts and interpretation frameworks generated and/or analyzed during this investigation are not publicly available due to the presence of potentially identifiable information. Anonymized transcripts can be provided by the corresponding author by reasonable request.

Competing Interests

The authors declare no competing interests

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Author Contributions

DPL developed the concept, research plan, interview materials, and first draft of the manuscript, with support from WAT and JKB. KSW, HA, and KNCS conducted data collection, assisted with analysis, and helped in translation with support from BK. All authors provided editorial and conceptual support in collaboratively developing the final manuscript.

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Table 1

Table 1: Inclusion Criteria for Depression and PTSD

Depression	PTS
Criterion A <i>Response of 2 or 3 on one of these items</i>	Criterion A <i>Response of 2 or 3 on one of these items</i>
Feeling Hopeless Feeling Sad Feeling Lonely Crying Easily	Recurrent thoughts/memories of the event Feeling as though the event is happening again Recurrent Nightmares Sudden emotional/physical reaction when reminded of event
Criterion B <i>Response of 2 or 3 on one of these items</i>	Criterion B <i>Response of 2 or 3 on one of these items</i>
Loss of sexual interest/pleasure Feeling no interest in things/less interest in daily activities	Avoiding activities that remind you of the event Inability to remember parts of the most traumatic or hurtful events Avoiding thoughts or feelings associated with the traumatic event
Criterion C <i>Total number of the following items endorsed with 2 or 3</i>	Criterion C <i>If at least 2 of the following 4 questions have responses with 2 or 3</i>
Low energy, slowed down OR feeling like everything is an effort Poor appetite Sleep difficulties Thoughts of ending your life Worry to much about things Blame self for things OR feel worthless	Feeling detached or withdrawn from people Unable to feel emotions OR hard to suppress feelings No interest in daily activities Feeling like you don't have a future
	Criterion D <i>A response of 2 or 3 on one of the following</i>
	Blame self for things OR feel worthless Feeling jumpy or easily startled Difficulty concentrating Feeling on guard Feeling irritable or having outbursts of anger

Items were derived from the PTSD Checklist (30), the depression subscale of the Hopkins Symptom checklist (31), and locally-derived items from previous formative work (32)