Motivators and barriers to help-seeking for mental health problems in men living in disadvantaged socioeconomic conditions

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Abstract

Mental health problems are particularly prevalent in men living in disadvantaged socioeconomic conditions. Despite that, there is a lack of psychological help-seeking in this population and the factors associated with this behaviour have received little attention from research. In order to increase understanding of this issue, the current rapid literature review aimed to identify motivators and barriers to mental health help-seeking in men living in disadvantaged socioeconomic conditions.

147 articles that were found on SCOPUS, Web of Science and PsycInfo were screened, leaving 6 quantitative and qualitative studies from North America and Sub-Saharan Africa with relevant data for analysis. The included studies' quality was assessed as good, and a narrative synthesis was conducted.

Barriers were categorised inductively, and the most commonly reported categories were the desire to solve the problem on one's own, mental health literacy and problem beliefs, structural barriers, financial reasons and stigma-related barriers. One study reported on motivators which were the belief men ought to provide for their families, support of friends and families, and being able to access individual therapy over group therapy to preserve one's anonymity. Socioeconomic status was mainly operationalised in terms of personal income or living in a low-income country.

The findings of this review can be used to inform interventions aimed at increasing help-seeking in the current target population. Further research is required to identify motivators and findings should be verified in other cultures. Additionally, the appropriateness of other modes of mental health service that could mitigate barriers such as online counseling should be investigated for this population.

Keywords: help-seeking, men, low socioeconomic status, mental health, literature review

Introduction

Mental health problems in men and associated mortality rates are alarming in recent times. 10-15% of men experience at least one major depressive episode in their lifetime across multiple Western countries and 13% of men suffer from an alcohol abuse disorder in the US (Parker & Brotchie, 2010; Center for Disease Control and Prevention, 2022). In addition, 75% of suicides in Australia are committed by men and 7.7% of all male deaths are attributable to excessive alcohol consumption in the US (Australian Bureau of Statistics, 2022; Center for Disease Control and Prevention, 2022).

Despite these high rates, only 9% of men in the UK receive psychological treatment (Mental Health Foundation, n.d.). Similarly, Hale and colleagues (2010) found that there is a considerable gap between the sexes in mental health service utilization with men engaging less in help-seeking behaviour regarding psychological problems than women. Help-seeking can generally be defined as any behaviour involving problem-focused planning and interaction with healthcare professionals (Cornally & Mccarthy, 2011). The finding that men engage less often in help-seeking behaviour has been supported by Addis and Mahalik (2003). Hale and colleagues (2010) also suggested a link between lacking help-seeking behaviour and higher mortality in men compared to women. The researchers argue that less help-seeking is associated with a higher mortality rate for men, as conditions are left untreated or treated too late.

The findings of Hale and colleagues (2010) suggest the importance of identifying the factors influencing men to engage in or refrain from help-seeking behaviour in order to ultimately find ways to deliver psychological treatment to more people in need of it. While a considerable amount of research has already been conducted on this topic, the population of men with a low socioeconomic status (SES) has received little attention. However, this group could particularly benefit from more frequent accessing of mental health services as 27.7% of people living in the lowest category of socioeconomic conditions suffer from psychological problems in the Netherlands compared to 14.1% of people living in the average and 9.5% of people living in the highest category of socioeconomic conditions (StatLine, 2022).

Having a low SES in terms of financial problems seems to be associated with an increased risk of social isolation (Hefner & Eisenberg, 2009). Additionally, unemployment is suggested to be correlated with an increased risk of suffering from mental disorders (Allen et al., 2014). Possible explanations for these findings are offered by the social causation hypothesis and the drift hypothesis (Mossakowski, 2014). According to the social causation

hypothesis, being economically disadvantaged contributes to poor mental health. It is argued that economic and financial difficulties manifest as stressors to the individual while also decreasing psychosocial resources to cope with these stressors which can lead to mental illness. The drift hypothesis presumes that suffering from mental illness can limit people's ability to function socially, thereby leading them to lose their jobs for example, and to drift into poverty (Mossakowski, 2014). Findings of a literature review by Kröger and colleagues (2015) indicate that health and economic circumstances influence each other, suggesting that the relationship between these two variables is more complex.

Despite the higher prevalence of mental illness in people living in socioeconomically disadvantaged conditions, help-seeking behaviour may not be adequate in affected men. The findings of Cook and colleagues (2014) suggest a positive correlation between SES and mental health care utilization in men, meaning that having a low SES seems to be associated with less help-seeking behaviour. In support of this, Yousaf and colleagues (2015) found low educational status to be associated with less help-seeking behaviour in men concerning medical and psychological problems.

The previously mentioned studies emphasize the importance of understanding the help-seeking behaviour of men living in low socioeconomic conditions so that ultimately, effective interventions targeting the lack of mental health service utilization in this population can be designed. However, a literature review focussing on the factors that motivate or hinder men living in disadvantaged socioeconomic conditions to seek mental health treatment has not been conducted yet. Therefore, the current study will aim to close this gap in the literature and the research question "What are motivators and barriers for mental health help-seeking in men with a low socioeconomic status?" will be explored.

Methods

Design

In order to answer the research question and summarise available quantitative and qualitative data, the research method of a rapid review was employed (Garrity et al., 2021). A rapid review is generally defined as a form of knowledge synthesis that accelerates the process of systematic reviews by streamlining or making methodological concessions to gather evidence in a resource- and time-efficient way (Garrity et al., 2021). This design choice is based on the lack of available resources for a master thesis and a short time limit of four months that does

not allow for the execution of a traditional systematic literature review. In order to ensure a standard of quality of the current review, the recommendations and quality criteria for rapid reviews developed by Garrity and colleagues (2021) were used as guidelines even though they could not entirely be adhered to due to the lack of resources. This was apparent in the fact that screening, data extraction, quality appraisal and data synthesis were done by only one researcher. A review and search protocol was devised before the data search with the support of an information specialist. The protocol was based on the PRISMA guidelines for systematic reviews (Page et al., 2021). The researchers propose to identify and describe eligibility criteria, search strategy, study selection process, the exact data items to be extracted, risk of bias assessment and data synthesis method in detail before carrying out the review (Page et al., 2021). The descriptions of these steps for the current study can be found below. Additionally, the PROSPERO entry of a systematic review investigating motivators and barriers to mental health help-seeking in a different population was used as guidance for the review protocol of the current study (Smith et al., 2016).

Eligibility criteria

Eligibility criteria were selected based on the PICO mnemonic which stands for population, intervention, context and outcome (Miller & Forrest, 2001). All studies were included in the review that reported data on motivators or barriers for adult men living in disadvantaged socioeconomic conditions to seeking help regarding mental health problems. Only peer-reviewed articles published in English in scientific journals were included. Similarly, only studies published since 2012 were included to reduce the risk of findings being outdated. Due to the lack of resources, only studies published in English were included. Grey literature was excluded from the review as accessing this kind of literature has been found to be especially time-consuming as it often cannot be found in scientific databases (Saleh & Bertolet, 2014). Garrity and colleagues (2021) also recommend limiting the inclusion of grey literature in rapid reviews for this reason. Meta-analyses, scoping reviews and systematic reviews were excluded from the review to avoid duplication of quantitative data.

Search strategy and study selection

Firstly, searches were conducted on the scientific databases SCOPUS, Web of Science and PsycInfo to identify relevant keywords and assemble a list of search terms (Appendix A).

Secondly, these search terms were entered in Web of Science, SCOPUS and PsycInfo. Limiting the number of databases searched is also recommended by Garrity and colleagues (2021). In line with these quality criteria, Web of Science and SCOPUS were used as large databases and PsycInfo was used as a psychology-specific database (Garrity et al., 2021). Duplications were filtered out using the tool Covidence which was also employed during the title, abstract and full-text screening phases as described in the PRISMA guidelines (Covidence, n.d.; Page et al., 2021).

Data extraction

The PRISMA guidelines and the Joanna Briggs Institute Reviewers' Manual 2015 Methodology for JBI Scoping Reviews were used as a blueprint for data extraction (Page et al., 2021; Peters et al., 2015). Quantitative and qualitative data were extracted and recorded using a modified spreadsheet put forward by the Joanna Briggs institute along with study and sample characteristics which included study population, intervention, methodology, operationalisations and outcomes of the included studies which can be found in Appendix B (Peters et al., 2015).

Quality appraisal

In order to examine the quality of qualitative studies, the checklist for qualitative research by the Joanna Briggs Institute was employed (Lockwood et al., 2015). This tool involves ten questions regarding the aims, different methodological aspects, data analysis and ethical considerations of a qualitative study (Lockwood et al., 2015). The Checklist for Prevalence Studies by the Joanna Briggs Institute (2020) was applied to appraise the quality of quantitative research. It involves nine questions on methodological choices along with guidance on what information is useful to investigate for each question (Joanna Briggs Institute, 2020). Both tools have been found to be popular among reviewers and the checklist for prevalence studies has been recently revised and improved (Barker et al., 2022).

Data synthesis

Firstly, a narrative synthesis was conducted to summarise the overall findings, categorise the barriers and motivators thematically and to investigate similarities and differences in

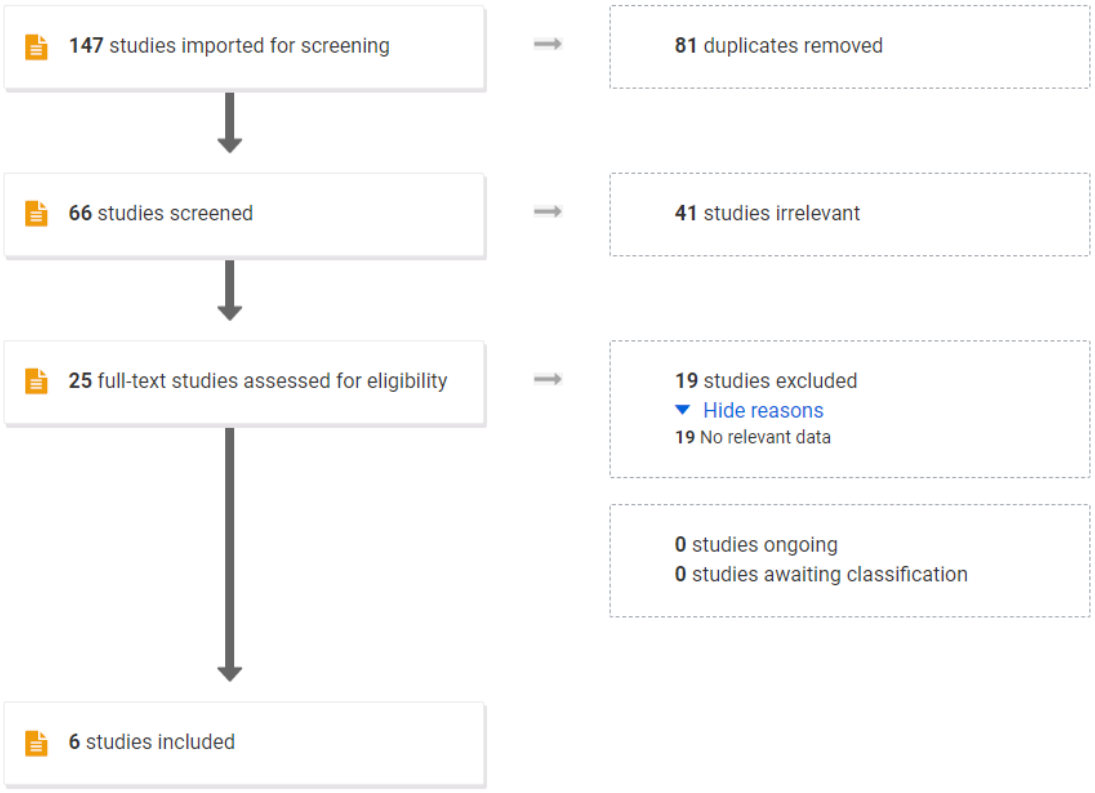
outcomes between the included studies (Popay et al., 2006). Characteristics of these studies and their populations were analysed descriptively. A thematic analysis in line with Braun and colleagues (2019) was conducted, creating codes inductively and data-based. The codes were mainly semantic, meaning they reflected the surface meaning of the data to keep interpretation minimal (Braun et al., 2019). Fitting category labels were drawn from quotes or from the included studies.

Results

The search identified 38 articles on PsycInfo, 59 on SCOPUS and 50 on Web of Science. Of these 147 articles, 81 duplicates were removed leaving 66 studies for screening. 41 articles were not in line with the eligibility criteria and were excluded in the abstract screening phase. In case of doubt, the full texts of articles were screened to make sure that all relevant data was included, even if studies focused primarily on a different topic and only reported a few relevant data points. 19 articles were excluded in the full-text screening phase, all due to not reporting relevant data leaving 6 studies to be included in the review. An overview of the screening process in the form of a PRISMA flow diagram is illustrated in Figure 1.

Figure 1

PRISMA flow diagram



Study characteristics

The included 6 studies were published between 2015 and 2022 although some of the data analysed were collected from 2002 onwards. 2 of these studies were conducted in North America (1 in the US, 1 in Canada) and 4 were conducted in eastern Sub-Saharan Africa (2 in Rwanda, 1 in Ethiopia, 1 in eastern DRC). 3 articles reported on quantitative data collected through self-report surveys, one study used a mixed-methods approach with a self-report survey and interviews, one study collected qualitative data through interviews and focus groups and one study collected qualitative data through focus groups. 4 studies asked men themselves to report motivators and barriers, one study asked mental health service providers and one triangulated reports of service providers, patients and community members. 4 studies used self-devised questionnaires and interview guides while 2 studies used the Barriers to Access Care Evaluation survey (Clement et al., 2012). SES was mainly operationalized as income in the two North American studies while data from the 4 Sub-Saharan African studies

were regarded as describing people living in low-income countries. The methodological quality of all 6 studies was appraised as being good and sufficient for inclusion. An overview of the study characteristics can be found in Table 1.

Table 1

Study characteristics

	Hayward & Honegger	Slaunwhite	Rugema et al.	Umubyeyi et al.	Zewdu et al.	Alexandre et al.
Year	2018	2015	2015	2016	2019	2022
Country	USA	Canada	Rwanda	Rwanda	Ethiopia	DRC
Aim	Understand perceived barriers to mental health treatment among low-income men serviced in a community-based program	Determine if gender and income predicted barriers to obtaining mental health care	Explore health care professionals experiences of barriers and facilitators that people with common mental disorders face when seeking mental health care services	Investigate help-seeking behaviour, barriers to care and self-efficacy for seeking mental health care among young adults with current depression and/or suicidality in a low-income setting	Assess the magnitude of the treatment gap for alcohol use disorder, help-seeking behaviour, stigma and barriers to care among people with alcohol use disorder in rural Ethiopia.	Explore challenges and barriers related to meeting the needs of male survivors of sexual violence with respect to their medical, psychological, socioeconomic and legal needs.
Type of Data	Quantitative from self-report surveys	Quantitative from self-report surveys	Qualitative with focus groups	Mixed methods with self-report survey and interviews	Quantitative from self-report survey	Qualitative data of interviews and focus groups
Sample	238 low-income fathers of underage children enrolled in a responsible fatherhood programme	2232 men with mood, anxiety or substance use disorder from different provinces with much demographic variation	43 male and female professionals from different hospitals throughout Rwanda	78 young men with depression and/or suicidality and 502 men and women as a comparison group	55 men and 2 women with moderately severe alcohol use disorder	3 doctors, 4 psychologists, 9 male survivors, 3 focus groups with 5-7 community members each
Age range	Not reported	Not reported, mean age= 36.4	26-59	20-35	<25->55	24-46 for male survivors

Barriers reported by	Men themselves	Men themselves	Health care professionals	Men themselves	Men themselves	Service providers, patients and other community members
Materials to identify motivators and barriers	Barriers to access care evaluation version 3	Self-constructed open-ended item with no predefined answer option	Self-devised interview guide	Self-devised questionnaire	Barriers to access care evaluation	Self-devised semi-structured interviews
Definition of SES	Low income	Annual household income below 30k CAD	Setting in low-income country Rwanda	Setting in low-income country Rwanda and further measured with possessing certain household assets	Great majority of sample were farmers or daily laborers with no formal education	Setting in low-income country DRC

Motivators and barriers

Of the 6 included studies, all reported on barriers while only one collected data on motivators for help-seeking. In total, 9 categories of barriers were identified across all included studies. These categories were 1. desire to solve the problem on one's own, 2. mental health literacy and problem beliefs, 3. structural barriers, 4. financial reasons, 5. stigma-related barriers, 6. shame and fear, 7. convenience-related barriers, 8. Aatitude towards and concerns about treatments and 9. being too unwell to reach out and lack of help in reaching out. The latter two categories were only identified by Hayward and Honegger (2018). The categories structural barriers, financial reasons, stigma-related barriers and convenience-related barriers were adopted from some of the included studies while the rest of the categories were created through an inductive approach identifying themes across studies (Alexandre et al., 2022; Hayward & Honegger, 2018; Rugema, 2015; Umubyeyi et al., 2016;). 3 relevant motivators by Alexandre and colleagues (2022) were summarised.

Desire to solve the problem on one's own

One of the most frequently reported barriers overall was wanting to solve the problem oneself. 77% of men indicated in a survey to experience this barrier making it the most frequently reported barrier in the American study by Hayward and Honegger (2018). Similarly, Slaunwhite (2015) reported "preferring to self-manage mental health issues" as a barrier significantly more often reported by Canadian low-income men in surveys compared to men with a middle or high income. This barrier seems to be of importance across cultures, as the findings of Rugema and colleagues (2015) suggest that "a request for help means acceptance of failure" for Rwandan men as indicated in focus groups. This is supported by Umubyeyi and colleagues (2016) whose survey results indicate that 15.4% of Rwandan men report that they "thought the problem was one I should be able to cope with myself". In this study, this was the second most cited barrier to accessing mental health services (Umubyeyi et al., 2016). Zewdu and colleagues (2019) found 63.3% of Ethiopian men with alcohol abuse disorder in surveys to report "wanting to handle the problem on my own" as a barrier making it the most frequently indicated barrier in this sample. As a possible explanation for these findings, Alexandre and colleagues (2022) report that many men in the DRC tend to have the belief that "men are physically stronger", "should be tearless", "should have the capacity to solve problems on their own" and "should not talk about their problems" as identified in interviews

and focus groups. This hints at a possible hindering effect of certain masculinity norms on mental health help-seeking behaviour.

Mental health literacy and problem beliefs

This category includes barriers indicating that a lack of knowledge on mental health and mental disorders or certain beliefs about mental health problems manifest barriers in accessing mental health care. One such barrier that was frequently reported was thinking "the problem would get better by itself" which was reported by 70% of respondents in a survey in the American study by Hayward and Honegger (2018). This factor also seems to be of cross-cultural significance as the most frequently cited barrier by Umubyeyi and colleagues (2016) was thinking "the problem would disappear by itself" with 17.9% of men indicating this barrier in a survey. Similarly, Zewdu and colleagues found 60.2% of men thinking "the problem would get better by itself" by means of a survey. In Canada, respondents indicated in a survey to "think nothing of the problem" as a reason for not seeking help (Slaunwhite, 2015). These responses could indicate a lack of literacy and knowledge of mental health and disorders both in North America and Sub-Saharan Africa. Rugema and colleagues (2015) report that a "lack of educational interventions" influenced delays in help-seeking in Rwanda according to health professionals.

Other barriers that could be related to a lack of education about mental health include thinking "it's not a problem that could be treated" which 30.5% of an Ethiopian sample of people with alcohol use disorder reported in a survey (Zewdu et al., 2019). Similarly, in the US, 55% of survey respondents indicated "thinking that professional care probably would not help" (Hayward & Honegger, 2018).

The researchers also found 56% of respondents to report "thinking I did not have a problem" which suggests a lack of realization or denial of the seriousness of the problem and a lack of knowledge of how certain mental disorders can be recognized (Hayward & Honegger, 2018). This barrier also seems to occur cross-culturally as 49.2% of respondents from an Ethiopian sample suffering from alcohol use disorder reported in a survey that the "problem didn't bother me" (Zewdu et al., 2019).

Structural barriers

Recurring structural barriers from both continents include not knowing where to get professional help, facing problems with transportation to the service provider and lack of available professionals in the area. “Being unsure where to get help” was reported as a barrier both in Canada and the US and in the latter, 64% indicated this as a reason for not seeking help in a survey (Hayward & Honegger, 2018; Slaunwhite, 2015). In Sub-Saharan Africa, Alexandre and colleagues (2022) describe “unawareness of service availability” as a hindering factor for not seeking help as identified in interviews. This is supported by Zewdu and colleagues (2019), who found 57% of survey respondents to be “unsure where to go”. Umubyeyi and colleagues (2016) described further that men had low confidence in “finding a place to get mental treatment”. This suggests a cross-cultural lack of awareness of where and how mental health services can be accessed. It was decided to categorise these barriers as structural; however, it can be argued that unawareness of where and how services can be accessed indicates mental health literacy issues for this population.

Zewdu and colleagues (2019) found 40.6% of survey respondents to face transportation problems in accessing mental health care. This is in line with Alexandre and colleagues (2022) who found greater “distance between home and hospital” to be a barrier for low-income men to seek help as described in surveys. This issue was also experienced by men in the US as Hayward and Honegger (2018) report that 53% of survey respondents had “problems with transport or traveling to appointments”. In Canada, “lack of transportation” was one of the most frequently reported barriers in a survey (Slaunwhite, 2015). Umubyeyi and colleagues (2016) similarly found low confidence among men to get means of transportation to the service provider. However, this could potentially also refer to a fear of stigma if participants meant by this that they were afraid to be seen by others on their way to a mental health service provider.

Possibly related to this, Slaunwhite (2015) suggested that a lack of available professionals in the area or at the time needed as well as waiting times being too long were encountered as barriers in Canada that were particularly relevant for men with a low income as identified in a survey. Similarly, Rugema and colleagues (2015) found a “shortage of trained staff” to hinder mental health care access in Rwanda by means of interviews suggesting that in some regions, mental health infrastructure is insufficient to meet resident needs.

"Having problems with childcare" was reported in both North American studies as a barrier to seeking help with 51% of survey respondents in the US facing this problem (Hayward & Honegger, 2018; Slaunwhite, 2015). However, this barrier was not reported in any of the studies conducted in Sub-Saharan Africa suggesting cultural differences in the experience of this issue.

Financial reasons

Financial barriers were reported in all but one of the included studies. In the US and Canada, not being able to afford the costs was one of the most frequently indicated barriers with 67% of survey respondents in the US encountering this problem (Hayward & Honegger, 2018; Slaunwhite, 2015). Similarly, Umubyeyi and colleagues (2016) found several financial barriers including "not being enrolled in a health insurance scheme" to be the most cited reasons for not accessing mental health services in Rwanda. Alexandre and colleagues (2022) added that while there are some cost-free treatments in the DRC, many people are not aware of this fact and do not access these services as a result as identified through interviews which could also be seen as a mental health care literacy barrier.

Stigma-related barriers

This category refers to all barriers related to external or internal stigma, concerns about one's status or the judgment of other people. Stigma-related barriers were reported in 5 of the 6 articles although the importance of these varied substantially across studies. In the US, 66% of survey participants indicated a "concern that I might be seen as weak for having a mental problem (Hayward & Honegger, 2018). Similarly, 57% of respondents reported "not wanting a mental health problem to be on my medical records". 53% indicated concerns about potentially being seen as crazy and 53% about being seen as a bad parent. This suggests a fear of being associated with unpleasant labels. More specifically, there was worry about the reaction of one's family as 57% reported a "concern about what my family might think, do, or feel". Additionally, respondents mentioned concerns about how their lives may be directly affected as 56% indicated a "concern that people might not take me seriously if they found out I was having professional care" and 51% agreed with the "concern that I might harm my chances when applying for jobs" when receiving mental health care (Hayward & Honegger,

2018). Interestingly, participants in a Canadian survey study did not indicate any stigma-related barriers (Slaunwhite, 2015).

Fear of labels was a shared barrier with men in Rwanda who indicated in interviews to be afraid of being labelled "mad men" which often had drastic consequences as many people suffering from mental health problems were hidden away by their families (Rugema et al., 2015). However, Umubyeyi and colleagues (2016) found stigma-related barriers to be the least reported category of barriers by men in a survey in Rwanda, suggesting that these barriers were not of primary importance to the majority of the population. In the DRC, fear of being labelled as a gay person or a woman were identified as barriers to help-seeking by male victims of rape in interviews (Alexandre et al., 2022). Both would mean a lack of masculinity and status for the man, which would often result in forms of cultural exclusion or not receiving help from important community figures such as priests. Similarly, respondents indicated being afraid that doctors or psychologists will not treat them if they come to know of the patient's experience with rape (Alexandre et al., 2022). This could indicate a lack of knowledge of mental health care and of communication on these topics, also on the side of the service providers. In Ethiopia, 36.7% of survey participants with a moderately severe alcohol use disorder were "concerned about what others might think" and reported this as a barrier to seeking help (Zewdu et al., 2019). Furthermore, 77.1% reported high internalized stigma associated with their drinking behaviour, suggesting that internalized stigma might be affecting more people in this population than external stigma-related factors such as negative opinions of other people (Zewdu et al., 2019).

Shame and fear

Unique to the North American studies were survey reports of shame and fear inhibiting help-seeking behaviour. 66% of respondents in the US indicated "feeling embarrassed or ashamed and being "afraid to ask for assistance" was a frequently reported barrier in Canada (Hayward & Honegger, 2018; Slaunwhite, 2015). In both studies, these barriers were not elaborated on further (Hayward & Honegger, 2018; Slaunwhite, 2015).

Convenience-related barriers

This category refers to all barriers relating to the required time and effort for help-seeking and treatment. Convenience-related barriers were identified by 3 studies by means of surveys, two

of which having been conducted in North America. 61% of respondents in the US indicated "difficulty finding the time" (Hayward & Honegger, 2018). This is supported by Zewdu and colleagues (2019) who found 31.3% of respondents in Ethiopia reporting that the "treatment would take too much time or be inconvenient". In Canada, participants indicated that they "didn't get around to it" due to personal or family responsibilities (Slaunwhite, 2015). This could indicate a lack of prioritization of one's mental health, particularly in North America.

Unique barriers in the US

Attitude towards and concerns about treatments, being too unwell and lack of help

The following barriers were only identified in the study by Hayward and Honegger (2018) from the USA and were reported by at least 50% of survey respondents. 64% of participants reported to "dislike talking about their feelings, emotions and thoughts" and 54% reported to "prefer to get help from family or friends" as barriers to mental health service utilization. This suggests that informal help-seeking might be preferred in this population. The researchers also found 64% of participants in the US to have "concerns about treatments available" which mainly referred to side effects of medication. Additionally, the researchers found 54% of participants in America indicating "being too unwell to ask for help" and 51% of respondents stating to have "no one who could help me get professional care", suggesting that outside assistance might play a role in accessing mental health care in the US (Hayward & Honegger, 2018).

Motivators in the DRC

Alexandre and colleagues (2022) identified the following 3 motivators by means of interviews and focus groups: 1. the "belief that men should provide for their families", 2. "support of families and friends" and 3. "the offer of individual therapy over group therapy to preserve anonymity". While the researchers also identified masculinity beliefs serving as barriers to help-seeking, the first motivator is an example of how the wish to conform to masculinity norms can engage men to seek help in order to get better and fulfil their perceived duties. The second motivator is in line with the findings of Hayward and Honegger (2018), suggesting that outside assistance is of importance in seeking help. Preserving anonymity through individual therapy could be seen as a way to reduce stigma-related barriers identified by

Alexandre and colleagues (2022) as patients would have to fear fewer people knowing of their condition.

Quality appraisal

The methodological quality of all included studies has been found to be generally good. All quantitative studies had adequate sample frames and sample sizes, although one study did not report its sampling procedure. The data analysis of all studies has been assessed as good. Two quantitative studies used the Barriers to Access Care Evaluation scale (BACE) for which there is preliminary evidence of its reliability and validity in identifying barriers to healthcare help-seeking (Clement et al., 2012). The quality of the qualitative studies has been assessed to be good across all dimensions and the influence of researchers was well addressed. However, one study did not report whether they received ethical approval from an appropriate institution. The filled-in quality appraisal sheets for the included quantitative and qualitative studies can be found in Tables 2 and 3 respectively.

Table 2

Quality Appraisal for Quantitative Studies

	Hayward & Honegger, 2018	Slaunwhite, 2015	Umubyeyi et al., 2016	Zewdu et al., 2019
1. Adequate sample frame for the population	+	+	+	+
2. Appropriate sampling procedure	+-	+	+	+
3. Adequate sample size	+	+	+	+
4. Detailed study subject and setting	+	+	+	+
5. Sufficient sample coverage in data analysis	+	+	+	+

6. Validity of measures	+	+-	+-	+
7. Reliability of measures	+	+-	+-	+
8. Appropriate data analysis	+	+	+	+
9. Response rate	+	+	+	+

Note. + Yes – No +- Unclear

Table 3

Quality appraisals for qualitative studies

	Rugema et al., 2015	Alexandre et al., 2022
1. Congruity between philosophical perspective and research methodology	+	+
2. Congruity between research methodology and research question	+	+
3. Congruity between research methodology and data collection methods	+	+
4. Congruity between research methodology and data analysis	+	+
5. Congruity between research methodology and interpretation of results	+	+
6. Cultural or theoretical location of researcher presented	+	+
7. Influence of researcher on research addressed	+	+
8. Adequate representation of participants and quotes	+	+
9. Accordance with ethical criteria	+	+-
10. Logic of conclusions	+	+

Note. + Yes – No +- Unclear

Discussion

The current literature review aimed to determine motivators and barriers to mental health help-seeking in men living in disadvantaged socioeconomic conditions. To the knowledge of the researcher, the current study is the first literature review on this topic. To answer the research question, scientific journal articles were searched on SCOPUS, Web of Science and PsycInfo which were further screened for relevance. Data from a total of 6 included quantitative and qualitative studies were synthesised. Barriers were grouped into a total of 9 categories that were created through an inductive coding approach and by drawing from appropriate category labels from the literature. The identified categories of barriers were 1. desire to solve the problem on one's own, 2. mental health literacy and problem beliefs, 3. structural barriers, 4. financial reasons, 5. stigma-related barriers, 6. shame and fear, 7. convenience-related barriers, 8. attitude towards and concerns about treatments and 9. being too unwell to reach out and lack of help in reaching out. Only one included study reported on motivators which were 1. the "belief that men should provide for their families", 2. "support of families and friends" and 3. "the offer of individual therapy over group therapy to preserve anonymity" (Alexandre et al., 2022).

Among the most frequently reported barriers were the desire to solve the problem on one's own, mental health literacy and problem beliefs, structural barriers, financial reasons and stigma-related barriers. These were reported in almost all of the included studies and were identified cross-culturally, in both North America and Sub-Saharan Africa. Additionally, the study populations were rather heterogenous, with some focussing on men enrolled in responsible fatherhood programmes, male victims of rape, men suffering from alcohol use disorder and men suffering from depression or suicidality. Despite the heterogeneity of the studies, findings were mostly similar, suggesting that these barriers are more universal and encountered by many different populations.

Similarly, a literature review investigating help-seeking barriers among refugees with depression found a lack of knowledge about mental health services, financial and transport challenges, mental health stigma as well as negative attitudes towards mental health treatment to be recurring barriers (Byrow et al., 2020). This literature review focused on both men and women and did not identify the desire to solve the problem on one's own as an important barrier, suggesting that this barrier is more relevant for men (Byrow et al., 2020). This is in

line with the findings of Alexandre and colleagues (2022), who propose that many men hold the belief that they "should have the capacity to solve problems" on their own. Noone and Stephens (2008) further found that often, men tend to consider traits such as being independent and in control as central to their self-concept as a man. This is supported by the findings of Smith and colleagues (2008) that suggest the more a man internalises certain norms of masculinity, the less likely he is to have a strong intention to seek help. These results suggest that the endorsement of masculinity norms could constitute an underlying barrier to help-seeking for men. Concerning negative attitudes towards treatment, O'Loughlin and colleagues (2011) suggest that many men tend to have a passive attitude towards health problems and prefer to wait and observe what happens before seeking help in order to appear tough and in accordance with masculinity norms.

However, Alexandre and colleagues (2022) found that masculinity norms can also manifest as motivators to help-seeking when men consider themselves to be responsible for providing for their families and consider help-seeking as a means to achieve this. Seidler and colleagues (2016) proposed that masculinity norms tend to be a hindering factor for help-seeking but also introduced the idea of reframing masculinity in a more fluid way. Coen and colleagues (2013) found that there are many different frameworks of masculinity, of which some are more flexible and allow for hurt and depression while still being a man. Johnson and colleagues (2012) propose that framing help-seeking behaviour as the responsible or action-oriented thing to do in accordance with masculine ideals makes this step easier. Similarly, Jensen and colleagues (2010) propose that considering help-seeking a strength-based action could be a motivator for men. Additionally, the researchers found that it is important that mental health treatments are strength-based and collaborative so that men still feel self-reliant, strong and in accordance with masculine ideals (Jensen et al., 2010). This suggests that masculinity norms can serve as both a barrier and a motivator depending on how these are framed.

A literature review on the factors associated with mental health help-seeking in men by Yousaf and colleagues (2015) identified among others mental health literacy, fear, treatment costs, lack of time and independence as important barriers similar to the present study. This suggests that men face many similar barriers to mental health help-seeking independent of SES or income. However, stigma-related barriers were not identified which is in line with the findings of a Canadian study by Slaunwhite (2015). A reason for this may be that the literature review by Yousaf and colleagues (2015) included studies from many different countries, of which most were Western while only one was conducted in Sub-

Saharan Africa, suggesting cultural differences. Slaunwhite (2015) measured barriers with an open-ended question without answer categories while the other quantitative studies included in the current review provided pre-defined answers to choose from. Thereby, priming could have played a role in the frequency of reports of stigma-related barriers. Priming refers to the phenomenon that attitudes can be subconsciously influenced by preceding information such as an item on a questionnaire which can contaminate the collected data (Vitale et al., 2008).

Regarding the repeated identification of a lack of mental health literacy as a barrier to mental health help-seeking, the findings of White and colleagues (2011) suggest that this could be in part due to men not tending to actively seek out health information in a European study. The researchers propose that; therefore, educational interventions may be beneficial to increase mental health literacy in men (White et al., 2011).

The finding that shame and fear may act as barriers to mental health help-seeking in men in the West was shared by Lynch and colleagues (2018). The researchers further argue that young men in Ireland are often afraid of rejection by their peer groups for seeking help and afraid of learning that they are "not normal" (Lynch et al., 2018). Latalova and colleagues (2014) additionally found that depressed men in Czechia often interpret symptoms in a way that there is "something wrong" with them, causing feelings of shame and internalized stigma which has been identified as a barrier to help-seeking by Zewdu and colleagues (2019). This suggests that internalized stigma and associated negative feelings may be a cross-cultural barrier to help-seeking in men.

Yousaf and colleagues (2015) additionally identified a lack of trust in mental health care professionals as one of the most important barriers to help-seeking in men. This could not be replicated in the current study which next to cultural differences may be due to differences in SES as the current review only focused on low-income men. This could indicate that lack of trust is only a relevant barrier in middle- or higher-income populations.

The finding by Alexandre and colleagues (2022), that the support of other people plays a role in help-seeking behaviour, is supported by Anderson and colleagues (2009) who found the support of close significant others to play a key role in seeking help for people with a gambling addiction. Similarly, most men in an Australian study were influenced in their decision to seek help by intimate partners and 37% reported that they would not have sought help without this influence (Cusack et al., 2004).

Anonymity as a motivator for mental health help-seeking in people living in low socioeconomic conditions has also been identified as such in a recent Canadian study by Hagen and colleagues (2022) investigating farmers, who preferred others not to know of their problem. Similarly, web-based counseling is suggested to be particularly relevant for gambling problems, partly due to its anonymity and convenience (Rodda et al., 2013). Furthermore, the researchers suggest that web-based counseling could be a way to mitigate stigma and convenience-related barriers and is applicable for gaining popularity among hard-to-reach groups. In addition, offering online treatment has increased mental health service access in young men (Rodda et al., 2013). Ellis and colleagues (2012) found young men to face similar barriers to help-seeking as the ones identified for men with a low SES in the current study, namely masculinity norms, stigma, lack of mental health literacy and lack of anonymity. Therefore, web-based counseling could be a useful alternative to ordinary mental health treatment.

Strengths

The current rapid review did not adhere to all methodological considerations of systematic literature reviews but was conducted in accordance with many proposed guidelines for rapid reviews by Garrity and colleagues (2021). Literature was searched on different relevant databases and some studies that focused on a different topic were also included if they reported data that could help answer the research question so that as much relevant data as possible could be extracted. For the same reason, quantitative, qualitative and mixed-methods studies were included. The data extraction form was created in accordance with the Joanna Briggs Institute Reviewers' Manual 2015 Methodology for JBI Scoping Reviews (Peters et al., 2015). The quality of each included study was appraised with an instrument by the Joanna Briggs Institute appropriate for the respective type of study (CASP, n.d; Hong et al., 2018; Joanna Briggs Institute, n.d.). An inductive coding approach was used in categorising the identified barriers so that these represent the data as accurately as possible. This was done because the categorisation of barriers in the individual studies varied widely and some studies used rather broad categorisations such as availability, acceptability and accessibility that were deemed to be less informative than more specific categories (Slaunwhite, et al., 2015).

The included studies used a variety of methods, target populations, materials, data collection procedures and operationalisations of SES and were conducted in different cultures. While this renders the comparability of data difficult, barriers identified across these studies

are more likely to be of universal relevance to men living in disadvantaged socioeconomic conditions. Additionally, the included studies were all assessed as being of good methodological quality.

Limitations

The findings of the current rapid review are restricted by several limitations. First, methodological streamlining as it is done in a rapid review compared to a traditional systematic literature review can have negative effects on the review such as introducing a greater risk of bias (Grant & Booth, 2009). To mitigate this risk, the quality of all included studies was appraised with appropriate instruments; however, only one reviewer was involved in the screening, data extraction and quality appraisal phases of the review which also carries a greater risk of bias (Garritty et al., 2021; Grant & Booth, 2009).

Second, the operationalisation of SES differed between studies. Some studies from Sub-Saharan Africa were included because they were conducted in low-income countries and it is unclear how living in a low-income country is comparable to having a low income in a high-income country (Rugema et al., 2015; Alexandre et al., 2022).

Third, the generalisation of findings on motivators for help-seeking is limited as only one of the included studies reported on these (Alexandre et al., 2022).

Fourth, most studies relied on self-report which introduces a risk of social desirability and recall bias (Zewdu et al., 2019). Some studies relied on the experiences and opinions of healthcare professionals and the accuracy with which these reflect the experiences of men remains unclear (Rugema et al., 2015; Alexandre et al., 2022).

Fifth, categorising the reported barriers across studies proved to present difficulties and a degree of data interpretation was required as it was not always clear what respondents exactly referred to with certain quotes. One example was “the problem didn’t bother me” and it was unclear, whether this person had in fact minimal symptoms, if this statement was a sign of denial or caused by fear of stigma (Zewdu et al., 2019). Additionally, several barriers could have been grouped differently based on the ambiguity of quotes.

Sixth, one study used older data collected in 2002 and it is unclear whether these still represent relevant barriers encountered today (Slaunwhite, 2015).

Seventh, two of the included quantitative studies employed self-devised questionnaires of which the reliability and validity remain unclear (Slaunwhite, 2015; Umubyeyi et al., 2016).

Implications

The current literature review contributed to the understanding of barriers and motivators for mental health help-seeking in men living in disadvantaged socioeconomic conditions on a cross-cultural scale. To the knowledge of the researcher, this is the first literature review on the topic and several important barriers were found across methodologies, materials, subpopulations and North American as well as Eastern Sub-Saharan African countries. These barriers were: the desire to solve the problem on one's own, mental health literacy and problem beliefs, structural barriers, financial reasons and stigma-related barriers.

Therefore, it is recommended for interventions aimed at increasing help-seeking behaviour among men with a low SES to pay special attention to addressing these factors. One way to achieve this could be by reframing masculinity norms in a more adaptive way to influence the desire to solve the problem on one's own (Seidler et al., 2016). This could be done by promoting the voices of men who consider help-seeking as an action based on responsibility and strength (Jensen et al., 2010). Additionally, it should be communicated to men that mental health treatments focus on the client's strengths and involve a collaborative relationship in which the client takes an active role so that men feel like they act in accordance with masculine ideals (Ellis et al., 2012; Jensen et al., 2010; Johnson et al., 2012). As the support and influence of men's social environments and especially their intimate partners have been found to be essential in help-seeking, incorporating them in an intervention could be beneficial (Anderson et al., 2009; Cusack et al., 2004; Jensen et al., 2010). This could be done by encouraging open communication about one's problems as men living in families or relationships in which such exchanges are normal reported to have more flexible and adaptive views on masculinity and help-seeking (Jensen et al., 2010; Johnson et al., 2012).

Interventions aimed at increasing help-seeking behaviour among men living in disadvantaged socioeconomic conditions have not yet been developed but King and colleagues (2018) executed an intervention aimed at improving attitudes towards mental health help-seeking for men in the US. The researchers presented participants with a

documentary about men talking about their mental health problems which should demonstrate that masculinity and help-seeking were not mutually exclusive which resulted in a significant increase in intention to seek help compared to a control group (King et al., 2018). This shows that interventions taking the identified barriers and motivators into account can be effective and are recommended to be carried out for men with a low SES as well.

This intervention can also be understood using the theory of planned behaviour which has been applied to mental health help-seeking behaviour in men (Smith et al., 2008). According to this theory, acting out a behaviour is mainly dependent on the intention to engage in this behaviour which in turn is influenced by one's attitude towards it, how one perceives the associated expectations of others and how confident one is to perform the behaviour (Ajzen, 1985). Smith and colleagues (2008) found attitude toward help-seeking to mediate the relationship between endorsement of traditional masculinity norms and seeking help in young men. Furthermore, the researchers propose three ways through which interventions could increase help-seeking behaviour by influencing men's attitudes: 1. Changing endorsement of traditional masculinity norms, 2. Altering men's attitudes towards mental health services and help-seeking and 3. adapting the nature of the offered therapy to align it more with masculinity norms (Smith et al., 2008).

Changing the endorsement of traditional masculinity norms is suggested to be done by engaging men to think deeply about their attitudes towards gender roles, which has been found to cause long-lasting changes in this attitude in men while a change in help-seeking behaviour could not be observed (Brooks-Harris, 1996). However, since then, no research has been conducted to replicate these findings and it remains unclear if these are still representative today. Altering men's attitudes towards mental health services could be achieved through interventions similar to the one by King and colleagues (2018) described earlier. Adapting the nature of the offered therapy to align it more with masculinity norms could be done by developing a "male-friendly" therapy in accordance with Brooks (2010). This should take place in "out-of-office" settings such as men's groups, offer flexibility for the client and the therapist should emphasize and authentic and empathetic relationship with the client (Brooks, 2010). In addition, the suggestions by Johnson and colleagues (2012) and Jensen and colleagues (2010) discussed earlier should be taken into consideration when designing a male-tailored therapy.

Next to that, educational interventions could be used to improve mental health literacy in men (White et al., 2011). The researchers propose to focus on boys' and men's health in

school to increase literacy and interest in health (White et al., 2011). Similarly, Wynters and colleagues (2021) conducted a school education intervention with adolescent males aimed at increasing mental health literacy by providing information and changing attitudes towards help-seeking and mental health problems through sports-specific examples which showed significant improvements in both literacy and intention to seek help. Similar interventions could be conducted with adult males, for example in the workplace. Similar to the "Help Out a Mate" intervention employed by Wynters and colleagues (2021) who used sports references, it could be beneficial to combine an intervention with a subject of interest to the participants, such as something related to their line of work or hobbies.

Also targeting men's mental health literacy, Hayward and Honegger (2018) propose providing informational brochures and prompt lists of symptoms of common mental health problems in waiting rooms of general practitioners to enhance knowledge in this area. Prompt lists in this context are lists of typical symptoms of disorders. Additionally, men reported finding these lists helpful in bringing up mental health issues in a way that made them less uncomfortable (Hayward & Honegger, 2018). Through such interventions, stigma and feelings of fear that manifest as barriers to help-seeking could be reduced.

Recommendations for future research

As only one study was found that reported on motivators for help-seeking in the target population, future research should be conducted in this direction, especially cross-culturally to establish whether the findings of Alexandre and colleagues (2022) are also applicable outside of Sub-Saharan Africa. In addition, it is particularly relevant to conduct research on barriers and motivators for this population in Europe because of the high prevalence of mental health problems in people living in disadvantaged socioeconomic conditions and the low tendency of men to seek help in this area in the west (StatLine, 2022; Mental Health Foundation, n.d.). Still, to the knowledge of the researcher, no such studies have been conducted in Europe to this day. Drawing from the available data in the current review and other research, it is advised for future research on this topic to use a differentiated operationalisation of SES, employ multiple methods to collect relevant data and recruit participants from different sub-populations.

Firstly, there is no universally agreed-upon definition of the concept of SES. The American Psychological Association (2010) has defined it as one's positioning on the

socioeconomic scale that is made up of a combination of economic and social factors including income, education level, the prestige of occupation and place of residence. Baker (2014) has defined it more broadly as a combined measure of one's social and economic status. The definition of the American National Cancer Institute (n.d.) states that SES is a way of describing people based on income, education and occupation. This shows that definitions vary in terms of the exact variables that are considered part of SES but commonly, some forms of economic and social measures are included. These differences in definition cause SES measurements to not always be reliable and precise and strong correlations between individual measures of SES are not found consistently (Shavers, 2007). Therefore, future studies should employ different economic and social variables such as income, education and occupation to adequately measure SES.

Secondly, barriers and motivators should be investigated both with quantitative and qualitative studies. Quantitative research offers a way to reduce social desirability bias which may be of special importance in this topic due to stigma (Bergen & Labonté, 2020; Byrow et al., 2020). Social desirability bias refers to the phenomenon that participants can give less truthful answers to be viewed more positively by others (Bergen & Labonté, 2020). Additionally, quantitative data could be useful to compare frequencies of mentioned barriers and motivators to identify those that are most commonly encountered. In order to reduce priming, it is advised to use an open-ended item asking participants what barriers or motivators to help-seeking they encounter without any answer options. Qualitative research is useful to explore motivators and barriers more in-depth. For example, in the included studies of the current review, barriers such as fear and shame were identified without further context (Hayward & Honegger, 2018; Slaunwhite, 2015). In interviews, follow-up questions should be asked to clarify what participants exactly mean with certain motivators and barriers and to determine, for example, what exactly participants are afraid or ashamed of to get a better understanding of these issues.

Next to that, it is recommended to collect data both from men themselves and mental health professionals. When only asking men themselves, findings would rely solely on self-reported data and only collecting data from professionals runs the risk that their impressions do not adequately capture the experiences of male patients (Zewdu et al., 2019). Combining both approaches could be a way to mitigate the associated risks although this claim is not yet supported by research.

Thirdly, future studies should recruit participants from differing sub-populations concerning variables such as age, marital status and type of mental health problem to get insight into potential relationships between these and experienced motivators and barriers and to establish which factors seem to be the most important across sub-populations. Participants could be recruited by reaching out to psychiatric institutions, low-income jobs or homeless shelters to gather data from both men who are already accessing mental health services and men who are not.

Furthermore, research suggests that web-based counseling could be a way to increase access to mental health services in men and mitigate experienced barriers (Ellis et al., 2012; Rodda et al., 2013). The appropriateness of this type of therapy should be investigated for men living in disadvantaged socioeconomic conditions by, for example, conducting interviews or surveys in low-income areas and by testing web-based counseling interventions to assess participant's attitude towards and effectiveness of such services. The theory of planned behaviour could be applied by asking men about their attitudes towards therapy and help-seeking to determine their intention to seek help through this medium (Smith et al., 2008). If attitudes are rather negative, interventions such as the ones mentioned above could be conducted to alter them (Brooks-Harris et al., 1996; King et al., 2018).

Lastly, investigating the relationships between individual barriers and motivators could be useful to broaden the understanding of how these operate. Seidler and colleagues (2016) found the relationship between adherence to traditional masculinity norms and attitude towards help-seeking to be partially mediated by self-stigma. While the researchers do not provide a supposed explanation, a reason for this could be that internalising certain masculinity norms while perceiving that one's circumstances, such as suffering from mental health problems, do not align with these could lead to self-stigma in men. However, further research is required to test this hypothesis.

Conclusion

Many men in need of mental health services do not reach out for help. Specifically in men living in disadvantaged socioeconomic conditions, mental health problems are highly prevalent while the factors associated with help-seeking in this population remain poorly understood. Therefore, a rapid review was conducted to answer the research question: What are motivators and barriers to mental health help-seeking in men living in disadvantaged

socioeconomic conditions? The most commonly identified barriers were the desire to solve the problem on one's own, mental health literacy and problem beliefs, structural barriers, financial reasons and stigma-related barriers. Only one study reported on motivators and identified the belief men ought to provide for their families, support of friends and families, and being able to access individual therapy over group therapy in order to preserve one's anonymity. Interventions aimed at increasing help-seeking behaviour in the current target populations are advised to consider these factors and future research should focus on identifying further motivators and verifying the findings of the current study, particularly in European populations.

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Appendix A: Search terms

("help seek*" or "treatment seek*" or "service utili*" or seek*) AND ("mental health*" or "mental illness" or "mental disorder" or "psych* illness" or "psych* health" or "psych* disorder" or "psychotherap*" or "psychol*" or anxi* or depress* or addict* or “eat* disorder*” or psychosis or schizo* or “personality disorder*” or “low wellbeing” or “low well-being”) AND (men or males or man or male or masc* or "gender diff*" or husband* or father* or son*) AND ("socioeconomic*" or "socio economic*" or "socio-economic*" or "income" or poverty or "low educat*" or “social status” or “social class*” or “disadvantaged condition*”) AND (facilitat* or motivat* or enable* or barrier* or disenable* or hindrance* or hindering*)

Appendix B: Data extraction sheet

Title:

1. Author(s)

2. Year of publication

3. Origin/country of origin (where the study was published or conducted)

s

5. Study population and sample size (including age range)

6. Who reports barriers and motivators (patients themselves, their environment, psychologists, doctors etc.)

7. Methodology (design, materials, type of data)

8. Intervention type, comparator and details of these (e.g. duration of the intervention) (if

applicable)

9. Definition of socioeconomic status used

10. Other operationalisations used

11. Theoretical basis (if applicable)

12. Identified motivators/facilitators (and quantities if applicable)

13. Identified barriers (and quantities if applicable)

14. Other relevant outcomes and details of these

15. Relationships between variables and outcomes