## Abstract

Males are less likely to seek help for mental ill health and more likely to end therapy prematurely. The question 'What are the barriers to help seeking for male adults experiencing mental ill health?' is explored in this systematized review. PsycArticles, PsychInfo, Cinahl ultimate, psychological & behavioural sciences collection were searched using terms related to mental ill health, help seeking and barriers (male adults). Thematic analysis was conducted and seven papers were reviewed. The themes were; structural barriers (subthemes cost and accessibility); stigma; health literacy and attitudinal barriers (subthemes, negative views of services and reluctance to talk about emotional issues). It would be helpful to understand more about how male help seeking behaviour compares to people of other genders. Attention to good therapeutic relationships focused on male needs may help to improve utilisation of support and therefore prevention of poor long-term health and premature mortality.

## Background

Approximately one in eight people live with a mental disorder worldwide (World Health Organisation, WHO, 2022). In England one in six adults experience common mental disorder, with females representing the higher proportion, 1:5 compared to 1:8 males

(McManus et al, 2016). This may be due to reduced recognition as males are less likely to report low mood and may present through self-destructive and violent behaviour towards themselves or others (Bilsker et al. 2018; Cole & Davidson 2019). Self-medicating with drugs is common due to the rapid (though temporary) relief, a behaviour seen with increasing frequency during the COVID-19 pandemic (Greenglass et al. 2022).

Help-seeking begins with awareness, problem identification and definition, influenced by individual, social and cultural factors (Lynch et al, 2018). When task demands outweigh individual resources and capacity for coping, the desire to seek help arises (Chan, 2013). However, when males do seek help, they are more likely to end therapy prematurely (Parent et al, 2018; Sagar-Ouriaghli et al, 2019), increasing risks for chronic health problems (Bilsker et al, 2018), addictions (Office for Health Improvement and Disparities, 2021) and premature mortality (Bilsker et al, 2018), including suicide, a major contributor to mortality in males (Bilsker et al 2018). Suicide rates are decreasing globally but suicide for males is reported as twice as common than women and higher in high income countries (WHO, 2024)

A systematic review (McKenzie et al. 2022) focused on ‘men’s mental illness stigma’, confirmed the need to explore what other barriers there might be to seek help, and to listen to male voices on what else might

prevent help seeking. No other reviews specific to barriers to help seeking in males were located.

## Methodology

A systematized review design was implemented, a purpose specific systematic literature review but without independent article assessment (Sutton et al 2019). The PEO framework was used to formulate the question to be explored (Munn et al, 2018), with P, the 'population' being male adults, E the 'exposure' being mental ill health, and O the 'outcome' barriers to help seeking. Thus, the question this review aims to answer is 'What are the barriers to help seeking for male adults experiencing mental ill health?'

## Search Strategy

The databases PsycArticles, PsycInfo, CINAHL Ultimate, Medline, and Psychology & Behavioural Sciences Collection were searched using the terms and combinations shown in table 1.

Insert table 1 here

The searches were conducted Dec 2022 - February 2023.

**Inclusion and Exclusion criteria**

Inclusion and exclusion criteria are outlined in Table. 2. The studies selected were published between 2013-2023.

Insert table 2 here

The selection process can be seen in the PRISMA diagram in figure 1. 921 papers were initially located, with 664 full text articles accessible whose titles were screened against the inclusion and exclusion criteria. The abstracts of the 84 papers remaining were then screened with 77 papers excluded for reasons shown in figure 1. This left seven studies for inclusion within the systematized review. Inclusion included a focus on formal rather than informal service provision.

Insert figure 1 here

CASP (2018a, 2018b) tools informed the appraisal of the papers and data extraction enabled synthesis of the literature. A summary of data extraction and critique can be seen in table 3.

**Analysis**

The principles of the Braun and Clarke (2006) thematic analysis method informed development of the themes with studies read and re-read to gain familiarity with the content, then findings coded and cross-checked to identify common themes for all the papers which are presented collectively.

Themes and subthemes identified can be seen in Table. 3.

Insert table 3 here

## Findings

### *Overview*

Seven research papers were reviewed, three of which were conducted in Australia (Rice et al. 2017; Rominov et al. 2018; Scholz et al. 2022), two in the United States (Ward & Besson 2013; Sivestrini & Chen 2022), one in the United Kingdom (House et al. 2018) and one in Ireland (Lynch et al 2018). Five were qualitative (Ward & Besson, 2013; Lynch et al. 2018; Rominov et al. 2018; Scholz et al. 2022; Silvestrini & Chen 2023) and two quantitative (Rice et al, 2017; House et al, 2018).

Participants across the papers ranged between ages 18 and up to age 80 which included young males 18-24 (Lynch et al 2018), American veterans (Silvestrini & Chen 2023) and new fathers (Rominov et al 2018), with others including mixed participants apart from Ward & Besson (2013) who focused on African American males.

### Structural Barriers

Five studies identified structural barriers that prevented males from to engaging with mental health support (Ward & Besson, 2013; Lynch et al. 2018; House et al. 2018; Rominov et al. 2018; Scholz et al. 2022). Structural barriers refer to a healthcare system's availability (Carrillo et al. 2011) and includes costs and accessibility.

### *Cost*

Two studies highlighted financial barriers to seeking professional help (Ward & Besson, 2013; Scholz et al. 2022) especially when chronic mental illness was experienced that required multiple or long-term service utilisation. This included lack of health care insurance, a hindrance to accessing professional services in the USA *(*Ward & Besson 2013).

### *Accessibility*

Travel distance (Scholz et al. 2022), waiting times (House et al. 2018), and the general availability of mental health services (Ward & Besson, 2013; Lynch et al. 2018; Rominov et al. 2018; Scholz et al. 2022) were identified as barriers. Travel distance was greater in rural areas, sometimes up to 200 km (Scholz et al, 2022), and Lynch et al. (2018) participants in Ireland were worried that due to small rural communities their doctor may reveal confidential information to their families.

House et al. (2018) found two factors were the best fit for the data in their Q sort study; factor 1, 'Help is available if you can get to the point of asking for it', and factor 2 (accounting for 11% of the variance), 'depression should be dealt with in private; help seeking makes you vulnerable'. Those significantly associated with factor 1 (n=14) held an optimistic opinion on service accessibility. In contrast, those associated with factor 2 thought that due to the time between first accessing the service to being offered an appointment was too long and could negatively affect attendance. Males struggled to find services that didn't solely operate during the traditional business hours of 9-5

(Rominov et al. 2018; Scholz et al. 2022) and telephone support was not always available (Scholz et al. 2022).

**Stigma**

Stigma refers to males believing they would receive negative, stigmatised responses if they were to seek help for mental health concerns. In the five studies that this theme appeared, stigma was underpinned by the participants' views of traditional masculine ideologies (House et al. 2018; Lynch et al. 2018; Rominov et al. 2018; Scholz et al. 2022; Silvestrini & Chen, 2023). Male veterans were reluctant to seek help for post-traumatic stress disorder (PTSD) as it was a 'sign of weakness' and that by requesting help from services you would need to 'admit you're not whole' (Silvestrini & Chen 2023). However, this was not unique to veterans as participants in Ireland were concerned that by seeking help for a mental health concern, you would be seen as 'a weak member of the group' and 'not really a man' (Lynch et al 2018). The Ward & Besson (2013) study with African American males in contrast did not endorse stigma associated with mental ill health and some participants even referred to mental illness as a 'normal and everyday occurrence', though they did not necessarily recognise it themselves.

**Health Literacy**

Four studies identified poor health literacy as a barrier to men's help-seeking behaviour (Ward & Besson 2013; Rice et al. 2017; House et al. 2018; Silvestrini & Chen 2023). National Health Service (NHS, 2023) define health literacy as the capacity to comprehend and use information to make decisions about one's own health. Participants disclosed that they lacked the appropriate knowledge of mental illness as a whole and the treatment options available to them. House et al. (2018) reported the belief that help seeking made you vulnerable and was therefore too risky. Ward & Besson (2013) also found self-reported lack of knowledge surrounding mental illness and medication used in the management of symptoms a barrier. Silvestrini & Chen (2023) found that

the (veteran) males did not believe PTSD was a legitimate mental disorder with one participant reporting that the military had told him 'you do not have PTSD, you just have postwar issues' (p.10).

## Attitudinal barriers

Attitudinal barriers were evident in five studies (Rice et al. 2017; House et al. 2018; Lynch et al. 2018; Scholz et al. 2022; Silvestrini & Chen, 2023). This theme refers to an individual's behaviours and beliefs based on assumptions that have developed through their socio-economic and cultural experiences. There were two subthemes; 'reluctance to talk about emotion' and 'professional services'.

### *Reluctance to talk about emotion.*

Lynch et al. (2018) reported that the young males found saying personal feelings aloud and communicating emotions challenging, and male veterans reported an unwillingness to talk about their problems or feelings as it was too personal (Ward & Besson 2013). Instead, these participants adopted negative coping strategies such as minimisation, ignorance and escaping the problem. Participants therefore reported that help-seeking is only seen as a last resort, when symptoms become too severe to endure.

### *Professional services.*

House et al. (2018) included positive views of health professionals, that 'men's requests for help are taken seriously' though Lynch et al. (2018) found views that 'most counsellors are just absolutely useless' (p.143). For some, those working in professional services were seen as only interested in box ticking exercises as part of their job, with no interest in getting to know the person (House et al. 2018; Scholz et al. 2022), which this caused dissatisfaction. Lynch et al. (2018) found participants

avoided approaching doctors for help out of fear of being prescribed medication, as they would rather ‘feel how I’m supposed to feel, rather than have medication’ (p.143).

## Discussion

This review identified structural barriers (cost and accessibility), stigma, health literacy and attitudinal barriers (professional services, reluctance to talk about emotion) as barriers to help seeking for males with mental ill health. Although there are differences found across the studies, generally there is a lot of common ground between the participants represented (there is diversity in age, and although there is some ethnic diversity, it is not always evident in sample descriptions).

Health literacy, stigma and cost are themes that continue to emerge in recent studies, for example Juillerat et al. (2023), van der Schyff et al. (2023) and Swetlitz et al. (2024; views of Spanish speaking Latino men in the USA). Trust is also repeated as an important factor for overcoming barriers (van der Schyff et al. 2023), which reinforces a need to focus on good therapeutic relationships with males implicated in this review. However, this could be challenging, as if males only access help as a last resort, they may be more acutely unwell at the point of first contact with services.

Socially constructed masculine identity appears to be an ongoing barrier to help seeking (Juillerat et al. 2023; Swetlitz et al. 2024), which has been associated with unfavourable mental health outcomes (Wong et al, 2017). Rice et al (2020), found that attitude was more predictive of males help seeking behaviour, and that only 8.5% (n=117) engaged in mental health support, with reluctance to disclose mood related symptoms and remain self-reliant. The reluctance for males to share with professionals was evident in this review, with particular challenges within military settings still evident in 2023 (Silvestrini & Chen 2023). This can result in hesitancy towards treatment and also increase the likelihood of prematurely dropping out of services, which in turn

can negatively affect their future use of mental health services (Spendelow 2015; Seidler et al. 2018).

The cost of professional help was only identified as a barrier in locations which did not have publicly funded healthcare, although waiting times in the UK's NHS have consistently been identified in literature as a problem for seeking help (House et al. 2018; Mursa et al. 2022; Scholz et al. 2022, Kwon et al. 2023). However, travel distance as a barrier was mainly found in Australia though there is also a suggestion of rural/urban differences in Ireland. Telephone services have potential to remedy this as they have high levels of satisfaction and are associated with reduced travel, greater flexibility over appointment time and having shorter waiting times (MIND, 2021). However, telephone services weren't always available out of hours (Scholz et al. 2022), and NHS telephone and online support have been found by many to be difficult to use (Hacker 2021).

Health literacy requires understanding of health information, knowledge of diseases and illnesses, and medication adherence, which can contribute to better health management, use of available healthcare services, lower expenses, and health equality (Cutilli et al. 2018; Liu et al. 2020). Difficulties with health literacy may not be exclusive to males however, with 42% of working-age adults unable to comprehend and utilise common health information, and this number jumps to 61% when numeracy abilities are needed for understanding (PHE, 2015). However, those who are older, male, from a minority group, and have less education appear to be more likely to have poorer health literacy (Ward & Besson 2013; Kumar et al. 2017).

**Strengths and Limitations**

The review is limited by the absence of a second independent reviewer (Stoll et al, 2019). In addition, only including studies written in English potentially contributes to an Anglocentric bias (Sue et al, 2011); all the studies located were conducted in English speaking countries, that is, UK, US, Australia and Ireland. Sample groups are not homogenous with Irish, African American, fathers and

veterans represented with an age range from 18 to 80. The fact that 257 articles out of the 921 initially located were not accessible (as full text) does potentially miss some relevant research, a common barrier when research is not available as public access (McBurney and Kubas 2022) and one that is not easily overcome in unfunded studies.

## Conclusion

The current available evidence seems to consistently, universally and to a lesser extent, transculturally find poor health literacy, stigma and traditional masculine constructions as key barriers to help seeking. However, there appears to be little research that enables comparison of male, female and transgender identities. Therefore, apart from masculine identities, it is difficult to judge whether these barriers are gender specific or universal concerns amongst much wider populations. For example, cost and accessibility may not be male specific concerns and so understanding the detail of this more would be beneficial, to compare the relative differences and similarities in these groups. Most of the studies reviewed included males with common mental health problems such as depression, therefore, research would also have to be done to apply these findings to those diagnosed with serious mental illness such as schizophrenia to understand any differences.

Issues in male mental health remains a rapidly increasing concern globally, especially with the apparent lack of professional service utilisation and the high suicide rate (WHO 2024). It is vital that mental health professionals focus on good therapeutic relationships with males, provide relevant and timely information and find ways to retain males in therapy once they engage such as activity-based interventions. The opinions and perceptions of males who experience difficulties in their mental health need to be heard so that interventions and management options can be tailored to suit individual male needs.

## Implications for practice

- Nurses need to concentrate on the internal world that males express in addressing their poor mental health. Avoiding a situation where males feel rejected is important for care as this could result in males disengaging with mental health services.
- Preparedness for increased acuity at point of contact.
- Health literacy needs to be a central focus of policy and practice as does consideration of the accessibility of services.
- Strategies to keep males engaged in treatment once they have accessed services, with a particular focus on males opinions of the importance of developing therapeutic relationships within mental health care is implicated.
- Other methods of males accessing services without males feeling they are deviating from upholding traditional masculine characteristics, for example more efficient online or telephone services could be helpful.

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Figure 1. PRISMA diagram showing process and decision making

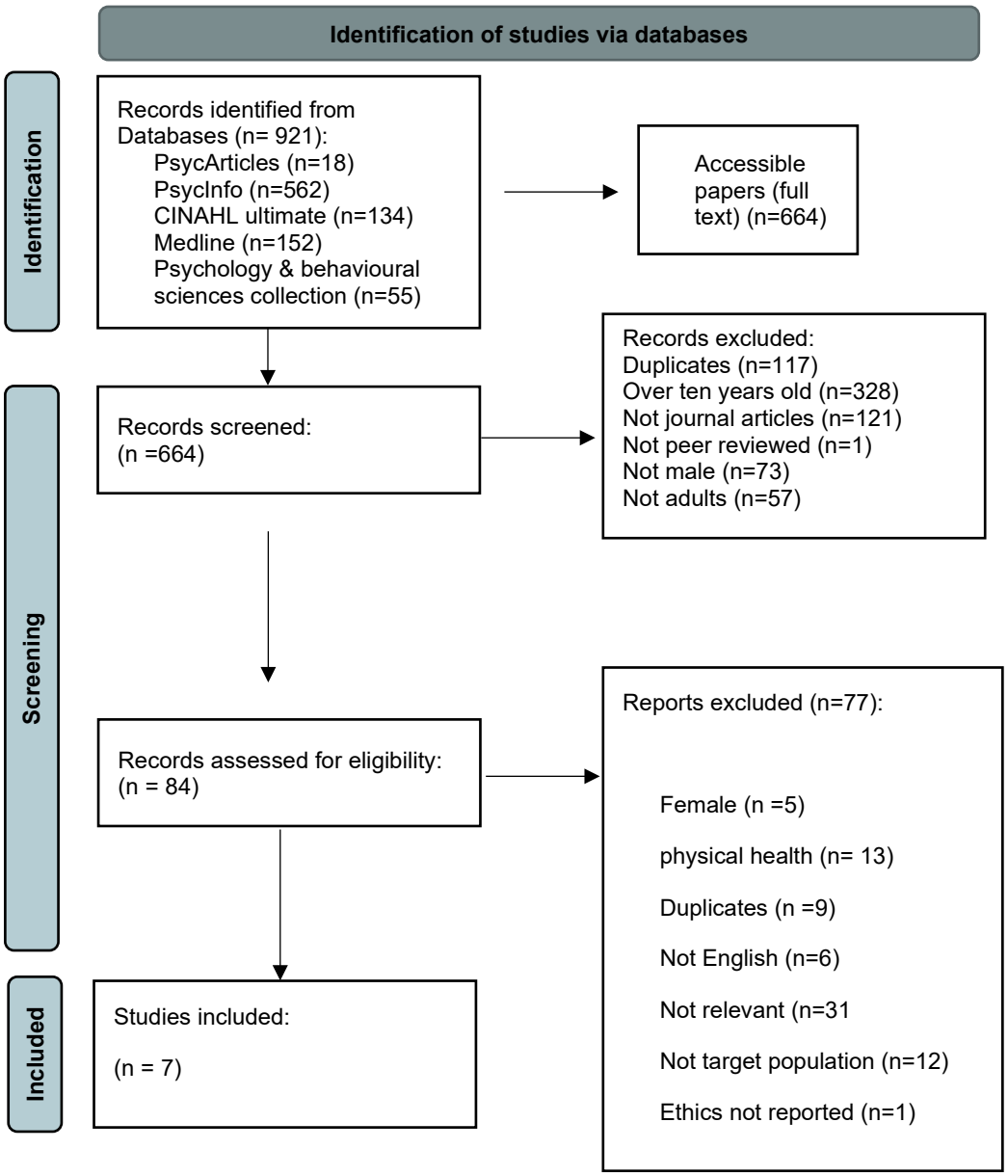

Table 1. Search terms and combinations

| **Male** | **AND** | **Mental illness** | **AND** | **Help seeking** | **AND** | **Barriers** |
|---|---|---|---|---|---|---|
| Male | | Mental Health | | Help seeking behavio#r | | Barriers |
| **OR** | | | | | | |
| Men | | Mental Illness | | attitudes | | Obstacles |
| **OR** | | | | | | |
| Man | | Mental Disorder | | treatment seeking behavio#r | | Challenges |
| **OR** | | | | | | |
| Males | | Psychiatric Illness | | | | |
| | **NOT** | Women female woman females | | | | |
| | **NOT** | Physical health physical wellbeing physical illness physical health problems | | | | |

Table 2. Inclusion and exclusion criteria

| **Inclusion criteria** | **Exclusion criteria** |
|---|---|
| Peer reviewed primary research | Reviews |
| 2013-2023 | Non-peer reviewed work |
| Male focus | Other gender focus |
| Adults (over 18) | Children and adolescents |
| Formal mental health support services | Informal support |
| English Language | Not reported ethics |
| | Physical health |
| | Clinician focused |
| | Intervention specific |

Table 3. Study characteristics and review themes identified

| **Authors** | Ward & Besson (2013) | Rice, Aucote, Parker, Alvarez-Jimenez, Filia & Amminger (2017) | House, Marasli, Lister & Brown (2018) | Lynch, Long & Moorhead (2018) | Rominov, Giallo, Pilkington & Whelan (2018) | Scholz, Lu, Conduit, Szantyr, Crabb, Happell (2022) | Silvestrini & Chen (2023) |
|---|---|---|---|---|---|---|---|
| **Location** | US | Australia | UK | Ireland | Australia | Australia | US |
| **Method** | Qualitiave study interviewing 17 African American men aged 24-75 | Longitudinal study using self report questionnaire of 125 men aged 18-67 tseeking. | A Q sort study with 29 male participants | A qualitative study with focus groups and interviews with 17 males | A descriptive qualitative study using telephone interviews with 20 fathers aged 30-42 | Qualitative study interviewing 10 men | Qualitative study interviewing 14 male veterans aged 22-72 (female data not included). |
| **Findings** | **Perceptions of stigma:** Most participants did not endorse stigma and encouraged others to get help.<br><br>**Barriers:** Limited knowledge of mental illness and medications used to treat mental illness. African American community MI not discussed openly. Lack | Long-standing depression group reported higher mean scores for barriers than the no-depression group.<br><br>Long-standing depression group scored higher on both minimising problems and concrete barriers than the transient depression late group.<br><br>Transient depression early group scored higher than the no-depression group on control and self-reliance, and higher than both the no-depression and transient depression late groups on minimising problems, and lower than the long-standing | Viewpoint 1: *Help is available if you can get to the point of asking for it – (Factor 1 explained 34% of study variance).* Many participants expressed a desire to cope alone and feared negative judgement from other men. Participants in 'factor 1' agreed more strongly that the benefits of help-seeking were worthwhile. Help-seeking is understood to be consistent with traits commonly perceived to be masculine.<br><br>Viewpoint 2: *Depression should be dealt with in private; help-seeking makes you vulnerable – (Factor 2 explained 11% of study variance)* Belief that you should control your emotion appears to intensify with | Barriers: Acceptance from peers, personal challenges (communication, symptom recognition), cultural and environmental influences, self-medicating with alcohol, perspectives around seeking help, fear of homophobic responses, and traditional masculine ideals | Barriers to support: Stigma – from fathers' own beliefs and perceptions of external attitudes about masculine norms. Hesitant to seek support out of fear of the perception of 'weakness'. Didn't want to shift focus from their partner and baby.<br><br>Work – Inflexible work arrangements. Perinatal services operating during business hours. | External environment: Health system (cost, distance to service), Gender norms/ stigma.<br><br>Individual characteristics: predisposing emotions (fear), enabling resources (communication) .<br>Previous service interaction: personalisation of services (previous negative experience, box ticking). | Reluctance to seek care: Distrust with MH care; the disbelief that PTSD was a legitimate MH disorder, perceived seeking help as a sign of weakness.<br><br>Support from family and friends encourages help-seeking behaviors: The male participants reported that their family members and partners encouraged them to seek help.<br><br>Need for gender-sensitive services: Need for services that are not combat specific. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | of awareness. System level barriers. | depression group on concrete barriers. | age. Seeking help can be career damaging. Waiting lists are too long and help isn't available when needed. | | | | |
| **Review themes identified** | | | | | | | |
| **Structural Barriers** ***Subthemes*** *Cost, accessibility* | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | |
| **Stigma** | | | ♦ | ♦ | ♦ | ♦ | ♦ |
| **Health Literacy** | ♦ | ♦ | ♦ | | | | ♦ |
| **Attitudinal Barriers** ***Subthemes:*** *Negative views of services, reluctance to talk* | | ♦ | ♦ | ♦ | | ♦ | ♦ |
| **Notes on critique** | May have limited generalisability to other ethnic or minority groups.<br><br>Unclear whether there are differences in beliefs because of mental health diagnosis. | Study relies on self-reported data. Group sizes were unequal. Subscale ratings for the BHSS were contextualised using within a hypothetical scenario of respondents experiencing major depression and this may have impacted the reliability of reporting | Written Q sorts rely on literacy of participants- if understanding is limited and it is not addressed by the researcher, validity may be compromised.<br><br>There was a lack of service user involvement during the development of the Q set.<br><br>Due to participant selection, the study may not capture viewpoints of alternative populations. | Recruitment was difficult and cannot generalise findings to other countries or cultures, e.g Irish travellers | Study was relatively homogenous sample and so findings aren't likely to be applicable to culturally diverse groups. | Acknowledge that others with more severe symptoms may have different perspectives.<br><br>Participants may not disclose all of their concerns and so data could understate concerns.<br><br>Only males over 45 from one | Study part of a wider qualitative study and so questions regarding gender-specific barriers were not part of the formal interview guide and were not standardised across the entire population.<br><br>The study was conducted during the COVID-19 pandemic, which limited in person contact and could affect data collection. |

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| | | | | | | Australian city; may not represent a wider population | Participants recruited from clinics that were part of one large healthcare system in the Northwest and so results cannot be generalised to other geographic areas, |