Help-Seeking Among Men for Mental Health Problems

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In this chapter, we will first review the current situation regarding the mental health of men. We will then review help-seeking among men and women before describing important factors which may contribute to men being less likely to seek help from mental health professionals. We will then go on to describe recent positive work that has been carried out on male help-seeking and suggest some ways forward.

The Mental Health of Men and Boys

The pattern of mental health problems among males changes with age. During early years, it is estimated that 11% of boys experience diagnosable mental health problems compared to 8% of girls (Green et al. 2005). The most common problems are developmental difficulties, including autistic spectrum disorders, specific learning disabilities and speech, language and communication problems (Kraemer 2000; MHF 2010). Boys are four times more likely to be

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diagnosed with behavioural and social difficulties including conduct disorder; and are three times more likely to be given the label of attention deficit hyperactivity disorder (NICE 2006).

However, in adult life, this pattern appears to switch as men are less likely to be diagnosed with a mental health problem, and prevalence rates of anxiety and depression are found to be higher in women (NHS Information Centre 2009). In the United Kingdom (UK), the Acute National Morbidity Survey 2007 (NHS Information Centre 2009) found that one in eight men compared to one in five women met the diagnostic criteria for a common mental health problem, whereas men are more likely to have what may be called 'externalising' problems like drug and alcohol problems.

Another sign that the mental health of men is not as good as it could be is to do with suicide. Suicide rates have been consistently reported to be higher in men compared to women since records began, with very few exceptions (Haggett 2015; WHO 2017). Suicide remains the most common cause of death in men under the age of 35 and remains at record levels among middle-aged men (45–49 years) (Office for National Statistics 2014). In the UK, men currently make up 78% of all suicides (Men's Minds Matter 2017), which is consistent with suicide rates across other high-income countries (WHO 2017). It is estimated that half of all those who commit suicide may also suffer from depression (MHF 2010), although many men who take their own lives do not have identifiable mental health problems.

Psychological treatments usually involve talking about problems and learning new ways of handling the presenting problems. It is important to note that while most users of Improving Access to Psychological Therapy (IAPT) services in the UK are female, no overall gender disparity in service use was found when taking into account the lower prevalence of depression and anxiety among men in IAPT services in the UK. However, the pathway into the service may be different as it has been found that fewer of the GP referrals were men compared to self-referrals, whereby men were able to refer themselves directly into the service (Brown et al. 2014).

A major problem is that men do not always use the health systems that are provided. Men do not always use traditional services (Conrad and White 2010), and may be reluctant to seek help from professionals when faced with mental and physical health problems, this being the case even before taking their own lives (Sullivan et al. 2015). In the instances where men do engage in treatment, some studies have found men to be more likely to drop-out (Cottone et al. 2002).

Secondly, mental health problems may underlie other more social problems such as homelessness, and forensic problems. Men make up 94% of the prison population and 90% of prisoners are believed to have a mental health

problem of some kind (Prison Reform Trust 2005). Similarly, it is estimated that 85% of rough sleepers in London are men (St. Mungos 2016), making up the vast majority of homeless people, where the rates of mental illness are high (Gill et al. 1996). The most frequently reported reasons for male homelessness are: relationship breakdown, substance misuse and leaving an institution (e.g. prison, care or hospital).

Help-Seeking

Help-seeking occurs when people are faced with problems that demand more resources than they alone can provide. In its broadest sense, it can be defined as any communication that occurs about a problem aimed at eliciting advice, support and assistance during times of distress and difficulty. People can therefore seek help from a range of places and people including friends, families, colleagues or neighbours. It is not just confined to seeking help from professionals and agencies.

Seeking help from health professionals for mental health (or formal help-seeking) generally occurs much less frequently than other forms of more informal help-seeking and occurs towards the end of the help-seeking journey (Timlin-Scalera et al. 2003). Bebbington (2000) noted that only 30% of people with a mental health problem in the UK had consulted a mental health professional. Additionally, this is consistent with the pattern in six European countries where only one in four adults with a mental health problem consulted mental health services (ESEMeD/MHEDEA 2000 Investigators 2004). Thus, only about 30% of people with mental disorders receive treatment (Kessler et al. 2005).

One of the most common findings in the help-seeking literature shows that males are less likely to seek help for mental and physical health problems than females (Addis and Mahalik 2003). Further, men of different ages, nationalities and ethnic backgrounds seek help from mental health services less frequently than women from comparative groups (Addis and Mahalik 2003).

While sex differences are helpful in highlighting men's underutilisation of services, they tell us very little about within-group differences or the underlying biological, psychological, or cultural processes (Addis and Mahalik 2003). Having said this, many authors claim that men's help-seeking behaviour can be directly related to the social construction and cultural representations of masculinities (Courtenay 2009). Indeed, it would appear that psychological and social factors have the greatest impact on men's help-seeking behaviours (Doyal et al. 2003; Courtenay 2009).

Despite this, there appears to be some processes that are shared by both men and women which reduces their likelihood to seek help. None the less, males are notably worse at seeking help for psychological support when compared to their female counterparts. We shall now briefly discuss factors that affect help-seeking among both genders before focusing on specific factors that are relevant to men.

Factors Affecting Help-Seeking Among Males and Females

There are a variety of factors that stop people seeking help. The most common reason people do not seek help is that they feel they can deal with the problems on their own (Meltzer et al. 2003). This has been consistently found, among young people (Rickwood et al. 2007), older people (Lawrence et al. 2006) and adults with diagnosable mental health problems who do not seek help (Savage et al. 2016). How people perceive their problems or their 'illness perceptions' also impacts on help-seeking behaviour (Leong and Zachar 1999; Edwards et al. 2007) as does a person's 'locus of control' (Fischer 1970). Although severity of problems did predict help-seeking, perceived need (Mojtabai et al. 2002) was seen to have a greater influence on whether someone sought help or not compared to their psychiatric symptoms. Perceived need was found to be related to sociodemographic factors (gender, younger people) and attitudes.

A commonly cited reason for people not seeking help is stigma which has been found to be the fourth most common reason for not seeking help (Clement et al. 2015). An influential review on stigma found that treatment stigma (stigma associated with seeking treatment for mental ill health) and self-stigma (holding stigmatising views about oneself and feeling shame) were the most strongly related stigma barriers to help-seeking (Clement et al. 2015). A meta-analysis of help-seeking in a college population similarly found anticipated benefits of treatment and self-stigma to be the two main obstacles (Nam et al. 2013). The threat to an individual's self-worth and how the person perceives the act of seeking help is also of importance (Vogel et al. 2006). Other factors, such as race, ethnicity, cultural background and sexual orientation are also likely to intersect with gender to influence help-seeking behaviour, but these have received more limited attention.

Let us now look at factors that make help-seeking more difficult for men.

Masculinity in the Context of Help-Seeking

Masculine Gender Role Socialisation

Gender-role socialisation theories posit that social environments teach men and women distinct sex-type behaviours and attitudes that influence how they see themselves in relation to their gender and how they perceive the expectations for their behaviour (Mansfield et al. 2003). Masculine scripts promote strength, independence, invulnerability and winning, therefore making it difficult for a man conforming to traditional masculine norms to seek help for mental health problems which involves relying on others, admitting and recognising that there may be a problem and addressing emotional difficulties (Sullivan et al. 2015).

Emslie et al. (2006) compared male and female experiences of depression and their treatment preferences in a qualitative study, and reported the contradiction between depressive symptoms and masculine ideals. Feelings associated with depression, such as shame and weakness contradicted masculine ideals of control, stoicism, strength and success. This makes seeking help difficult, as some men would expect to be ridiculed by other men for 'weakness' if they opened up about emotional difficulties (Emslie et al. 2006).

In a recent review, Seidler et al. (2016) reinforced the importance of masculinity and concluded that conformity to traditional masculine norms has a threefold effect on men experiencing depression, affecting firstly, how they experience depression, secondly, attitudes about and actual help-seeking, and thirdly, how they manage their symptoms. However, the review also highlighted that the type of help men with 'masculine' norms chose or were offered was important. The type of social support was found to be important in moderating the effect of these attitudes (Houle et al. 2008). Men preferred talking to a close other, typically their mother or female partner with the weakest preference being for a male friend (Lane and Addis 2005). Furthermore, men preferred therapy approaches that were more practical and problem-focussed rather than just involved talking about their feelings (Emslie et al. 2007).

Masculine Emotions and Male Development

Male gender role socialisation may mean that boys are socialised to minimise, ignore or lack awareness of their emotional experience and as a consequence may become less able to recognise or process their emotions in

later life (Sullivan 2011; Sullivan et al. 2015). From an early age, caregivers appear to conform to cultural gender norms and unwittingly respond differently to boys and girls, subtly reinforcing gender consistent expressions of emotion (Fivush et al. 2000).

Male clients may assume that they will be expected to talk about emotions and explore the emotional context of their life experience during psychological work (Mahalik et al. 2003). Gender role socialisation seems to encourage boys and men to ignore and devalue emotions and many men may believe that feelings are unnecessary and better left unexplored (Mahalik et al. 2003).

O'Neil (1981) hypothesised that some men develop restrictive emotionality, which refers to difficulties in self-disclosure, recognising feelings and processing the complexities of interpersonal life. Large-scale self-report surveys with undergraduate students in the US have supported this hypothesis by showing that restrictive emotionality is a predictor of men's negative attitudes towards psychological help-seeking (Lane and Addis 2005).

Furthermore, the socialisation of men to not discuss or be aware of their emotions or feelings can result in other difficulties. For instance, alexithymia is hypothesised to be a common and widespread condition in men, whereby one experiences the inability to put emotions into words (Levant 1998). Subsequently, this inability to identify and recognise emotions may leave men at greater risk of poorer health outcomes and increased somatisation of psychological problems. More importantly, emotions are central to forming relationships.

Masculine Intimacy in Close Relationships/Self-Reliance

There is evidence to show that men tend to interact less intimately than women do and overall their relationships are less intimate, particularly with the same sex (Reis 1998). This may be due to disruptions in early attachment relationships (Diamond 2004) and/or connected to emotional developmental opportunities during childhood. Indeed, men often report having fewer social support networks than women (Pevalin and Rose 2003), which may be related to an avoidance or difficulty forming close attachments (MHF 2006). Additionally, focus groups carried out by Ritchie (1999) found that young men from the UK had difficulty accessing confiding relationships with male friends for emotional difficulties.

Associated with intimacy is the masculine ideology of independence, which may signify a discomfort with needing assistance from others, including

health care professionals (Mahalik et al. 2003). In the development of the Barriers to Help-Seeking Scale, Mansfield et al. (2005) found that within a sample of 537 undergraduate men in the US, those who reported more self-reliance showed less willingness to seek psychological help. They concluded that self-reliance was an important psychological process related to lower help-seeking in men.

Johnson et al. (2012) suggest that men's reluctance to seek help could be addressed by nurturing genuine connections between depressed men and health professionals, promoting acceptance of 'guarded vulnerability' until trust is established and working with men as equals in a partnership.

Masculine Coping Styles

When men experience problems, masculine norms can lead to social withdrawal, increased work hours, alcohol and substance abuse and anger-fuelled conflict to cope. Some even mention suicide as a brave masculine attempt to re-gain control (Emslie et al. 2006; Oliffe et al. 2012). This helps explain to why men with depression are more likely to cope by drinking alcohol or taking part in sporting activities, whereas women are more likely to find ways to express their emotions, and to believe more in religion (Angst et al. 2002).

As a result, gender role socialisation on how to manage mental health problems may reflect the difference in symptom profiles between men and women, with men demonstrating more acting-out behaviours, lower impulse control, more risk-taking and substance misuse, more anger, irritability, aggression and antisocial behaviour, and women showing more overt signs of sadness, tearfulness, appetite and sleep disturbance, worthlessness and guilt (Angst et al. 2002). This may help explain the patterns of service use seen in men and boys described earlier.

Other Contributory Factors to Help-Seeking

Beliefs About Mental Illness

A number of studies have explored the relationship between beliefs about depression and help-seeking behaviour and compared these between males and females. A systematic review of 71 quantitative and qualitative studies found that females were more likely than males to attribute depression to

medical or biological causes, as opposed to non-biological, psychological, or environmental causes (Prins et al. 2008). Research findings also suggest that men might not believe depression or anxiety to be as serious as women do, in terms of length or severity of problems (Edwards et al. 2007). It might therefore be hypothesised that men perceive less need for treatment in health services but this hypothesis has not been formally tested.

Expectations of Treatment

There is some evidence that females have more positive attitudes towards mental health care than males (Mackenzie et al. 2006). In the systematic review conducted by Prins et al. (2008), when compared with women, men expressed less confidence in mental health professionals, were more likely to think that antidepressant medication was addictive and appeared more concerned with the costs and side effects of treatment (Prins et al. 2008).

There appears to be heterogeneity within males about what they want from professionals (Emslie et al. 2006). Expected satisfaction with treatment has been shown to correlate with the likelihood of having a depression-related outpatient visit over a 6-month follow-up period (Fortney et al. 1998). However, findings relating to the relationship between perceived need for treatment and help-seeking behaviour have been inconsistent (Lin and Parikh 1999; Fortney et al. 1998).

Finally, a recent study by House and colleagues (House et al. 2018) using a Q methodology compared men who had and had not sought help. They found that while all men held the view that depression should be something that was dealt with in private, those men who actually sought help believed more strongly that treatment could be effective.

Frequency of Contact with Other Services

Men come into contact with health services less frequently than women do, as the latter attend more often for family planning and perinatal appointments. This gives medical professionals fewer chances to recognise signs of depression in men and offer support. However, when men do see the doctor, they are more likely to describe physical than emotional symptoms (Galdas et al. 2005) which can make underlying or concurrent depression difficult to identify.

Recent Interventions for Men

Public Health Campaigns

Public health campaigns in the UK by leading UK charities including the Campaign Against Living Miserably (CALM), Samaritans, Rethink, Men's Health Forum and Men's Minds Matter have focused on raising awareness of the issues faced by men, sought to legitimise and redefine help-seeking as a strength, and encouraged men to open up and support one another with problems where they exist. Although difficult to measure directly the effectiveness of public health campaigns, they do directly address men about a previously invisible problem which has made it more open.

Interventions to Engage Men

There have only been a few successful evaluated interventions to encourage help-seeking among men.

When attempting to engage men Pollard (2016) talks about the importance of gender-sensitive language. He suggests using terms such as 'stress' rather than 'mental wellbeing' because it externalises the problem and may be more acceptable to men. He also suggested that men should feel in control of the service rather than be expected to fit in and feel disempowered. In an intervention aimed at sleep, Archer et al. (2009) marketed the intervention to men using a physical symptom which was successful in engaging men to the insomnia workshops.

While Rochlen et al. (2006) found few benefits of a National Institute of Health (NIH) male-sensitive brochure, Hammer and Vogel (2010) found that a specifically tailored male sensitive brochure improved help-seeking attitudes and reduced self-stigma among 1397 depressed men who had not sought help. Similarly, an outreach brochure (McFall et al. 2000), designed to increase mental health service enrolment for veterans diagnosed with post-traumatic stress disorder, significantly improved the likelihood of scheduling an appointment with a service, presenting to the initial intake appointment, and attending at least one follow-up treatment session.

Reframing help-seeking as a sign of strength and as a preventative action has been suggested as a way of increasing help-seeking. Indeed, more flexible masculine ways of coping have been described (Kiselica and Englar-Carlson 2010) such as seeking help to maintain the role of looking after others (Emslie et al. 2006).

While not evaluated, helplines seem to be effective in engaging men and are an effective source of support for people in times of need. The charity, Samaritans, improved their engagement of male callers by training staff in how to speak to male callers. These frontline sources of support may also be the first place that men test out what it might be like to talk about a psychological difficulty. A positive experience of using helplines may impact on whether someone goes any further into their help-seeking journey.

Interventions

It has been suggested that men have a preference for short-term, directive goal-oriented, action-focused interventions based on problem-solving strategies, emphasising the practical utility of CBT over other forms of 'just talking' therapies (Emslie et al. 2007; Kingerlee et al. 2014).

In the only successful treatment study published so far, Primack et al. (2010) did find large positive changes on depression and increases in social support following an 8 session CBT group treatment including masculine norm discussions for six depressed men in a pre-post study. However, there were no significant effects on conformity to male norms and there were mixed results for self-stigma.

However, it is also important to note that there are recent community initiatives that seem to be successfully engaging men. 'Men's sheds' have been expanding with about four new sheds opening each week. These are places where older—as well as younger—men can meet and share practical skills, learn informally and work on community projects. Although originally set up to combat loneliness, they are also places where mental health issues can be addressed. Culph and colleagues found that depression scores were significantly reduced as a result of attending (Culph et al. 2015).

There is some evidence indicating that men who seek help are staying in treatment and are also improving (Kingdom, in preparation). However, there may still be difficulties with some cultural groups, such as men from black and ethnic minority groups who are more likely to drop-out after assessment (Kingdom, in preparation).

The setting can make a difference. Hunt and colleagues reported on a RCT for a gender sensitised programme (FFIT) for weight loss for 747 male football fans (aged 35–65) run in football clubs (Hunt et al. 2014). This was run because of the poor take-up of men in weight loss programmes. Here, the intervention group received a weight management booklet and received a weekly weight loss programme delivered by

community coaches for 12 weeks. At one-year follow-up, the intervention group lost significantly more weight compared to the waitlist control group. Running the programme in social settings, such as sports clubs and workplaces helps to engage men.

Finally, the content of the programme can be important. Robertson et al. (2014) in a weight management programme for men reported that men preferred more factual information and more emphasis on physical activity.

Some Ways Forward

We shall attempt to highlight some key clinical and research considerations when developing interventions for men. Particular emphasis should be placed on the way interventions are marketed to men, gender sensitivity to the male experience and, the execution and delivery of evidence-based interventions.

Marketing of Interventions to Men & Treatment Stigma

There is some evidence to suggest that men are more willing to access helplines and online text support. This appears to be particularly important when a gender sensitive approach is used. Services designed specifically for men, such as CALM, Men's Health Forum and Men's Minds Matter have been successful in engaging men in mental health conversations, partly due to the gender sensitive language used and their non-psychiatric focus. The language around marketing these initiatives is likely to be a crucial factor as many men do not identify with a mental illness model.

There is evidence highlighting that men will seek help if it is accessible, appropriate and engaging (Spendelow 2014). Thus, the combination of easy access helplines/online text support, a non-psychiatric focus and male appropriate language appear to improve engagement while offering a confidential and distal form of informal support. This probably creates a positive first impression of help-seeking, gives information about potential treatment options and helps men decide on what steps they would like to take next.

It appears men may have different, possibly erroneous, ideas of what psychological treatment comprises. Providing factual information is therefore important and will help to avoid any misconceived ideas, improve understanding of the available services and contribute towards reducing treatment stigma (Robertson et al. 2014). Once help-seekers get to know more

about the efficacy of psychological therapy services, the perceived benefits of help-seeking may then outweigh the negatives (House et al. 2018). Additionally, adaptations to the delivery of services may also make them attractive. Interventions that do not conform to traditional 'talking' therapy such as using physical and/or leisure activities can also appear to be engaging and effective (Kingerlee et al. 2014).

Using concepts men use could be very helpful. Results from a large European study indicate that men often attribute depressive symptoms to work stress (Angst et al. 2002) or physical illnesses, particularly heart and blood pressure problems, whereas women attribute depression to relationship problems or illness/death in the family (Angst et al. 2002). The tendency to somatise psychological experience may occur more frequently in men, as it is likely to be linked to poor emotional awareness. Thus, marketing interventions that address these concerns may also improve engagement.

Masculinities & Self-Stigma

Men who could benefit from psychological support may choose not to pursue it because many aspects conflict with dominant masculine gender roles (Sullivan 2011; Sullivan et al. 2015). Identifying with having a psychological problem is likely to be self-stigmatising and entwined within a relationship to masculine ideals. Psychological therapies often emphasise traits such as emotional expression, introspection, intimacy and acknowledgement of vulnerability which may be alien and threatening to some men. There may be fears about performance, control and mastery of the therapy, questions about the utility of such approaches or fears about what might be uncovered. These terms may not yet be part of a familiar vocabulary for many men and work may need to occur before we get to this stage of intervention.

Psycho-educational material aimed at men is likely to be important for increasing awareness of psychological difficulties, developing a psychological vocabulary and for introducing key concepts and ideas. Combining psycho-education with non-stigmatising approaches such as Acceptance and Commitment Therapy has been shown to be more successful in reducing self-stigma generally, for both psychologically flexible and inflexible participants than psycho-education alone (Masuda et al. 2007). A lighter touch may be required before moving deeper into the psychological world of men in order to reduce possible anxieties.

Services can adopt 'male-sensitive frameworks' that are more sensitive to the needs of diverse men (Englar-Carlson and Kiselica 2013).

One aspect emphasised by Pollard (2016) is the need to help men feel in control of the service offered by empowering men to choose their preferred treatment plan (e.g. Cheshire et al. 2016). Another example would be services that adopt 'male positive' attitudes and be more accepting about male distress. This framework could be beneficial for reducing feelings of shame and self-stigma, reaching marginalised groups, encouraging help-seeking and improving treatment engagement.

Developing Male Appropriate Interventions and Improving Treatment Engagement

Wholesale changes to existing evidence-based practices are unlikely to be needed to meet the needs of men. What is more likely required is a gender sensitive approach in the delivery of the intervention and sensitive engagement at the right entry point for different men in their psychological journey. By doing so we are likely to improve men's engagement with the available evidence-based therapies.

Men's preference for short-term, problem-focused goal-oriented interventions should not be ignored. However, the dynamic interpersonal context and men's relationship to emotional experience should not be discounted as a potential focus for change. Indeed, social and emotional isolation may underlie many of the difficulties men experience and is likely to be a valuable focus for change. However, some work may need to be done prior to reaching this point.

Conclusions

Two types of intervention may help men seek help. Firstly, engaging men to perceive treatment as a possible viable option is essential to enable them to access professional support. Secondly, ensuring that the support they do receive is appropriate to their needs will help to reduce treatment drop-out.

Recent developments indicate some positive signs of change as more men seem to be willing to access help in different settings. There are also signs that they do not always drop-out of treatment once they decide to seek help.

There is still a need for future research about effective ways of marketing interventions to men alongside evaluating the uptake to and outcomes from existing and newer interventions such as practical interventions with factual information, men only groups and physical/leisure activity-type formats.

In summary, there are factors that make it more difficult for men to seek help for their mental health problems. However, there are also recent clinical and research developments in terms of public health campaigns, approaches to engaging men into seeking help, as well as the development of gender-sensitive interventions. These are all positive developments that could be helpful to men with mental health problems in improving their help-seeking.

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