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Research Article

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Barriers to Help-Seeking in Suicidal Men: A Systematic Literature Review

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Abstract

Background: *The incidence of suicide in the United Kingdom is at its lowest since 1981 though the number remains catastrophic (Office for National Statistics, 2018). In particular, high rates of male suicidality causes a level of controversy, suggesting inadequate health service provisions and on an individual level, poor help-seeking (Macdonald, 2011; Möller-Leimkühler, 2003). Research has suggested that two thirds of males who had died by suicide had not been in contact with a mental health service (Luoma, Martin & Pearson, 2002; Owens, Booth, Briscoe, Lawrence & Lloyd, 2003). Studies have also identified the homogenous difficulties males experience when accessing the required care for suicidal ideation (Foster & Wu, 2002). The current review aimed to provide an overview of the research in this area, pertaining to the barriers to help-seeking in men experiencing suicidal ideation.*

Methods: *A systematic literature review was performed on Web of Science and PsychInfo using truncations of the terms (help-seek*, behaviour*, suicid*, male*).*

Results: *Of the 522 articles identified 7 papers were eligible for review. All of the papers provided qualitative findings. A synthesis of the data identified four reoccurring themes: masculinity, stigma, self-medicating and mislabelling pathology and four sub themes: social humiliation and self-humiliation, incorrect identification and false rejections by clinicians. The current literature, though entirely qualitative and somewhat homogeneous, revealed that males with suicidality when help-seeking experience specific barriers.*

Conclusion: *Although the available literature has provided themes for study on how self and societal appraisals may impact help-seeking behaviours in males, comparative quantitative and longitudinal studies are required imminently to increase understanding and approach this health crisis effectively.*

Keywords: Help-Seeking, Barriers, Suicidal Men, Systematic Review

Introduction

Suicide is a significant worldwide public health concern with 5,821 suicides in the United Kingdom (UK) in 2017 alone [7]. A striking 4832 of these suicides were by males (75.3%) further confirming the longstanding gender imbalance evident in UK rates, though conversely suicide ideation and self-harming behaviours are more prevalent in females [8, 9]. Indeed, UK deaths by suicide occur 3.53 times more often in men than women with suicide being the leading cause of death in males under 40 making this cohort the largest single group for death by suicide worldwide [10, 11].

Despite the incidence of suicide in UK males being the lowest since 1981, the rate has still increased significantly since 2017 [1]. It is estimated that two-thirds of men who die by suicide did not have contact with mental health services [4, 5]. A retrospective, observational study also suggested that those who were not in contact with services prior to death by suicide were more likely to be male, and had not been diagnosed with a psychiatric disorder[12]. Men's high rates of suicidality are argued to be as a result of inadequate health service provisions and sometimes irremediable, poor help-seeking [2, 3]. The suggestion that these problems are homogenous to men and mental health services fails to contemplate the nature of help-seeking in males in relation to the diverse health services they encounter [13].

Approximately 1 in 10 males in the UK are diagnosed with a common mental health disorder though only 36% of all referrals to services are male, which suggests men are less likely to seek appropriate treatment via help-seeking behaviours [14]. Conversely, males experiencing suicidal ideation engaging in help-seeking behaviours often face difficulties receiving the care they require [6]. For example, lessons from a comprehensive clinical audit of users of psychiatric services who died by suicide identified key factors

associated with poor therapeutic relationships between the clinician and patient, as well as incomplete assessment [15].

Incidence of male suicide has also been discussed in both the Five Year Forward View and NHS Long Term Plan, indicating a need for improvement of services across the country and highlighting a reduction in suicide rates as a priority over the next decade, thus adding to the pertinence of this review and its objective, as follows:

To provide an overview of the research in this area a systematic review of the literature pertaining to the barriers to help-seeking in men experiencing suicidal thinking will be undertaken [16, 17].

Materials and Methods

To the extent that they were applicable to observational studies and to the qualitative synthesis of results, the methods and results are reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA).

Search Strategy

This review searched both Web of Science and PsycInfo electronic databases in March 2019. Truncations of the search terms (help-seek*, behaviour*, suicid*, male*) with the Boolean operator 'OR' were used to expand the quality of the search. These terms aimed to represent the concepts of 'Suicidality in Males' and 'Help-Seeking'. No date range was indicated in this search.

Definition of Terms

Help-seeking behaviour is defined as "communicating with other people to obtain help in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience" [18]. Male's help-seeking behaviour was investigated with regards to suicidality and possible barriers to seeking help.

Inclusion and Exclusion Criteria

The inclusion criteria required publication in a peer-reviewed journal and help-seeking behaviour accounts of males experiencing suicidality. Exclusion criteria were articles where participants did not experience suicidality or were bereaved through the loss of someone who died by suicide.

Results

Initially 522 papers were identified, following which an independent screening was undertaken: 504 papers were excluded due to lack of pertinence. An independent screening of the article title and abstract was undertaken of 18 papers; six papers were deemed suitable for the review. An additional paper was accessed from a reference list of one of the aforementioned papers and is subsequently included in this review. The decision to include studies was based on a priori defined inclusion criteria as discussed earlier. A number of studies were not included due to the inability to distinguish between genders within their result reporting or the lack of focus on suicidal expressions and help-seeking behaviours specifically.

Table 1: Characteristics of reviewed studies

Study	Location	MAS sample size (age range) & diagnoses	Method	Findings
Cleary (2012)	IRE	52,18-30	QUI, Grounded theory	• Perceived stigma of emotional pain • PMN, SM
Cleary (2017)	UK	52, 18-30	QUI (Follow up of Cleary 2012)	1/3 never attended outpatient appointment. 28% attended less than 1 month. 25.7% attended up to 6 months. 37% attended at least 1 year. • Non-disclosure of distress. • Unfamiliarity with psychological symptoms • Negative attitudes to psychiatric treatment • SM
Fogarty, Wilhelm and Christensen (2017)	AUS	35, 18-67 and 47 family/ friends	Qualitative secondary analysis	• Perceive frequent inquires as invasive and patronising • Lack of flexibility in the delivery of support • Lack of understanding of both the men and their family • PMN
Howerton, Byng, Campbell, Hess, Owens and Aitken (2007)	UK	35 offenders, 18-52	QI	• Chaotic upbringing • Distrust • MD
River (2018)	USA	18, 22-66	QI	• 17% actively avoid services "not too manly" • 33% struggling with escalating distress thus sought help • 50% help-seeking triggered via unsolicited encounters • Rejection of clinician centred services • MD, PMN

Shand, Proudfoot, Player, Fogarty, Whittle, et al. (2015)	AUS	251, 18 and over. Attempt 6-18 months prior	Surveys and open ended survey questionnaires.	• 66-88% did not want to burden others • 63% isolated themselves • 57% couldn't see the point in getting help • 58% supressed feelings • 36% PMN • 1 in 6 said they did not know where to get help • 45-60% afraid of hospitalisation
Strike, Rhodes, Bergmans and Links (2006)	AUS	15, 18 and over with diagnosis of BPD or APD, NAG	QI	• Negative previous experience • Insufficient time to discuss long-term consequences • Overreliance on medications • Chaotic upbringing • Preserving dignity • SM, MD

Note: Location: IRE, Ireland; UK, United Kingdom; USA, United States of America; AUS, Australia. Sample: MSA, Male Attempted Suicide; BPD, Borderline Personality Disorder; APD, Antisocial Personality Disorder; NAG, No age given. Method: QUI, Qualitative Unstructured Interview; QI, Qualitative Interview. Findings: SM, Substance misuse; PMN, Perceived masculine norms; MD, Mislabelling distress.

Methodological Quality

Whilst the highest age-specific suicide rate in the UK was reportedly among males aged 45 to 49 years with international statistics suggesting that men over the age of 85 are the largest single group the majority of the reviewed literature had few participants over the age of 40 [1, 19]. Additionally, whilst men are consistently less likely to seek help than females at all ages, the difference appears greatest during adolescence, with only 13% of males seeking help compared to 31% of females aged 16-24 years [20]. Mean age ranges across included studies were between 30 and 40 years, with less younger and older participants; arguably the most at-risk representatives of the male suicidality cohort. Though a limited number of studies were found no articles were excluded due to poor methodological quality.

Discussion

A synthesis of the data identified four reoccurring themes: masculinity, stigma, self-medicating and mislabelling pathology and four sub themes: social humiliation and self-humiliation, incorrect identification and false rejections by clinicians. The emergent themes discussed below reflect the barriers that suicidal males described regarding their help-seeking behaviours.

Masculinity

Most of the studies recognised characteristics of masculinity and how this can be a barrier to help-seeking behaviours; emerging as a significant theme throughout the body of literature. This included the unhelpful conception of stoic beliefs influencing the disclosure of mental health difficulties and suicidal ideation. Disclosure of emotional distress was evidently concealed throughout the articles as males viewed emotional expression as weak and un-masculine.

"You're telling someone you failed. I feel like I failed, that's why I did that [attempted suicide]. They [men] don't tell anyone about their problems. Men feel they have to be strong, that you have to be able to manage when you are a man."

"Men, if they feel depressed or whatever, they see themselves as being weak and man is supposed to be the stronger one" [21].

Emotional pain and mental health difficulties were also associated with femininity and a deviation from conventional masculinity norms with men appraising emotional self-sufficiency as an appropriate response to trying circumstances [22, 8]. Argues that men are less likely to demonstrate help-seeking because dominant societal idealisations are of invulnerability and not requiring psychological support. The example below demonstrates such paragons of masculinity impede on male help-seeking [23].

"I think because we are afraid to. Not to seem weak. We're afraid of weak or something. Because we have to have this image of being macho, we have this image of not being girls" [21].

Stigma

Throughout the review beliefs or assumptions regarding stigmatisation were repeatedly implied as obstructions to male help-seeking. Such evaluative beliefs appear dependent upon both 'self' and 'other' environmental judgements (see sub themes) leading to the attitudes voiced by many.

Social humiliation

Men revealed that their attempts to kill themselves were to avoid revealing their weaknesses and the stigmatising labels they would be subject to had they sought help. Three articles described how means of management leading to isolation, and reliance on coping mechanisms requiring less immediate effort and providing short-term alleviation of distress and suicidal ideation (see superordinate theme 3).

"...I wouldn't allow myself to show it to my friends and family. It was a stranger where it was kind of like you felt that if you were going to be judged it would be less than what it would be from family and friends"[24].

This concept of perceived judgement was expanded throughout papers describing how family members, in particular fathers and male siblings, were key enforcers of dominant masculine values and beliefs, who often teased and manipulated, describing participants as:

"*Too sensitive…Stop whingeing, stop your moaning about it*" [21].

Consequently, many feared that through a formal diagnosis, resulting from accessing services, would lead to stigmatisation from wider society and not just friends and family. Overall, males demonstrated a conspicuous fear of the external and social consequences from help-seeking.

"*…and then you're diagnosed with a mental illness, then they all seem to turn their back like…it seems like people are scared of mental illness"* [25].

Self humiliation

Five of the reviewed studies found that suicidal males described a failure to manage their emotions or fulfil expectations of happiness. Consistently males reported frequent feelings of guilt and enragement with themselves, whilst also apprehensive of their difficulties being divulged.

"*With my closest friends it was, 'I don't want you to know how I feel'. I'm a Dad of three and a husband. I've got a good job. I don't want you to know that I am so sad that I cry at red lights"* [24].

Whereas masculinity was identified as a key barrier to help-seeking, the appraisal of a failing to meet this self-imposed expectation of oneself may fuel self-humiliation, thus further contributing to reduced access of help from services [20]. The example below demonstrates how embarrassment can hinder male disclosure of emotional difficulties and suicidal ideation.

"*For two years when I did feel down I didn't talk to anyone. I just kept it all inside. I just didn't tell anyone anything. I just didn't want to involve anyone; I just didn't want anyone else to tell*" [21].

Five articles describe men refusing to recognise their emotional difficulties and suicidal ideations/behaviour as mental illness, including the hesitancy disclosed, and fear of, a formal diagnosis. Besides a consistent stigma that a diagnosis would bring, for many it also meant having to confront their problems, otherwise ignored.

"That's one of the worst fears, actually being diagnosed as mentally ill" [25].

Self-medicating

Throughout the papers it was discussed that men do not seek help because they report hoping to manage their emotional distress through self-medication. Substance use may be a means of camouflaging underlying problems that males are faced with, whilst also contributing to self-harming behaviours [26]. Across the reviewed articles males disclose that use of alcohol and drugs was often their way to self-medicate and is thus considered an impediment to help-seeking behaviours. Additionally, non-take-up of services prior to the suicidal episode was often reported due to attempts at masking distressing symptoms, and thus formed a barrier to their help-seeking.

"Drinking was a way of escaping for me, keeping myself inebriated to make it to the next day…using alcohol was just a way of not facing up to things" [27]. "I was using all sorts of drugs to, just king of, to go out and enjoy myself basically…To forget about everything, to forget about it, you know that was what I was doing, to basically forget about it" [28].

Mislabelling pathology

Males expressed both their own inabilities to identify their symptoms and also the clinician's ability to recognise male's genuine need for support and thus form the following two subthemes.

Incorrect Identification

Across the articles reviewed, males reported their own mislabelling of physiological symptoms and inability to identify acute manifestations of distress.

"I was brought into…about three times with panic attacks... I thought I was having a brain haemorrhage or something, a heart attack…I thought I was going to die" [28].

"I didn't pay attention to them [symptoms]. I didn't notice them, and didn't do anything about it…I didn't think they were serious" [28].

False rejections by clinicians

Males informed that when describing symptoms to services these were deemed at sub-clinical thresholds. In one case it was suggested that service providers concluded this was a case of inappropriate help-seeking or attention-seeking, whilst also labelling them as "bad patients" [27].

"Doctor said this isn't a hostel; I wasn't looking for a hostel. I had a fridge full of food and my rent was paid. I had everything I needed, except for a safe place" [27].

Men who appeared expressionless within a health service setting were less likely to be labelled with a mental illness than women who are often more physically emotive:

"*I get turned away…Maybe it's along with the thing that men don't get wishy washy it's hard to tell what a man is thinking"* [27].

Overview

The current literature, though entirely qualitative and somewhat homogeneous, revealed that males with suicidality when help-seeking experience specific barriers. These have been conceptualised around themes of "Masculinity", "Stigma", "Substance misuse" and "Mislabelling". Taken together, these barriers as discussed by the individuals themselves suggest a weakened ability of individuals to accept and manage what is perceived by them as personal failure.

Despite the recommendations provided by the Department of Health, suggesting a reduction in male suicide [16, 17] and an appreciation of how this may differ from that of females, a specific policy target may be premature [29]. Considerable further elucidation of the nature of the themes identified is required if barriers to help-seeking are to be understood and resolved through targeted provisions and promotion. The literature is exclusively qualitative in nature with a single follow-up study [28]. Although this has provided themes for study on how self and societal appraisals may impact upon help-seeking, comparative quantitative and longitudinal findings are urgently required if this health crisis is to be better understood and tackled effectively.

Currently, non-specific targeting of generalised rather than specific clinical populations through zero tolerance approaches, campaigns at sporting events and in the media, and services such as male-focused support hubs with the aim to increase the wellbeing of males who

are socially isolated, are being promoted. However, there is little robust evidence that demonstrates how, and to what extent, such interventions are effective at improving help-seeking for suicidal men or impacting on male deaths by suicide.

Recommendations

- For health services to target the critical framework of masculinities and how this leads to delays in help-seeking
- For service providers to adopt a more nuanced and locality-specific understanding of suicidal men's efforts to seek help
- Providers should ensure they recognise and challenge evidently dominant gender norms in the services they provide.

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