Barriers to help seeking in men

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Males continuously account for ~75% of deaths by suicide. The motivation for ~50% of suicides implicate physical and/or mental disorders such as depression and anxiety. Depression and anxiety are two leading causes of global disease burden and disability, however not all those suffering with symptoms will seek help. Increased mental health literacy through formal education, such as psychology or mental health education, may lead to a greater awareness of the symptoms of anxiety and depression, and the potential repercussions if left untreated, and may therefore promote help-seeking. This study investigated whether awareness of anxiety and depression symptoms among men in the North of England related to help seeking behaviours by conducting two separate focus groups among men with (i.e., psychology students) and without formal mental health education. A thematic analysis on the resulting data identified four main themes: (1) sex differences; (2) knowledge; (3) individuality; and (4) influences on help-seeking – each with subthemes. Findings support existing research suggesting increased mental health literacy improves the ability to recognise symptoms of anxiety and depression, however this does not promote help-seeking behaviours. Barriers to help seeking behaviours revealed the main deterrents included mental health information, support, and treatment not catering to male needs. The findings highlight the need to separate research and interventions on males and females in order to tailor approaches and treatments appropriately, indicating a "one-size fits all" approach to mental health and well-being does not apply.

Keywords: barriers; male psychology; men's mental health; sex differences; suicide rates

In recent years, the importance of acknowledging mental health conditions has increased. Such conditions have become prevalent throughout populations and are now even observed in around 20% of children and adolescents worldwide (World Health Organization [WHO], 2022). While some individuals can manage their mental health conditions for years, some are prone to die prematurely by suicide. Deaths by suicide have remained at approximately 5,000 annually in England alone over a 40-year period (Office of National Statistics [ONS], 2021). Furthermore, year-on-year approximately 75% of completed suicides are by males (ONS, 2021) despite research indicating females present greater risks of suicidal ideation and attempts (Miranda-Mendizabal et al, 2019), indicating suicide is a gendered issue. In a time where public awareness of issues related to mental health and well-being is at an all-time high, and modern interventions to support mental health, such as mobile phone apps (Bakker et al., 2018), are freely available and easily accessible, the fact that death by suicide has remained at consistently high levels is concerning and demands urgent attention. The current research explored the understanding and awareness of symptoms and triggers of common mental health disorders, anxiety and depression, in a male-only sample, as well as factors promoting or deterring help-seeking.

Jobes and Mann (1999), investigating individual's reasons for living (RFL) and reasons for dying (RFD), identified dying to be considered as a means of escaping one's individual circumstances, whereas RFL centred around enjoying future events and milestones. This highlights the importance of a positive mindset relevant to individual circumstances in encouraging RFL over RFD. However, research from New Zealand suggests that suicidal ideation may be considered a socially acceptable way of escaping one's life stressors particularly among adolescents and young adults (Stubbing & Gibson, 2019). It seems logical to suggest that suicide being a socially acceptable response to RFD would negatively impact on the ability to maintain a positive mindset, further increasing risk of suicide. However, much of this research comes from female participants, therefore the findings may not be fully applicable to understanding the gendered disparity of suicidal ideation and completion.

Maintaining optimism for the future, and therefore RFL, becomes increasingly difficult in the face of adverse life events, which contribute to RFD. This may be further exacerbated when individuals are experiencing symptoms of mental illnesses such as anxiety and depression (MacLeod & Byrne, 1996). Anxiety and depression are two of the most prevalent and leading causes of global disease burden and disability (WHO, 2021) and research suggests that 50% of suicide motives originate from physical or mental health disorders (Fegg et al., 2016). Depression has an aggregate prevalence of 14.4% for women and 11.5% for men (Lim et al., 2018) and common symptoms of depression include disturbed sleep, feelings of guilt and low self-worth (National Health Service [NHS], 2022) with severe cases of depression impairing quality of life and increasing suicidality (Cuijpers & Smit, 2002; Trivedi et al., 2010). The association between major depression and suicidality has been demonstrated consistently across various methodological designs and population samples (Chachamovich et al, 2009). Identification of such links would suggest that through treating depressive symptoms, RFD, and therefore suicide, may be reduced.

Generalised anxiety disorder (GAD), highly comorbid with depression, is characterised by persistent, excessive, and uncontrollable worry, reducing quality of life (Yu et al., 2018) and therefore potentially increasing RFD. Symptoms of anxiety can be difficult to recognise because some anxiety is to be expected in everyone – the difficulty can come in identifying when this is excessive. The development of anxiety symptoms can be very slow and are often independent of specific triggers, making it harder for an individual to identify that they are experiencing anxiety (Beyond Blue, 2022). Symptoms of anxiety include panic attacks, restlessness, muscle tensions, excessive fear, catastrophising, and obsessive thinking. The co-occurring nature of anxiety and depression further increases the difficulty for individuals to identify symptoms of either one or both disorders they may be experiencing further exasperating RFD and struggles in identifying RFL. It is therefore imperative that individuals can identify symptoms of anxiety and depression and seek help in a timely manner to help combat suicide.

Advances in public health has led to greater accessibility of knowledge and interventions for those with anxiety, depression, or suicidal ideation. Many good quality resources are freely available online, by smart apps, and in person in the UK, such as NHS online, local general practitioners (GP), and charities such as Samaritans, Young Minds and CALM. Depression and anxiety are typically treated via pharmacological and/or psychological interventions. Psychological treatments such as cognitive behavioural therapy (CBT), psychotherapy and mindfulness are usually preferred because they can promote positive mental well-being (Strohmaier et al., 2021) without adverse side effects, which may

improve RFL. Indeed, CBT has been shown to be effective for treating anxiety in randomised control trials (Otte, 2011) though remission rates are around 50% (Springer et al., 2018).
In cases where symptoms are persistent and/or severe, pharmacological treatments may be recommended instead of, or as well as psychological treatments. However, adverse side effects are common with pharmacological treatments, including sexual dysfunction, weight gain and insomnia (Hirschfeld, 2003; von Moltke & Greenblatt, 2003). These adverse side effects may negatively impact on wellbeing and increase RFD and deter people from continuing with the treatment. Evidence suggests a combined approach towards treating depression and anxiety is more effective than either treatment in isolation (Cuijpers et al, 2020; Springer et al., 2018). However, a recent metanalysis examining remission rates in anxiety called for a more nuanced approach to the understanding and awareness of how anxiety presents differently in different people (Springer et al., 2018). The authors suggested this would help develop more tailored approaches to the treatment of anxiety leading to higher remission rates. The gendered nature of suicide ideology and completion suggests this is an important factor to consider in terms of understanding different symptom presentations, the effectiveness of different treatments, and differences in help seeking behaviours.

In addition to widely available support from the NHS and various charities, technological advances have made it even easier to access good quality information about the symptoms of anxiety and depression, and to identify sources of support for those experiencing these symptoms and/or suicidal ideation. Some apps exist where individuals can interact asynchronously with qualified clinicians, however uptake and engagement with such apps is poor (Fleming et al, 2018). This suggests that despite the flexibility of appropriate mental health support, and the high quality of such support, barriers remain in terms of accessing such support.

One aspect that may impact help-seeking behaviour concerns mental health literacy and disorder recognition. It seems logical to suggest that individuals experiencing symptoms of anxiety and/or depression would need to be able to identify them as such in order to initiate help seeking, and greater awareness of symptom variation and prevalence may aid recognition. In a mixed male and female Saudi-Arabian sample, Aletesh et al., (2021) found that although the majority could identify at least one symptom of depression, only 26.4% of the sample were able to correctly answer more than 75% of the remaining questions about depression. This suggests that, though there is *some* awareness around symptoms of depression, the extent is limited. However, the link between disorder recognition and help seeking behaviour may be more tenuous than one would expect. Research suggests that though greater mental health literacy increased one's disorder recognition ability, this did not necessarily translate into greater help seeking behaviours (Tomczyk et al., 2018). Research in England consistently shows depression to be more prevalent in females than males, and likewise help seeking behaviour is likely in females (Asher et al., 2017; McManus et al., 2016). This may partially account for the sex difference in suicidal ideation and completed suicides. It is therefore important to examine the links between mental health literacy, disorder recognition, and help-seeking behaviour specifically in males to help us to understand why suicide occurs more in males and identify steps to reduce this.

Research into the male experience of disorder recognition and subsequent help seeking behaviour is somewhat limited, however it suggests that males view depression as something to be managed privately because help-seeking behaviours conflict with social constructions of masculinity (House et al., 2018). While stigma associated with mental illness can deter help seeking in anyone (Curcio & Corboy, 2020), this indicates an additional barrier to help seeking applicable to males. Specifically, House et al. (2018) suggest males with depression must overcome a considerable amount of shame to engage in help seeking behaviours due to internalised stigma surrounding the conflict between masculine norms and seeking help. This offers a further explanation as to why females are more inclined to seek help for mental health disorders than men, which may also help explain sex differences in suicidal ideation and suicide completions. However, Grant et al. (2016) suggest that self-stigma associated with mental illness is reduced in those with greater mental health literacy, indicating greater mental health literacy may support men in overcoming the conflict with masculine norms in order to seek help for mental health disorders.

With male suicide rates in England remaining consistently around 75%, despite females being more likely to experience anxiety, depression, and suicidal ideation, there is a clear gap in help-seeking behaviours. Females are more likely to seek help for mental health difficulties, which may partially explain why more men consistently complete suicide. Despite the increased availability and flexibility of resources, males continue to avoid seeking help for common mental health problems (Beckstein et

al., 2021). Potential contributing factors to this include stigma around having mental health difficulties, conflict with masculine norms which promote stoicism and dealing with mental health difficulties in private, and differences in mental health literacy and how this may impact on disorder recognition. Examining these inter-linking factors further may ultimately help us to bridge this gap and may help reduce male suicide rates. The current research therefore the perceptions and awareness of symptoms of anxiety and depression in male participants with varying levels of mental health literacy to examine potential barriers and facilitators of help-seeking behaviours. With limited research conducted specifically on males, this research will help elucidate some of the complex factors which contribute to the high rates of male suicide.

METHOD

Participants

Two samples of male participants were recruited from social media advertisements and from the University's psychology participant pool. Participants accessed the information sheet, hosted in Qualtrics, via weblink. Participants were all male aged over the age of 18 and living in the North of England. Those who felt discussions of suicide, depression and anxiety may trigger adverse mental health responses were advised not to participate. One sample of participants included psychology students, i.e. those with formal mental health literacy education (N = 4, aged 21-31, M=27, SD = 3.74). The second sample had no formal mental health literacy training (N = 4, aged 35–44, M = 39.25, SD = 3.49). No incentives were provided for participation, though psychology students gained partial course credit. Ethical approval was granted by the Institutional Research Ethics Group of the University of Sunderland.

Design

This study employed a qualitative design, using semi structured focus groups to explore the attitudes and knowledge of two demographic groups. The focus groups utilised both open and closed questions to encourage participant engagement in discussions. Using an inductive approach, thematic analysis was used to identify, analyse and report themes within the data. Thematic analysis was considered the most appropriate method for this data collection due to its flexibility and exploratory nature (Braun & Clarke, 2006)

Materials

Qualtrics was used to provide participants with the study information sheet and to collect consent and demographic information. Twelve questions were designed based on the literature reviewed to explore the participants' perspectives and knowledge relating to symptom awareness, disorder recognition, and treatments for anxiety and depression as well as their approaches to help-seeking for these disorders. Two separate focus groups were held, audio recorded, and transcribed verbatim using the online software Otter.ai.

Procedure

On consenting to participate, participants provided demographic information and arrangements were made to attend the University to conduct the focus groups. Upon arrival each participant was met by the researcher and introduced to the other participants. Before entering the recording suite, the study information sheet was overviewed verbally by the researcher, as well as covering ground rules, including the procedures should anyone wish to withdraw from participation. Recording devices were then started and the researcher worked organically through the schedule to allow for flexible discussion around all twelve questions. Participants were then debriefed and thanked for their participation.

Data analysis and results

Due to the exploratory nature of the research, data were analysed using Braun and Clarke's (2006) six-step thematic analysis process. Transcripts were read multiple times for data familiarisation, then initial codes were generated. Only content specific to the UK and UK systems and processes were analysed requiring the exclusion of discussions involving therapeutic experiences in Greece by one

participant. Both semantic and latent themes were then searched for within the codes, and a thematic analysis map was generated. Four themes and nine subthemes were defined and named (Table 1).

Table 1
Themes and subthemes identified from thematic analysis

Theme	Subtheme	Quotes (participant number, page number: line number)
1.Sex differences	1.1. Priority	*"there's more out there for women for that kind of support."* Participant 1.
	1.2. Social gender roles	*"I think stuff like depression, anxiety, things like that. It's sort of always been seen as more of a female sort of issue.*" Participant 4.
2. Knowledge	2.1. Sources	*"Just from watching, you know, close family members"* Participant 2.
	2.2. Depth and influence	*"I feel very fortunate that I am a psychology student. And I've always worked in health care and have that knowledge behind me."* Participant 7.
3. Individuality	3.1. Help-seeking	*"There's someone wanting some intervention, and then there's actually getting the right intervention, because they're two different things."* Participant 2.
	3.2. Treatments	*"I was annoyed that the treatment that I got that didn't look at the situation going on in my life."* Participant 6.
4. Influences on help-seeking	4.1. Self	*"You've got to recognise there's a problem."* Participant 2.
	4.2. Others	*"if I wasn't encouraged by my family members I probably wouldn't have, probably would not have done the therapy."* Participant 7.
	4.3. Accessibility	*"It's got to be accessible for you to be able to continue it."* Participant 2.

DISCUSSION

Gender differences

Theme one consists of two subthemes centred around perceptions and experiences of gender inequality in mental health support. Participants perceived female mental health to be prioritised by support services whereas male mental health is often overlooked. Participants also expressed perceptions of a female-focus on psychological treatment and support. Together, these perceptions deterred participants from seeking help, reinforcing the stigmatising view that support for mental health conditions is female-specific whereas males must manage mental difficulties in private.

Priorities

The non-student participants consistently reported views around mental health awareness and support being female-focused. This perception may contribute to the pressure of socially constructed masculine norms around men remaining stoic and dealing with mental health difficulties alone in private, deter help-seeking behaviours and ultimately exasperating ill mental health. These perceptions may further compound an individual's RFL versus RFD by contributing to feelings of worthlessness due to being a low priority. Participants acknowledged that help for mental disorders is available for males and females, but there symptoms and triggers may manifest differently and therefore a more balanced and equitable approach to disseminating and promoting information and resources would be welcomed.

> "*I don't think that's like, sexist, where women get more support... I think it's more about the things that go on maybe in the social media... like seeing murders and stuff as women get beaten up by men and murdered so there's more out there for women for that kind of support. But the men still need the support... I think it's the need to be more aware that like, suicides of men are a lot higher, like 3 to 1 so like, there should be more out there for men as well as women like because then you'd know what to do or where to go to.*" Participant 1.

Participants expressed that the perception of female-focused mental health awareness and support is useful for disorder recognition and help-seeking in females, but it negatively impacts male help seeking and disorder recognition: "*They're being given the platform to do that, and men aren't getting the platform to come forward. And maybe that's why they don't open up as much."* Participant 1. Recent research called for direct research into the male experience of treating anxiety in order to improve clinical care and public health resources (Fisher et al., 2021). This would promote more male-friendly approaches to help-seeking for mental disorders, which would ultimately increase men's RFL over RFD. However, one participant suggested male-focused support would not help if it was not utilised: *"When we have issues we don't speak out...so then why would why would it be given more advertising if we don't speak up?*" Participant 4.

Men have been found to avoid seeking help for mental health disorders, choosing instead to attempt to address issues alone (Fisher et al., 2021). However, participants indicated that even when willing to discuss mental health issues, there remains a reluctance to do so with medical professionals because they do not feel their issues are taken as seriously as females presenting with similar difficulties.

> "*If I want to take two minutes, he doesn't sit and see how you feel, or how is your mood. But when my wife goes in, he asks how she's feeling, in terms of her mood, as opposed to just other stuff."* Participant 4.

Feelings of dismissal extended to tangential encounters with medical professionals, for example one participant recalled the following during the birth of their child:

> "*If you go in a hospital, when you're with your wife, or whatever. And obviously, yes, the lass is having the bairn. But everything is aimed solely at how they are feeling and how they're feeling after. There's not even a thought of what the man's involvement is."* Participant 4.

There is little acknowledgement generally of the changes males experience during the transition to fatherhood, however as well as psychological and behavioural changes, men also undergo many

hormonal changes (Bakermans-Kranenburg et al., 2019). While this does not discount nor undermine the female role in gestation and birth, which is extremely demanding physically and psychologically, men are clearly also in need of support at this time.

Social gender roles

Non-student participants expressed greater concerns than the student group around sex differences in society, and how stereotypical expectations of males can affect help-seeking behaviours.

> "*If you think back historically I think stuff like depression, anxiety, things like that has always been seen as more of a female sort of issue. And I think that's sort of where the focus has been…gradually, it's starting to shift along…but that's where the focus always was.*" Participant 4.

> *"It is hard for men to do it, I think you feel like you can't really speak…I don't want to put on them I don't want to be like feel like I'm a burden."* Participant 1.

The impact a disorder may have on family and friends was also identified as a concern:

> "*You don't want to bring down your partner's mental wellbeing either. As a male, you just you just want to get on with it and try and fix it in your own mind. And you don't want to bother anyone else, your family or your friends…you just want to fix it yourself.*" Participant 7.

These views reflect research by House et al., (2018), who also identified that males view mental health issues as something to be managed in private because of the conflict between help seeking behaviours and socially constructed gender role expectations. However, participants still indicated psychological treatment would be a preferred treatment, *Talking [treatment] for me, that's basically my personal experience. That's my preference all day long."* Participant 1; "*I mean, I've never had [psychological treatment] but I would definitely think that kind of treatment would be preferable to drugs or medication."* Participant 3. Despite reporting a preference for psychological therapies, participants felt these services did not cater to men's needs: *"I know it sounds daft, but [the GP asking how I am] it's just a tiny little thing like, I don't think there's the awareness. And I don't think they asked as a man."* Participant 4.
The views discussed provide insights into why men are reluctant to engage in help-seeking behaviours; specifically, the pressure they feel due to male gender roles and the perception that support services are not tailored to men. Kingerlee et al., (2019) suggests this 'one size fits all' approach to mental health care ultimately deters men from initiating and/or sustaining psychotherapy (Seidler et al., 2018b).

Knowledge

Both student and non-student participants indicated knowledge of anxiety and depression. They were able to list specific symptoms and treatments for both disorders and showed awareness of the similarities and differences between them, including symptom manifestations and their triggers. However, similarities across different symptoms could lead to difficulties in disorder recognition. Though a range of knowledge was demonstrated across all participants, these subthemes concern the *source* of that knowledge, and how knowledge can influence help-seeking behaviours.

Source

Participants' knowledge of anxiety and depression came primarily from first-hand experiences, and/or the experiences of a loved-one. They learned through such experiences about identifying symptoms and different approaches to treatments: *"I see quite a lot of [anxiety symptoms] with my nephew he suffers really bad, there's something that just triggers in his brain, he just almost freezes and can't do anything, and he can't explain why."* Participant 4; *"Just from watching close family members."* Participant 2; and "*just in my experience of having depression and seeing people who I live with have depression."* Participant 7.

Personal experiences were a great source of knowledge especially for the non-student participants. When asked how further information could be sourced, non-student participants indicated they would look on the internet, though they did not offer specific examples or sources, indicating

knowledge about anxiety and depression was primarily gained through experience rather than through official sources: *"If you ask me where I would go, I'd have to google it."* Participant 3. Though there is a positive association between disorder literacy and disorder recognition (Tomczyk et al., 2018), this research suggests disorder literacy does not necessarily need to come through formal education or training, because close personal experience aided disorder recognition.

The student participants also offered online suggestions for seeking further information about symptom and disorder recognition, however they offered specific suggestions. Aside from the GP, student participants suggested NHS online, or online diagnostic manuals such as the DSM or IDC: *"A lot of people will just research this sort of stuff online, by just, you know, going on the NHS websites or you know, using these, like, online sort services."* Participant 6. This suggests that formal mental health education and training may be advantageous in sourcing more accurate and relevant information.

Depth and influence

More specific and detailed knowledge of mental health disorders were often displayed by student participants, including the likelihood of anxiety and depression co-occurring and/or the degree of overlap between the symptoms. Students demonstrated wider knowledge of the treatment for anxiety and depression as well as help-seeking and awareness of treatments including specific and common therapeutic approaches. This was perceived by participants as advantageous: *"I feel very fortunate that I am a psychology student…having that insight I think is important."* Participant 7.

While student participants reflected on the advantages of increased disorder literacy, non-student participants discussed help-seeking concerns related to their limited awareness: *"You also might have a concern about what seeing somebody might lead to, you might not want to take it that far initially because you might have read something or heard something."* Participant 3. Lack of formal education or training may make it harder to identify appropriate sources of information, instead finding incorrect or contradictory information, or information may be misinterpreted: "*I think you'd research it, but whether you'd act on it because of believing what you'd researched is different."* Participant 2.

While it can be observed that mental health knowledge can be gained from multiple sources, those with increased academic literacy display advantages in the recognition of developing symptoms and disorders. As a result of increased academic knowledge, individuals are also able to source more accurate information and support, as well as having an awareness of treatment procedures in advance. Such advantages may promote positive optimism for the future supporting RFL, while potential feelings of hopelessness or fear expressed by those with less knowledge may increase RFD.

Individuality

Participants who had experienced mental health difficulties and help-seeking themselves also described treatment and support as lacking individuality. This led to the development of two relevant subthemes: the first concerns a lack of individuality in help-seeking, and the second a lack of individuality in treatment.

Help-seeking

When participants were asked about sourcing information about mental health and illness, responses overwhelmingly involved the internet. However, this seemed to be a double-edged sword because although it is easily accessible, it can be difficult to ensure the quality of the source and information can lack personalisation. This can increase confusion, impacting on barriers to disorder recognition and help-seeking, which may ultimately affect RFD: "*When you go on Google and search, 'I've got anxiety'…you read things and then it causes anxiety. Well, I'm dying! And it turns out, you've got a broken toe or something."* Participant 4. *"Yeah, you could even…follow some psychometric for depression and you might even come up with clinical depression. What does that actually mean? You've got depression?"* Participant 6. Generalised information and self-misdiagnosis were linked to a potential misunderstanding of current symptoms being a result of a clinical disorder rather than situational:

> "*It's hard to distinguish something you should feel sad about, and it's a natural response, and we have something that's pathological. I think that's why a lot of these online resources…they're not really fit for purpose because you could you know, your parent or your parents just died, or something bad just happened like broke up with*

> *girlfriend or whatever. You've got all the symptoms of depression, you've had it for over a month so like, you go online and now looks like you've got depression by reading in this sort of stuff*." Participant 6.

This lack of individualisation extended to those who had experience of approaching the GP for help with mental health difficulties. The consensus among participants was that visiting a GP can often be a negative experience, increases the sense of hopelessness, and impacting on RFL and RFD: *"Docs not so sympathetic…my experience, you know, to just try me on some tablets, if it doesn't work we'll change them just seems to be the answer."* Participant 2. *"Even if support's there, it's not coming over as a priority."* Participant 3. The lack of individualised support from GPs was believed to be primarily a result of inadequate appointment time, and secondly poor generic advice. *"If I was to speak to someone, I wouldn't ever say I would just see a doctor because you don't get that time. You don't feel as though the supports there from your doctor."* Participant 1. *"They give you the packs to read, the information packs. And… it wasn't for me at all. I'm not going to, I'm depressed, I don't want to read like these big, long books of depression."* Participant 7.

Clearly the prevalence of mental health difficulties in the UK, such as anxiety and depression, warrants further attention and funding due to the personal burden and the increased demand on public services. We know the male perspective on such issues is already lacking, and participants indicated they feel males are a low priority in accessing help and support, however this theme suggests that a lack of individualised information and support may cause a larger deficit in terms of help seeking rather than bridging the gap.

This subtheme mirrors aspects of the second theme, 'Knowledge', where those with improved mental health literacy are better able to identify symptoms and differentiate between situational and pathological causes. This confusion could potentially impact on RFL and RFD by further decreasing optimism through increasing anxiety and hope for the future.

Treatments

Participants also perceived approaches to treatment lacked individualisation:

> "*I was probably only like 19 or 21 when first got put on antidepressants and I felt like there was like there was so many other things going on in my life that were situational, like I was drinking I was using drugs and stuff which they kind of new about which I thought was surprising them giving me antidepressants and stuff they're really strong ones that I'm struggling to get off now."* Participant 6.

Participants viewed the overly generic approach to treatment as a way of GP's achieving fast symptom relief and patient turnover, which deterred participants from seeking help: "*My experience, to just try me on some tablets, if it doesn't work we'll change them, just seems to be the answer."* Participant 2. Responses indicate that while some individuals may respond well to medication, others may require a different treatment approach, and one that provides an understanding of symptoms in order to alleviate symptoms.

> *"If you do phone the doctor or go into the docs and you're sitting there, and they're like I'll give you…these tablets, that will help you and that's not really the help you want you want. You want that like more support, we don't have a proper chat.*" Participant 1.

Research suggests that males prefer psychological treatment, such as therapeutic approaches, often with a clear structured approach (Seidler et al, 2018a; Seidler et al., 2018b), for example, men (rather than women) tend to emphasise the importance of achieving practical, structured solutions in psychological therapy as opposed to 'just talking' (Emslie et al., 2007). These findings support Fisher et al.'s (2021) suggestion that male-focused research will help tailor treatment approaches to better suit their needs. This would help increase the likelihood of men seeking professional help and reduce the sense of hopelessness in the face of struggles. This was a notion reflected in the current study whereby participants who were able to access personalised psychological help reported positive experiences: *"I felt better once I was speaking and getting it out… to friends, family, colleagues, as well as [redacted] Mind…it all came out then. I just felt relieved."* Participant 1. Generalised approaches to therapy made participants feel like they were being rushed through the system and ultimately deterred them from engaging:

> "*The counselling I've seen tends to have a limit as to how many sessions you get, what a course looks like in terms…treatment time and then after that, it's like right, we've done what we can you need to use the tools you've been given to just progress…it's not for me I've seen it not stop and then revert back again."* Participant 2.

When participants were asked about the likelihood of seeking professional help for anxiety or depression, those who had previously sought help responded similarly: "*Not me personally, no, because I think they were trying to medicalise everyday feelings of sadness."* Participant 6, and: "*I wouldn't be willing to, just my experience was terrible.*" Participant 5,. An important factor in the efficacy of individualised therapy highlighted here was that the therapist and client were aligned and able to work in alliance:

> *"It's all about that person that's giving you that therapy. If they can open you up and…ask certain questions, talking on a level where you can just open up then you'll go back again and again. But I think if you get someone who's sitting there and, maybe got their feet up and they're just taking notes saying how do you feel, that wouldn't work so I don't think I'd go back.*" Participant 1.

While psychological treatments have been shown to be effective, negative experiences of treatment can cause symptoms to increase (Crawford et al., 2016). Increased suffering following treatment may decrease optimism for the future. Together, reduced optimism and increased symptom severity may cause RFD to increase. Though this is a serious outcome, it is thought to affect a minority of individuals due to a lack of knowledge about how mental health difficulties are approached and treated (Crawford et al., 2016). This further supports the suggestion that increased mental health literacy can help disorder recognition and help-seeking, as well as the importance of developing tailored approaches to mental health support.

Influences on help-seeking

An important influence on help-seeking for these participants identified was previous experience, either their own or of a loved-one. Three subthemes were identified, encompassing both positive and negative influences on: their own experience, the experience of others, and experiences of accessibility of mental health support.

Self

Help-seeking serves to gain relief from unwanted symptoms, whether mental and/or physical (Fegg et al., 2016), which are the main contributors of RFD (Jobes & Mann., 1999). The student participants indicated their greater mental health literacy afforded them a greater awareness of the benefits of treatments, increasing the likelihood of help-seeking before symptoms escalated, and therefore helping retain elevated RFL over RFD: *"I feel very fortunate that I am a psychology student. And I've always worked in health care and have that knowledge behind me."* Participant 7. Despite increased mental health literacy, knowing *when* to act was still considered difficult because of the cyclical nature of symptom development and reduction: *"Because depression could come in waves, by the time it comes around to you having that therapy, actually you might feel alright, then you don't fancy speaking to someone, and then you're in this cycle."* Participant 5. This was reflected in the non-student participants too who indicated they found it harder to identify symptoms in themselves than in a loved-one: *"It's harder as a person to recognise and go oh it's me with a problem, whereas if other people see it, then you might start waking up to it".* Participant 1. This view links back to the difficulty in knowing whether symptoms are reactive due to situational events, or whether they indicate something pathological requiring professional help: *"You might have the notion of it, but until you get a diagnosis or something, you can't ever be certain about it."* Participant 8.

A further barrier to the identification of symptoms was suggested to be denial: *"[People] might play it down a little bit. You might not want to admit to yourself you're feeling these things."* Participant 3. This lack of objectivity when considering symptoms in oneself negatively impacts on a person's willingness to seek help: *"I think you'd research it, but whether you'd act on it because of believing what you'd researched is different."* Participant 2. These responses reflect previous literature regarding the positive association between symptom recognition and help-seeking behaviours; specifically, individuals need to be able to recognise symptoms within themselves otherwise they will not be motivated to seek help (Palazzo et al., 2014; Tomczyk et al., 2018).

Others

Participants identified positive and negative views, actions, and experiences of others. Students acknowledged that having had loved one's experience mental health difficulties, they were able to increase their own self-awareness around such issues and improve their own likelihood of engaging in help-seeking behaviours. As well as gaining through second had experience, loved ones were identified as sources of support throughout treatments, encouraging continued engagement with treatments, and/or helping maintain a positive focus while waiting for treatments: "*There was a lot of times where if I wasn't encouraged by my family members I probably wouldn't have done the therapy…I'm very fortunate to have those around me who did encourage me to take the opportunity of getting therapy.*" Participant 7; and: "*From experiences I think sometimes you don't necessarily know things aren't right. I think you need external contacts, so I think that's what stops people with going for help.*" Participant 2. Again, this reflects findings from previous research whereby loved ones play a key role in whether individuals seek professional help (Han et al., 2018).

There was a concern around speaking to others about one's mental health difficulties and the risk that they may have poor knowledge, give poor advice, and potentially contribute to declining mental health and deterring help-seeking behaviours:

> *"If you went [to my place of work] all of them are out there and loud. If you're trying to talk about depression or anxiety with them, they will just be like no you are a man you just need to do this…so then at that point… you kind of go back into yourself."* Participant 4.

A related concern around disclosing mental health difficulties to others involved the potential for being stigmatised: "*It's probably a concern about other people judging us. If you have to tell people at work or friends or family."* Participant 3. Fears around stigma relate back to the importance of, and benefits of increased knowledge of symptoms of mental disorders and their triggers, as well as the importance of having supportive people around you to maintain optimism.

Another factor relevant to the subtheme of 'Others' concerns how individuals felt about their own symptoms impacting on their loved ones. Participants indicated that this in itself could potentially promote help-seeking behaviours due to a fear of negatively impacting on those around them:

> *"Well, it's one of those things where like, if you see someone who just looks depressed, it's like it's not really a big thing. When you see someone who looks anxious that puts other people on edge. So, like if you're anxious and you're talking to someone they pick up on the fact that you're anxious and then they do something anxious."* Participant 6.

This subtheme highlights the important, multi-faceted impact of those around us in terms of help-seeking behaviours. However, an important point to note here is how men appear to be treated differently in regard to mental health concerns, or at least there is a perception that they will be treated less favourably than women would be in similar situations. The perception that men should not, or cannot, seek mental health support, an artefact of stereotypical gender roles, further deters males from seeking help, decreasing RFL and increasing RFD. This further increases the likelihood of men engaging in risky behaviours, such as substance and/or alcohol abuse, as an alternative coping method, further contributing to a decline in mental health (Bolton et al., 2009; Robinson et al., 2009).

Accessibility

When contemplating reasons for and against help-seeking, access to services was identified as a prominent barrier. While self-help methods were reported to be easily and readily available, seeking professional help was viewed as a difficult and timely act, often with negative outcomes. Accessing professional help was seen to be a long, drawn-out process with many loopholes to jump through to access it. Waiting lists of eighteen weeks are common in England; extensive waits have been shown to exacerbate negative mental and physical health issues, previously identified as major causes of suicides in England (Punton et al, 2022):

It's referral after referral... then you wait maybe another six months before seeing them again...when I have reached out you're waiting that long thinking, what's the support? Is it just a tick box or is it really support, we have that long to wait to get support, maybe it's then too late?" Participant 1.
When help services are obtained, mixed outcomes were described; some responses suggested that the benefit of receiving treatment outweighed negative stigmas, while some participants reported difficulties with the services provided:

> *"It's got to be accessible to like coming back to your point around impacting work and time, it's got to be accessible for you to be able to continue it."* Participant 2.

Difficulties round accessibility decreases willingness to engage in the preferred phycological treatments, because pharmacological alternatives are more readily available and are therefore likely to be offered at an earlier stage of help-seeking: *"Not a fan of drugs in any way, shape, or form but I suppose...it might just be you know, what, if the meds block it out, it's an easier option, rather than going and talking to someone?"* Participant 4. Such difficulties in receiving professional support and the preferred treatment methods, along with willingness to engage with an alternative treatment approach which may cause unpleasant side effects, may decrease RFL and increase RFD.

Limitations

This study relied on a male-only demographic to further understand males' reluctance to engage in help-seeking behaviours. Previous research primarily considers female participants therefore, although the current findings are not generalisable to females, it compliments previous research, allowing male voices to be heard. However, this does make it difficult to integrate the findings of the current study with previous research, for example, Tomczyk et al., (2018) relied on female and male participants when considering the influence of mental health literacy on help-seeking behaviours, however males only accounted for twenty seven percent of the participant sample, therefore it is not clear how much of their findings are truly applicable to males.

A further consideration in terms of generalisability is that the current sample were all males from the North of England. Results therefore may not apply beyond this region, however it is reasonable to expect that results would generalise to similar regions at least. This region is generally a working-class region, where resources, including in professional services such as the NHS, are stretched and difficult to access. This may explain some of the points raised in the focus groups, however it is expected that some of these suggestions, such as the availability of professional services, would be applicable beyond this region, particularly in regions without government-subsidised healthcare. Though this sample is very localised, we have reason to believe that some of these findings would extend to a global context, for example, the need to incorporate local masculine norms in order to tailor therapy for males will likely encourage men to engage in help-seeking behaviour.

An additional limitation to the accuracy of findings in the current study, may result from the semi structured focus group approach. While each focus group contained only four participants, and attempts were made by the researcher to create a relaxed, friendly and safe environment, discussing sensitive topics in front of others may have caused a degree of social conformity. Quieter participants may have felt obligated to agree with the opinions of more vocal group members, or indeed may not have had the chance to express themselves. However, feedback following the focus groups indicated that the focus groups were very professional and supportive and that participants did feel comfortable in discussing these issues.

When recruiting participants for the current study, non-academic participants were expected to provide a baseline level of mental health awareness to allow identification of any benefits of academic mental health literacy. This however was impacted by both demographic groups having extensive first-hand experience of anxiety and/or depression which was found to be a main source of knowledge, meaning this comparison was not as clear cut as we had expected. However, this may suggest that formal mental health education or training is not as important in symptom recognition and help-seeking behaviours as we initially expected. It may be that exposure to mental health difficulties either first or second hand provide comparable benefits in terms of help seeking behaviours. This could be further examined by including participants both with and without first or second-hand experiences of mental health difficulties, as well as with and without formal education or training.

Future research

In addition to recruiting participants both with and without formal mental health education, and with and without first or second-hand experience of mental health difficulties and exploring how these factors impact on help-seeking behaviours, it would also be beneficial to conduct focus groups with other demographics of male participants, including different age groups in order to identify whether awareness of such issues changes across the lifespan.

The importance of individuality during professional assessment and treatment approaches for mental health issues was highlighted throughout the current findings, supporting Fisher et al., (2021) who recommended more male focused research was required to better tailor clinical and public health services. To further address this issue and the actual or perceived barriers to males accessing professional help, a comparison of the needs and preferences of men against current and potentially future available resources would be recommended. This would identify if men's needs were able to be met now or in the near future. Findings from such research may also provide useful suggestions to health service providers for improving their existing services.

Finally, the current research specifically examined knowledge of mental illnesses and how they relate to help-seeking behaviours, however there are further factors which impact on help-seeking, and ultimately on suicidality, that warrant exploration. For example, some of the biggest triggers of male mental health difficulties and suicide are loss of status, financial difficulties, and relationship breakdowns (Knizek & Hjelmeland, 2018). Examining how these factors interact with those in the current research, and across different regions/nations will further help to strategies effective mental health services for males.

CONCLUSIONS

This study sought to investigate the reluctance of male help-seeking behaviours for mental health disorders, despite the risks this may pose. Findings support theories that increased mental health literacy is associated with an increased ability to: recognise mental health related symptoms, locate accurate and credible disorder information, and show awareness of treatment options and the therapeutic approaches. Participant responses within this study however also strengthened findings that despite increased literacy and positive intentions of help-seeking, engagement in such behaviours has little correlation with mental health literacy.

Despite increased disorder awareness not necessarily translating to increased help-seeking behaviours, it may well increase optimism for the future, increasing individuals RFL and potentially deterring suicidal acts or ideation. While increased awareness positively influences RFL, additional barriers to help-seeking identified within this study may also increase RFD, and therefore influence suicidal acts as a means to escape current difficulties. While the benefits of treatments were acknowledged by participants, the main deterrents to help-seeking were generalised mental health information, generalised support and treatments, and difficulties in accessing necessary treatments, in particular psychological treatments. Current findings therefore further support the necessity of increasing research with male samples, specifically assessing experiences and effective treatments, in an attempt to better tailor future health services, public awareness and the wellbeing of men.

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