Submitted: 05 June, 2025 Accepted: 28 July, 2025 Published: 30 September, 2025 DOI:10.22514/jomh.2025.114

ORIGINAL RESEARCH

JOMH Journal of Men's Health

Health professionals' perceptions of a group intervention to address men's psychosocial distress

Antonio Iáñez-Domínguez[1,*], María Soledad Palacios-Gálvez[2], Elena Morales-Marente[2]

[1]Department of Social Work and Social Services, Faculty of Social Sciences, Pablo de Olavide University, 41013 Seville, Spain
[2]Department of Social, Developmental and Educational Psychology, Faculty of Education, Psychology and Sport Sciences, University of Huelva, 21071 Huelva, Spain

***Correspondence**
aiadom@upo.es
(Antonio Iáñez-Domínguez)

Abstract

Background: Men's psychosocial distress rates are underestimated, and the reason may be linked to gender mandates which make them reluctant to seek help. Their distress and mental health problems, therefore, may be silenced and are being concealed from the health system. In this line, the Andalusian Public Health System (Spain) is currently developing an initiative to address psychosocial distress: the GRUSE (socio-educational groups) intervention. The study objective was to explore how health professionals perceived the impact of the intervention initiative on men experiencing psychosocial distress. **Methods**: A qualitative phenomenological approach was followed. Four focus groups took place between 2023 and 2024 in which health professionals participated (n = 37). A semi-structured script was used. Two researchers (interviewer and observer) implemented the groups, audio-recorded the discourses, and subsequently transcribed them for later analysis. Twenty-five codes were defined and sorted into five thematic categories. **Results**: The health professionals underscored the fact that hegemonic masculinity norms have negative effects on men's health. They highlighted group intervention as a valuable and effective health system strategy to promote mental health based on a non-medicalising approach. The professionals stressed that the group presented the benefit of providing a platform for emotional containment, peer support, and the generation of networks. In addition, a change in the men's attitude was observed after the intervention: though initially reluctant, they learned to seek help, without perceptions of male weakness. **Conclusions**: The health professionals recognised the benefits of the intervention for the male participants but found it difficult to initially engage and involve men. Therefore, the challenge is to design specific strategies to increase men's participation and achieve greater overall effectiveness and social impact. It is important to consider the gender perspective when implementing this type of intervention and to train health professionals to ensure the non-reproduction of traditional gender roles.

Keywords

Men; Masculinity; Gender roles; Mental health; Psychosocial distress; Healthcare system

1. Introduction

Mental health problems are acknowledged today as a major, widespread ailment all over the world. According to the World Health Organization (WHO) [1], approximately one in eight people suffer from a mental disorder, with anxiety and depression increasing the most in recent decades. Men present a lower prevalence of anxiety disorders and depression than women, yet they experience higher rates of death by suicide [2]. In 2023, a total of 4116 people died by suicide in Spain (3044 men and 1072 women), that is, an average of 11 people per day [3]. This discrepancy between the lower rates of anxiety disorders and depression and the higher rates of suicide in men the need to understand how gender norms may conceal male distress and calls for targeted public health responses.

The hegemonic model of masculinity [4] can contribute to accounting for some of men's psychosocial disorders. Mandates such as self-sufficiency and autonomy imply that men should be able to solve their problems on their own, without depending on others [5]. In addition, men are expected to be providers and to protect their families [6]. Men should therefore show resilience, strength and emotional control [7]. All these attributes lead a large number of men to experience male gender role stress when having to confront situations which they perceive as threatening to their masculine identity [8]. These same attributes and stressful situations pose specific risks to their health, as manifested by the following self-destructive behaviours: high rates of substance abuse [9],

aggression [10], lack of emotional expression [11], and suicide [12].

These conditions are difficult to address because men are unlikely to look for professional support or treatment for mental health problems [13]. Added to this is the perceived threat and transgression of masculine gender norms, such as being strong and in control. Men find it difficult to seek help, not only when facing problems but also in terms of health care and daily well-being. Furthermore, those who do take the initiative receive a medicalised and pharmacological response: they are prescribed tranquillisers, sedatives, sleeping pills, antidepressants, as well as any other drug for psychosocial disorders [14]. This approach explains how healthcare systems in Spain perceive and respond to illnesses, ignoring the social and structural determinants.

Men's reluctance to appear vulnerable, to express their emotions, or to acknowledge their problems has been associated with psychosocial distress and suicide risk [15]. Yet it is not the only reason underlying mental health problems and suicidal behaviour. The social determinants that cause these situations should not be overlooked, such as loneliness and isolation, unemployment, economic difficulties, marital separation or addictions.

Within this context, the design of public policies plays a pivotal role in the promotion of men's mental health. On the one hand, research indicates that the majority of policies, both at the international level and in Spain, lack gender sensitivity and fail to explicitly address men's health [16]. This approach to policy design highlights the lack of comprehensive frameworks that incorporate a gender perspective, based on the understanding that talking about gender involves not only addressing women's issues, but also those of men [17]. On the other hand, health policies continue to prioritize biological and psychological approaches, while models that consider the social and cultural determinants of mental health remain limited and underdeveloped. It is therefore essential to acknowledge and incorporate the diversity of theoretical models that address mental health issues [18].

Under these premises, the Andalusian Public Health System (Spain) designed the socio-educational groups (GRUSE) [19] intervention as a strategy to promote the health and emotional wellbeing of people presenting somatic symptoms without organic cause and who need help to cope with everyday life adversities. The scheme began in 2011 with groups of women, and research was conducted on its impact: it was found that not only did the women's depression and anxiety symptoms diminish, their self-esteem also improved [20]. In response to the consequences of the 2008 economic crisis, the programme was extended to groups of men in 2016. Indeed, unemployment was identified as a mental health pathology risk factor [21], and it was related to the loss of the productive role underlying traditional male gender mandates.

The intervention target profile is that of men presenting psychosocial distress and difficulties in dealing with adverse situations of everyday life (unemployment, separation, bereavement, family conflicts or loneliness). The most frequent symptoms diagnosed at their Primary Care health centres are as follow: insomnia, sadness, low self-esteem or irritability. The group sessions are led by social workers and involve different professionals. A variety of topics are addressed (Table 1), and the groups are composed of a maximum of 15 people. A total of 8–10 working sessions are held at the health centres. They take place once a week and last 90–120 minutes each.

GRUSE is a meeting place, designed to encourage self-knowledge, and self-help. It addresses the influence of gender mandates on physical and emotional distress. This psychosocial support strategy helps participants to identify individual (self-esteem), community (social networks), and institutional (public and private resources) assets which they can use to face everyday life situations in a healthy way. An innovative aspect of this intervention is that instead of medicalising everyday difficulties and problems, it considers the gender approach as a determinant of psychosocial disorders.

Interventions to promote and strengthen men's mental health are increasingly necessary and they appear to be effective. In recent years, various programs have addressed men's psychosocial distress through interventions that incorporate gender-sensitive approaches, yielding promising results in terms of improvements in emotional well-being, shifts in attitudes toward mental health, and increased help-seeking behavior [22, 23]. Initiatives such as Heads Up Guys [24] in Canada and Men in Mind [25] in Australia have demonstrated that tailoring content to align with masculine norms facilitates men's engagement and reduces stigma-related barriers. While these interventions have proliferated globally, critical analysis of their relationship with gender theory, particularly hegemonic masculinity, is still limited. In the Spanish context, the GRUSE intervention represents a pioneering experience in primary care by incorporating a psychosocial and gender-sensitive approach. The objective of this article is to examine the impact of the GRUSE intervention on male participants, as perceived by healthcare professionals. This analysis aims to contribute to reflection on the role of the health system as a space for generating more equitable mental health strategies that respond to the determinants of male gender.

2. Materials and methods

This study is part of a mixed-method research project entitled "Analysis of the impact of socio-educational groups on men's well-being and mental health", funded by the General Secretariat for Research and Innovation of the Junta de Andalucía, Spain (ProyExcel_00138). This article presents the results of the focus group study which was based on a qualitative methodology.

2.1 Design, setting, participants, recruitment and sampling

A qualitative methodology based on a phenomenological approach [26] was adopted and applied to the health professionals' series of views on the GRUSE intervention. Focus groups were used as the information collection instrument. A total of 4 groups attended sessions which were held at primary health care centres in the region of Andalusia (Spain), between July 2023 and May 2024. Thirty-seven health professionals participated in this study. Two focus groups were composed of social workers (n = 21), *i.e.*, those who conduct the GRUSE

TABLE 1. GRUSE-Men intervention design.

Descriptors	Contents
Participants per group	8–15 men.
Profile	Men with non-specific and/or emotional symptoms with no apparent physiological explanation, presenting difficulties in handling and/or coping with adverse situations.
Number of sessions	8–10.
Duration Sessions	90–120 min.
Contents	(1) Identification and empowerment of personal assets; self-esteem; relationship, thinking, emotion and behaviour; emotion management; development of goals and objectives; and problem solving. (2) Identification and use of community assets. (3) Group cohesion. (4) Cross-cutting approach to gender equality.
Access/Referral	Health professionals (doctor, nurse and psychologist). Social workers. Other sectors (Social Services, Non-governmental organizations). Own initiative.

Source: Own elaboration.

interventions directly, and two other groups were mainly made up of doctors (n = 8), nurses (n = 5), psychiatrists (n = 1), psychologists (n = 1) and health education technicians (n = 1) (Table 2). In terms of gender, 24 women and 13 men participated, with an average age of 54 years. The vast majority had extensive work experience and training in health and gender issues.

Participants were recruited from the eight provinces that make up the region of Andalusia, so contextual differences (rural-urban environment and socio-economic differences) were represented. However, a stratified purposive sampling [27] according to professional category was used to form the groups, as we were interested in collecting significant and in-depth information on each professional's group intervention experience. The social work professionals were selected according to their group development practice: we were interested in including both those who had the most group implementation experience and those who had barely any. The rest of the health professionals were selected based on their involvement in group intervention, taking as a reference the number of male referrals since the GRUSE-men had begun. We sought to achieve maximum discursive variability using these criteria.

Potential participants were invited via telephone by the coordinator of the GRUSE program, based at the Andalusian Public Health Service (Spain) and a collaborator in the research, who explained the purpose of the focus group. All selected participants accepted the invitation; however, some were ultimately unable to attend due to work-related reasons or illness, which explains the unequal number of participants in each focus group (Table 2). The groups were organized according to the territorial areas corresponding to the health centers where the professionals worked.

2.2 Data collection

The participants completed a brief demographic and employment questionnaire to allow us to characterise the sample (Table 2). A semi-structured focus group script was elaborated. It fell into three blocks of open questions that guided the discussion: (1) GRUSE definition, origins, and evolution of the group intervention; (2) intervention weaknesses and strengths; (3) perception of its impact on men participants. Two researchers experienced in qualitative techniques conducted the focus groups, one acting as interviewer and the other as observer, the latter taking field notes on non-verbal communication and group dynamics. The moderator who conducted the focus groups was a middle-aged Spanish man with a background in anthropology and social work. The observer was a middle-aged Spanish woman with a background in social psychology. Both are university professors and researchers. The knowledge produced must be situated and contextualized within these subjective conditions [28].

The focus groups lasted between 60 and 120 minutes. All participants gave their written consent and were informed that their data would be anonymous and their testimonies confidential. Participation was voluntary and they were given the information sheet with the research references.

2.3 Data analysis

The focus groups were audio-recorded and transcribed verbatim for comprehensive reading and in-depth analysis. In addition, field notes were considered for analysis. We applied a thematic analysis [29] and first coded 25 significant and recurrent ideas found in the collected data. Once the codes were defined, they were reviewed and refined to ensure internal consistency and avoid overlaps or duplications. These codes were then structured and grouped into 5 analytical categories, which represent the central dimensions of the discourse. These categories emerged through the identification of conceptual relationships and patterns among the codes, allowing for the development of a solid and representative interpretative framework grounded in the empirical material. The thematic analysis was conducted inductively, adopting a bottom-up approach to data processing. To analyse the data, the Atlas.ti programme (version 24, Cleverbridge GmbH, Cologne, NRW, Germany) was used as a support tool.

TABLE 2. Characteristics of the focus group participants.

Group	Participants	Sex	Age	Profession	Years of work experience
G1					
	P1	Woman	65	Doctor	40
	P2	Woman	54	Nurse	33
	P3	Man	51	Doctor	23
	P4	Man	50	Doctor	20
	P5	Woman	49	Doctor	23
	P6	Man	54	Nurse	33
	P7	Woman	48	Nurse	25
	P8	Woman	63	Doctor	33
	P9	Man	63	Psychiatrist	34
	P10	Woman	44	Doctor	19
	P11	Woman	60	Health education technician	30
G2					
	P1	Woman	50	Social worker	8
	P2	Man	57	Social worker	2
	P3	Woman	49	Social worker	20
	P4	Woman	62	Social worker	30
	P5	Woman	63	Social worker	39
	P6	Man	62	Social worker	38
	P7	Woman	51	Social worker	26
	P8	Man	53	Social worker	24
	P9	Woman	59	Social worker	20
	P10	Woman	49	Social worker	3
G3					
	P1	Man	50	Social worker	18
	P2	Woman	59	Social worker	36
	P3	Man	63	Social worker	36
	P4	Woman	57	Social worker	31
	P5	Woman	60	Social worker	25
	P6	Woman	56	Social worker	39
	P7	Woman	59	Social worker	15
	P8	Man	58	Social worker	38
	P9	Man	38	Social worker	17
	P10	Woman	64	Social worker	20
	P11	Man	47	Social worker	7
G4					
	P1	Woman	46	Doctor	20
	P2	Woman	38	Doctor	13
	P3	Woman	56	Psychologist	32
	P4	Man	50	Nurse	30
	P5	Woman	48	Nurse	21

Source: Own elaboration.

3. Results

A total of 5 main result categories were identified based on the discourse analysis: (1) conceptualization of the GRUSE intervention; (2) gender differences in participation; (3) impact of the intervention on men's wellbeing; (4) difficulties in implementing the intervention with men; (5) improvement strategies. It is important to note that health professionals referred to men based on traditional masculine stereotypes, supporting the idea that hegemonic masculinity norms have negative effects on mental health.

All participant quotations have been labelled with the focus group in which the individual took part, the identification number assigned by the researchers during the analysis, and the participant's profession, in order to contextualize the standpoint from which the discourse is produced.

3.1 Conceptualization of the GRUSE intervention

The professionals recognised that the GRUSE intervention has been consolidated over the years in the health system and is now valued as an effective resource to promote mental health. The first GRUSE groups focused on women and only later were male groups incorporated. Professionals therefore recurringly compared different groups and underscored gender differences regarding intervention participation and impact. They recognised that it was easier to involve women than men, because women attended medical consultations the most anyway, presenting non-organic somatic symptoms. The likelihood of offering them the resource was therefore also greater.

"Women are more willing to participate and are more used to sharing problems and seeking support. Men tend to avoid these kinds of places where they have to speak in public and talk about their emotions with strangers." (G3; P6; Social Worker)

"More women consult than men, and men are more reluctant to speak in public." (G1; P10; Doctor)

The intervention was described as an important health system resource that offered an alternative to the medicalisation and "pharmacologisation" of psychosocial disorders.

"Personally, I think that GRUSE is an opportunity for men, because not everything has to be medicalised, pills are not necessarily a solution, there are other possibilities, such as taking part in a group. And the benefit comes precisely from participating in the group." (G1; P11; Health education technician)

"I explain to them that they will be taught how to solve everyday problems, distress, nervousness, without taking medication and how to change their way of seeing things a little bit. You may learn to manage your life a little better if you go." (G4; P1; Doctor)

However, it is argued that some professionals are less receptive to utilizing this resource, as it may be more convenient to prescribe medication or, from a more biomedical perspective, they may not believe in the benefits of alternative interventions that move away from medicalization.

"Some doctors are much more clinical, others more technical, others... So, I also believe that it is quite subjective, some professionals know how to delve deeper and detect the patient's needs." (G1; P1; Doctor)

The intervention is also conceived as a support platform providing emotional help and peer identification as they share their personal experiences. The group itself thus becomes an engine of change, fuelled by the relationships the participants build between themselves. The professionals highlighted how the group format allowed men to see themselves through the experiences of others.

"The group is hugely therapeutic.... The people who participate in the group are the main players; it's down to the people who are in it. But we are not used to seeing the power of group work." (G1; P9; Psychiatrist)

"Well, the group offers an essential function of support. I think you learn more in a group and it represents a basic work tool that we hardly exploit in primary care. We should use it more. Fortunately, though, it is being increasingly used." (G1; P11; Health education technician)

3.2 Gender differences in participation

Practitioners perceived that women's GRUSE have been more successful than men's groups. The latter face multiple challenges: from difficulties in recruiting participants to sociocultural resistance which inhibits men's emotional expression in group settings. Gender discrepancy was constantly referred to in the discourses.

"... it is very difficult to reach men, for cultural reasons, in other words, it is much more difficult for men to open up and show their emotions because they have been brought up to be strong, and they have strongly internalised that." (G3; P7; Social Worker)

"Men suffer as much as women, but they have been conditioned to hide it. Before talking about their emotions, they need to feel empowered to do so first." (G4; P3; Psychologist)

The professionals emphasised that men are not used to sharing their emotions and problems, they attempt to solve them alone. Conversely, they explained that women were more willing to disclose personal experiences and to seek emotional support. In short, they believed that it was masculinity norms which stopped men from joining these groups, because they perceived as alien to their male identity.

"For me, there are two gender issues here: the obvious one, let's say, patriarchal society, and another which underlies it all, the question of emotions. women have a huge advantage over men in the whole issue of emotions, and it lies at the heart of many problems we have to face." (G2; P6; Social Worker)

"We all suffer from gender mandates. It seems that only women suffer from gender mandates, but men suffer a lot from gender mandates too. He has to be strong, he has to be proactive, he has to solve, he has to provide, he has to have status, he has to dominate. And, naturally, some men can't carry that overload and break down." (G4; P3; Psychologist)

Women's groups are more established because they have been running for more years, but the time factor is not the only reason behind men's low participation. There has been a constant recurrent connection between men's difficulty expressing their emotions and masculinity norms. We understand that this sociocultural construct is modifiable and that it is precisely part of the GRUSE intervention.

3.3 Impact of the intervention on the men's wellbeing

The professionals' opinions revealed that men who succeeded at engaging with the group intervention experienced significant changes in different spheres of their lives. One common aspect they agreed upon was the improvement in the men's emotional wellbeing, as they acquired skills to cope with stress in a healthier way. In this sense, the intervention helped men to challenge traditional masculinity norms, allowing them to explore and manage their emotions more effectively. Greater self-awareness was also underscored, as the men were able to identify difficulties which caused them distress in their daily lives. They also acquired skills and strategies to address these everyday problems.

"The main advantage is on a personal level. You can see improvements when the patient comes to the clinic, because he is physically and psychologically better, he can face life situations better, and he is not always settled in that sadness. They also accept that their masculinity does not mean that they have to be the head of the family, that they have to bring everything home, because they often feel bad if they don't have a job. They are also brought to accept the separation from their wife, which causes them a lot of sadness and anxiety. Being separated from their children, from their home..., this affects them a lot emotionally. So, I think that accepting this whole situation helps them to improve their future life, both psychologically and physically." (G1; P8; Doctor)

"Men use other means to deal with the emotional dimension that they were not connected to..., they learn to control their emotions. I remember once, during a visit, I was administering a questionnaire to a man who had done a GRUSE. The wording 'control of emotions' appeared in the questionnaire, and he suddenly became very serious and told me: Madam, there is a mistake here because it says 'control' and we have been taught that it's not about controlling, it's about managing." (G4; P2; Doctor)

The professionals considered that the intervention facilitated the men's ability to open up about dealing with emotions, learning that talking about them was not a sign of weakness, nor was it associated with being feminine. In fact, the social workers pointed out that the men gradually changed their way of expressing feelings as the sessions unfolded. This was clearly visible in the way they adopted a more emotional language.

"Well, my experience is that the platform helps men to allow themselves to connect with what is really happening to them. Rather than, let's say, have superficial exchanges. The first contact is like dropping the armour so that they can allow themselves to enter a world of emotions, which is not easy at all. And, obviously, I work on gender issues, on what we are born into. You are dealt blue cards or pink cards, and those are the ones you have to play with. What interests me the most is that they know that they can open up, that they can enjoy being in contact, that they can express themselves, that they can ask things, that they can make mistakes. That they can show they are vulnerable, behind their strengths and hardness. Lately, the men were much more relaxed in the sessions. They were much more willing to talk and express themselves." (G2; P5; Social Worker)

More specifically, the social workers' discourses showed that they identified four key phases in the evolution of men's attitudes: initial scepticism, adaptation to the group, acceptance of vulnerability and acquisition of strategies and learning for their personal wellbeing. Initially, the men distrusted the group, doubting that it would serve any purpose, but they gradually changed their attitude as they observed that other men shared similar experiences, thus diminishing their feelings of isolation and loneliness. This is when they began to realise that talking about emotions was not a sign of weakness and that they learned how to manage the difficulties of their daily lives.

"GRUSE men go against the norm. Usually it's: I have an emotion that I don't like, and I avoid it by drinking, by smoking. I have an avoidant attitude towards an emotion. GRUSE does the opposite: it confronts me with the emotion, it forces me to feel it, experience it, process it. And well, that's a very powerful change." (G2; P8; Social Worker)

It was again noted that despite men's initial emotional reticence, conditioned by gender mandates such as "men don't cry" or men should "be strong", the group became valuable as a platform to express feelings and mutual empathy. It was highlighted that sharing experiences helped to process emotions, to be more open about them, and to learn skills to manage them better.

"At first, the men are reluctant to participate, but then they value the group as a safe arena where they can talk without being judged. As the group session progresses, they are the ones who ask each other how they are doing, they hug each other, and you can tell that they care about how they are doing from one week to the next." (G3; P11; Social Worker)

Other reported groupwork benefits included the networks that the men built among themselves, leading to mutual support within and outside the sessions. Another factor was health and personal wellbeing. The biggest challenge is overcoming initial scepticism, but once in the group, men begin to value the platform as an essential support network both during and after the intervention.

"I can assure you that they share a connection afterwards, outside the group, because I met them in the village and I saw them together, and they told me that they were from the GRUSEs." (G4; P4; Nurse)

"I agree with what you said about them feeling close, because they also have a common language. In the end, the GRUSE men get together, and they share a common language that they learned in the GRUSE sessions." (G2; P3; Social Worker)

3.4 Difficulties in implementing the intervention with men

The difficulties identified can be grouped into three areas: (a) recruitment difficulties due to emotional stigmas associated with masculinity; (b) practical limitations such as session schedules; (c) personal self-limitations and personal predispositions.

Health professionals have highlighted the difficulties in recruiting and involving men in the group intervention, pointing out the low male participation rate in comparison to that of

women.

"I have dealt with GRUSEs for many years through the social worker at my centre. I have in fact tried to refer men to the group session. But I have never been able to get any of them to go. In my case, they completely refuse to speak in public, to express emotions publicly. It's complicated." (G1; P6; Nurse)

The professionals believed that for men, taking part in a psychosocial distress treatment programme was associated with weakness and would thus be an admission of mental health problems, which would transgress masculinity norms.

"Men don't want to share their feelings because they see it as a sign of weakness, going to the doctor and saying what you need is taboo, because it's as if you have a weakness." (G1; P8; Doctor)

Another identified barrier was time constraints. The session schedule usually coincided with most men's working hours, reducing their possibility of access to the intervention programme. Some, however, considered that the schedule incompatibility was used as an excuse not to attend.

"They always give the excuse that they have work in the morning, but the truth is that it is very difficult for them, especially to open up. When you ask them, they sometimes tell you the problems they have, but I think they are too embarrassed to tell other people. That's why they don't want to attend." (G1; P8; Doctor)

Practitioners equally acknowledged their own difficulties or self-limitations in engaging and referring men to join a group, which also explains the low male participation rate. They explained that because they assumed that men would be less receptive to this type of intervention, they failed to offer it perhaps as frequently as they did to women.

"I am a doctor, and I work in a health centre. I know about it, and I refer a lot of women to GRUSE groups, but I didn't actually know that there were male GRUSEs. In reality, no male group has been set up in my health centre." (G1; P5; Doctor).

"I have referred women to our social worker, but I have never referred men." (G1; P4; Doctor)

One narrative was that women were seen as emotionally open and men as emotionally reserved. This gender discrepancy conditioned the way in which professionals perceived each group intervention. A critique of traditional gender roles is clearly visible in the discourses, but at the same time they are based on an essentialist view of masculinity as an obstacle to participation.

It was also observed that GRUSE was implemented differently across health districts. This depended on the availability, willingness, or training of professionals both to refer men to groups and, in the case of social workers, to lead and manage a group.

"It also depends on each person's availability and involvement, and I think that, at least for me, based on what I have found with my colleagues in primary care, some people are more open to referrals than others." (G1; P1; Doctor)

"I know that social workers also find it a bit more difficult to get involved in a man's group than a woman's group. There seems to be a certain fear of working with men, being a woman." (G1; P9; Psychiatrist)

"I have done GRUSEs with men and it's a bit of a surprise. You start out a little concerned, you're thinking, I don't know, because you're used to doing GRUSEs with women, which is easy, known territory, and you have that barrier of facing men, right? And then you're surprised at what they are capable of in a group." (G3; P10; Social Worker)

3.5 Improvement strategies

At the health system level, health professionals widely support the potential of the GRUSE intervention to promote mental health. However, low referral rates and consequently, men's limited access to these groups hamper their overall effectiveness. This is why health professionals warn about the need to achieve higher male referral rates and involvement through the recruitment strategies.

"...regarding referrals, we have to look for other strategies. When we mention referrals in the team, sometimes there are none at all. This year, when we opened the men's GRUSEs, we received many referrals from the mental health services and from associations. The association network can be another way to get men to be referred to us; I'm saying this to suggest new strategies." (G2; P10; Social Worker)

Similarly, the need to adjust timetables to facilitate men's attendance and make their working hours compatible with the group sessions was raised.

"Another issue is schedule availability. Timetables are set for the groups and sometimes they interfere with the men's working schedules. This is also an obstacle. And that's why some men say 'I can't come on that day' when the group is proposed to them. There are many kinds of limitations." (G4; P2; Doctor)

Social workers highlighted the need to make the intervention visible and legitimate within the health care system. They also pointed out the importance of collecting data and evaluating the intervention results, in order to not only demonstrate but also disseminate its impact on both men and women.

"On the one hand, I believe that the administration, the public authorities should disseminate the strategy more widely. On top of that, social workers are not communicating the results of the GRUSE sessions. The results obtained and the problems are not being divulged out there." (G3; P7; Social Worker)

This highlights the need to promote specific professional health training on the important role of the gender perspective. And self-knowledge building platforms should be created, so that professionals can reflect on their personal positions and avoid perpetuating traditional gender roles.

"It's important for professionals to be involved, but they also need to be trained as well as be given opportunities for self-exploration. If we don't look inwards, we don't change inside as people and as professionals, that's why training in self-knowledge is necessary." (G2; P6; Social Worker)

4. Discussion

The study findings are consistent with that of previous research regarding the existence of gender differences in access to and participation in interventions aimed at improving emotional

wellbeing and mental health: women clearly participate more frequently in these initiatives [30]. In this work, health professionals highlighted the difficulties in involving men. This finding implies that these male groups are not reaching their full potential and fail to reach out to sufficient numbers of men. Women's higher participation rates are not related to a greater need to intervene with women, but to various socio-cultural and gender role socialisation barriers [31, 32]. Men internalise traditional masculinity norms, making it difficult for them to seek help [13]. Another barrier is the fact that men do not relate these platforms to their masculine identity, perceiving these groups as more oriented towards women.

Health professionals have framed their discourses within binary conceptions of "masculine" and "feminine", without questioning these social identities as fixed and rigid categories [33]. Recent studies increasingly challenge this binary opposition [34], emphasizing that such identities are socially constructed, performative, and culturally variable. Furthermore, the discourses were articulated from the perspective of hegemonic masculinity, without accounting for the diverse forms of masculinity that coexist today (such as complicit masculinity, subordinated masculinity, and marginalized masculinity) [35]. Within this hegemonic framework, a heteronormative male figure predominated in the professionals' imaginaries. However, not all men experience psychosocial distress in the same way. Factors such as socioeconomic status, ethnicity, sexual orientation, and age may influence both access to and the impact of interventions [16]. At present, acknowledging the plurality of masculinities, gender ideologies, and adopting an intersectional perspective would be useful in understanding men's resistance or receptivity to group-based interventions.

Neoliberalism—characterized by precarious labor markets, individualism, and the erosion of social ties—has transformed the context in which men construct their identities [36]. The economic provider role traditionally associated with masculinity is increasingly challenged, leading to psychosocial distress and identity crises [21]. In this light, the GRUSE intervention should be understood not only as a strategy to address men's psychosocial discomfort but also as a response to broader structural changes and current social dynamics.

Men who succeed at engaging with the GRUSE intervention gain benefits and implement changes in their lives. This result supports other research findings on the effects of health interventions with men, where improved emotional wellbeing and a change in attitude towards mental health were similarly achieved [23]. Though initially reluctant to participate in this type of intervention, they are now able to seek help to face the difficulties of daily life.

A higher incidence of mental health diagnoses, such as anxiety and depression, is reported in women. Such a difference is evidence that certain ailments are underestimated in men [37]. Likewise, failure to seek help and to consult a doctor can especially hinder the identification of mental health problems. Indeed, mental and emotional health in men has been described as the "silent crisis" [38]. It is therefore crucial to train health professionals in identifying male profiles that may be presenting distress due to discrepancies with hegemonic masculinity norms. Studies have shown that medical recommendations are a determining factor in men's acceptance of GRUSE interventions, so such initiatives would help to increase men's participation in the GRUSE intervention [39]. Moreover, awareness of gender mandates and their implications for mental health treatment must be present in the intervention design, especially to avoid resistance from men.

Consistent with this, it is necessary to critically examine the role of medicalization. The dominant biomedical model often reinforces norms of masculinity by offering pharmacological solutions while failing to address the social and gender-related determinants underlying men's distress [14]. Indeed, many men resist psychotropic medications due to their association with weakness, loss of autonomy, or potential side effects that may impact sexual performance and libido [40]. While medicalization may offer relief, it can simultaneously threaten core masculine ideals such as virility and self-sufficiency.

The literature shows the value of group work as a peer support strategy. Indeed, group work provides a platform to share experiences, mutual empathy, and to facilitate social connection. Isolation or social disconnection is a significant risk factor for mental health, and group intervention is a strategy to build support networks, as it is a key factor in men's adherence to this type of intervention [41]. The group format seems to work for the men who participate in the GRUSE intervention, revealing a progressive transformation process from start to finish. Indeed, initially reluctant to participate, they eventually come to value the group as a safe and trusting arena to express their emotions. The challenge is to overcome the initial barrier of scepticism. Research shows that it can be useful to introduce problem-solving exercises and experiential learning models into these male groups. This can minimize men's perception of being in therapeutic spaces that create a sense of emotional vulnerability and recommending activities that are more attractive and functional [22]. Yet, we believe that based on our results, it would be interesting to work on the idea that expressing emotions should not be associated or understood as a sign of weakness. Rather, group intervention should be oriented towards identifying emotional expression as a positive step, one that leads towards personal wellbeing.

The findings of this study should be interpreted in light of the following limitations. First, although data were collected on the profiles of the healthcare professionals who participated in the focus groups, their gender identities were not explored, which may have influenced their perceptions and attitudes toward masculinities and the provision of care to men within health services. Second, the majority of participants were women, and all were white Spaniards. Finally, the study was not geographically representative, as the GRUSE intervention is implemented in a region of southern Spain, and participant recruitment was therefore limited to professionals working in health centers within that area. Future research could incorporate a more balanced sample in terms of gender, ethnicity, age, and cultural backgrounds. Exploring plural forms of masculinity through intersectional approaches may offer a more nuanced understanding of the findings.

5. Conclusions

In this article, we explored the perception and opinion of professionals regarding a non-medicalising and innovative strat-

egy in the context of a health system that focuses on medicalisation and care. The professionals' discourses showed that the GRUSE intervention was consolidated within the health system, and that despite gender participation differences, the results are effective for both men and women. In the case of men, hegemonic norms of masculinity remain a major obstacle and therefore the GRUSE intervention is a valuable and effective tool for mental health promotion. It provides a range of benefits to those who participate. However, to overcome men's reduced participation rates, specific strategies are required in which a gender perspective is mainstreamed.

Gender training for health professionals is also important to avoid reproducing gender stereotypes when dealing with men. Understanding and challenging norms of masculinity is key to avoid the trap of underestimating men's psychosocial distress. Thus, identifying men's emotional needs may help to increase referral frequency and, consequently, more men may participate in and benefit from such interventions.

The findings of our study provide relevant insights into the complex relationship between male psychosocial distress and masculinities. However, it also becomes evident that a gender-sensitive, non-medicalizing group intervention, such as the GRUSE program in primary care, is not only feasible but essential if men's mental health is to cease being a silent crisis. By analyzing emotional change through a gender lens, the study contributes to filling the gap around how health systems might support plural masculinities rather than reinforcing hegemonic norms.

AVAILABILITY OF DATA AND MATERIALS

The data presented in this study are available on reasonable request from the corresponding author.

AUTHOR CONTRIBUTIONS

AID—collected the data and wrote the first draft of the manuscript. MSPG and EMM—critically reviewed the manuscript, provided feedback, approved the final version, and contributed to editorial revisions. All authors conceptualized and designed the research study.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The research was approved by the Biomedical Research Ethics Committee of Andalusia (SICEIA-2024-000639) on 13 June 2024, and the Ethics Committee for Research Involving Human Subjects at Pablo de Olavide University, Spain (23/1-2) on 24 January 2023. Participants signed informed consent forms and received an information sheet outlining the purpose of the study.

ACKNOWLEDGMENT

The authors would like to thank Patricia García Roldán for facilitating access to healthcare professionals. We also extend our gratitude to the professionals for their time and for sharing their insights and experiences.

FUNDING

The research was funded through a Resolution of the General Secretariat for Research and Innovation, granting support for Excellence Projects within the framework of the Andalusian Plan for Research, Development, and Innovation (ProyExcel_00138).

CONFLICT OF INTEREST

The authors declare no conflict of interest.

REFERENCES

[1] World Health Organization. World mental health report: transforming mental health for all. 2022. Available at: https://www.who.int/publications/i/item/9789240049338 (Accessed: 20 April 2025).

[2] World Health Organization. Depression and other common mental disorders: global health estimates. 2017. Available at: https://www.who.int/publications/i/item/depression-global-health-estimates (Accessed: 20 April 2025).

[3] Instituto Nacional de Estadísticas (INE). Deaths due to suicide (In Spanish). 2023. Available at: https://www.ine.es/jaxi/Datos.htm?tpx=72065 (Accessed: 23 April 2025).

[4] Connell RW, Messerschmidt JW. Hegemonic masculinity: rethinking the concept. Gender & Society. 2005; 19: 829–859.

[5] Elliott K, Roberts S, Ralph B, Robards B, Savic M. Understanding autonomy and relationality in men's lives. The British Journal of Sociology. 2022; 73: 571–586.

[6] Zuo J, Tang S. Breadwinner status and gender ideologies of men and women regarding family roles. Sociological Perspectives. 2000; 43: 29–43.

[7] Aggarwal A. "Examining emotional resilience": a comparative analysis of gender differences in emotional strength between women and men. Library Progress International. 2024; 44: 22653–22666.

[8] Stanaland A, Gaither S, Gassman-Pines A. When is masculinity "fragile"? An expectancy-discrepancy-threat model of masculine identity. Personality and Social Psychology Review. 2023; 27: 359–377.

[9] von Zimmermann C, Hübner M, Mühle C, Müller CP, Weinland C, Kornhuber J, *et al*. Masculine depression and its problem behaviors: use alcohol and drugs, work hard, and avoid psychiatry! European Archives of Psychiatry and Clinical Neuroscience. 2024; 274: 321–333.

[10] Logoz F, Eggenberger L, Komlenac N, Schneeberger M, Ehlert U, Walther A. How do traditional masculinity ideologies and emotional competence relate to aggression and physical domestic violence in cisgender men? Frontiers in Psychology. 2023; 14: 1100114.

[11] River J, Flood M. Masculinities, emotions and men's suicide. Sociology of Health & Illness. 2021; 43: 910–927.

[12] Galvez-Sánchez CM, Camacho-Ruiz JA, Castelli L, Limiñana-Gras RM. Exploring the role of masculinity in male suicide: a systematic review. Psychiatry International. 2025; 6: 1–21.

[13] Vickery A. Men's help-seeking for distress: navigating varied pathways and practices. Frontiers in Sociology. 2021; 26: 724843.

[14] Casas Martínez ML. The medicalization of life: an interdisciplinary approach. Heliyon. 2023; 9: e16637.

[15] Bennett S, Robb K, Zortea T, Dickson A, Richardson C, O'Connor R. Male suicide risk and recovery factors: a systematic review and qualitative metasynthesis of two decades of research. Psychological Bulletin. 2023; 149: 371–417.

[16] Griffith DM. Gender health equity: the case for including men's health. Social Science & Medicine. 2024; 351: 116863.

[17] Seidler ZE, Rice SM, River J, Oliffe JL, Dhillon HM. Men's mental health services: the case for a masculinities model. The Journal of Men's Studies. 2017; 26: 92–104.

[18] Richter D, Dixon J. Models of mental health problems: a quasi-systematic review of theoretical approaches. Journal of Mental Health. 2023; 32: 396–406.

[19] Mateo I, García-Cubillana P, Conde P. Guidelines for the design and implementation of socio-educational groups in primary care (GRUSE). 2011. Available at: https://www.sspa.juntadeandalucia.es/servicioandaluzdesalud/sites/default/files/sincfiles/wsas-media-pdf_publicacion/2020/GRUSE_MANUAL.pdf (Accessed: 23 April 2025).

[20] Palacios-Gálvez MS, Morales-Marente E, Iáñez-Domínguez A, Luque-Ribelles V. Impact of primary care socio-educational groups in mental health of women. Gaceta Sanitaria. 2021; 35: 345–351. (In Spanish)

[21] Franke AG, Schmidt P, Neumann S. Association between unemployment and mental disorders: a narrative update of the literature. International Journal of Environmental Research and Public Health. 2024; 21: 1698.

[22] Seidler ZE, Rice SM, River J, Oliffe JL, Dhillon HM. Men in and out of treatment for depression: strategies for improved engagement. Australian Psychologist. 2018; 53: 405–415.

[23] Kim S, Yu S. Men's mental health and interventions tailored to masculinity: a scoping review. Journal of Men's Health. 2023; 19: 1–10.

[24] Ogrodniczuk J, Oliffe J, Beharry J. HeadsUpGuys: Canadian online resource for men with depression. Canadian Family Physician. 2018; 64: 93–94.

[25] Seidler ZE, Wilson MJ, Benakovic R, Mackinnon A, Oliffe JL, Ogrodniczuk JS, *et al*. A randomized wait-list controlled trial of men in mind: enhancing mental health practitioners' self-rated clinical competencies to work with men. American Psychologist. 2024; 79: 423–436.

[26] Taylor SJ, Bogdan R, Devault M. Introduction to qualitative research methods: a guidebook and resource. 4th edn. John Wiley & Sons Inc.: Hoboken. 2015.

[27] Patton MQ. Qualitative research & evaluation methods: integrating theory and practice. 4th edn. Sage Publications: Thousand Oaks. 2014.

[28] Haraway D. Simians, cyborgs, and women: the reinvention of nature. 1st edn. Routledge: New York. 1990.

[29] Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006; 3: 77–101.

[30] Stefan Ek. Gender differences in health information behaviour: a finnish population-based survey. Health Promotion International. 2015; 30: 736–745.

[31] Emslie C, Ridge D, Ziebland S, Hunt K. Men's accounts of depression: reconstructing or resisting hegemonic masculinity? Social Science & Medicine. 2007; 62: 2246–2257.

[32] Addis ME, Mahalik JR. Men, masculinity, and the contexts of help seeking. American Psychologist. 2003; 58: 5–14.

[33] Butler J. Gender Trouble. Feminism and the Subversion of Identity. Routledge: New York.1999.

[34] Schudson ZC, Morgenroth T. Non-binary gender/sex identities. Current Opinion in Psychology. 2022; 48: 101499.

[35] Connell RW. Masculinities. 2nd edn. University of California Press: Berkeley. 2005.

[36] Connor S, Edvardsson K, Fisher C, Spelten E. Perceptions and interpretation of contemporary masculinities in western culture: a systematic review. American Journal of Men's Health. 2021; 15: 15579883211061009.

[37] Oliffe JL, Hannan-Leith MN, Ogrodniczuk JS, Black N, Mackenzie CS, Lohan M, *et al*. Men's depression and suicide literacy: a nationally representative Canadian survey. Journal of Mental Health. 2016; 25: 520–526.

[38] Ogrodniczuk JS, Oliffe JL, Kealy D, Seidler ZE, Sharp P, Rice SM. Silence and its manifestations in men's mental illness. Nature Mental Health. 2023; 1: 446–448.

[39] Kwon M, Lawn S, Kaine C. Understanding men's engagement and disengagement when seeking support for mental health. American Journal of Men's Health. 2023; 17: 15579883231157971.

[40] Courtenay WH. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. Social Science & Medicine. 2000; 50: 1385–1401.

[41] Sharp P, Zhu P, Ogrodniczuk JS, McKenzie SK, Seidler ZE, Rice SM, *et al*. Men's peer support for mental health challenges: future directions for research and practice. Health Promotion International. 2024; 39: daae046.

How to cite this article: Antonio Iáñez-Domínguez, María Soledad Palacios-Gálvez, Elena Morales-Marente. Health professionals' perceptions of a group intervention to address men's psychosocial distress. Journal of Men's Health. 2025; 21(9): 24-33. doi: 10.22514/jomh.2025.114.