Factors that influence Irish men to seek help for depression

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Abstract

Suicide rates in Irish men are among the highest worldwide, yet statistically, women consistently show higher rates of depression. This presents a complex predicament: If women are showing higher rates of depression, why is it that men are showing higher rates of suicide? One suggestion is that men are not reporting depression or seeking help. There is a limited amount of research that focuses on this area, with a particularly conspicuous absence of qualitative research. This study aims to investigate the influencing factors that may prevent men from seeking help for depression. One-to-one interviews were conducted using flexible, open-ended questions to gain an in-depth insight into the participants' attitudes towards depression and seeking support and treatment. 8 men from various backgrounds took part in the study. Thematic analysis was used to identify four main themes in the data: (i) Childhood and Learning, (ii) The Impact of Irish Culture, (iii) Attitudes Towards Supports and Treatments, and (iv) Masculinity. Education, family, friends, Irish culture, mental healthcare, traditional views of masculinity, and the roles they all play in men's mental health are all discussed with recommendations and implications given for each.

According to the World Health Organization (WHO, 2020), depression is the leading cause of disability worldwide. As depression rates continue to rise globally, investigation into effective preventative, diagnostic, and treatment measures is more important than ever. To do this, we must first look at the demographics of those with depression. Depression affects all genders, ethnicities, ages, sexualities, and socioeconomic backgrounds, still research shows increased susceptibility in some groups. For example, research repeatedly shows rates of depression are almost twice as high in women than in men (Kessler et al., 2005; WHO, 2020). However, data consistently contradicts this when considering the substantially higher rates of suicide in men (Mokdad et al., 2016; WHO, 2016).

One suggestion for the discrepancies in these data is lower instances of help-seeking behaviours by men; Research shows men to be significantly less likely to seek help for depression than women (Addis & Mahalik, 2003), therefore it is likely that research showing higher rates of depression in women than men do not reflect reality. With lower instances of help-seeking, men are less likely to receive sufficient intervention and support (Emslie et al., 2007). This review aims to examine the current literature and determine the current state of knowledge regarding the factors that contribute to men's help-seeking for depression.

Men tend to mask their emotions, often only seeking help for their depression when it has progressed to the later stages (Addis, 2008). In a systematic review by Seidler et al. (2016), the authors dissect current research regarding the impact of masculinity on men's help-seeking behaviour for depression. The main findings show gender differences in the ability to recognise symptoms of depression. Men find communicating their symptoms more difficult and often attribute self-identified symptoms to physical ailments. This may partially be due to reduced literacy of mental health and emotional vocabulary (Oliffe et al., 2010). The research included in the review also found that traits associated with depression, such as weakness and shame, conflict with traits associated with masculinity, such as stoicism,

withholding emotions and independence (Emslie et al., 2006). Men, therefore, tend to associate depression with femininity which not only contributes to their reluctance to seek help for depression but can enhance their symptoms as their perception of their own masculinity is challenged (Rochlen et al., 2010).

A review by Rice et al. (2018) highlights how adolescent and young adult men have consistently different health profiles from adolescent and young adult women, with young men showing higher instances of suicide, substance abuse and aggression than their female counterparts. The paper looks at mental illness determinants such as disengagement with health services, social stigma, lack of understanding of mental disorder symptomology, cultural norms of traditional masculinity, diagnostic issues and service accessibility. Consistent with previous research, this review shows that in comparison to females, males generally have a reduced understanding of mental health disorders, such as identifying symptoms (Kaneko & Motohashi, 2007) and suggests that improved literacy in mental disorders such as depression plays a critical role in increased reporting rates of depression (Jorm, 2012).

The research consistently shows traditional views on masculinity have a negative impact on men's help-seeking behaviours for depression (Addis & Mahalik, 2003; Courtenay, 2000; Tang et al., 2014). Researchers also call for a change to societal norms regarding men's attitudes towards help-seeking and traditional masculinity (Rice et al., 2018; Seidler et al., 2016). Social stigma is frequently discussed as a contributing factor to why men are less likely to seek help for depression, which is closely linked to the perception of traditional masculinity (Latalova et al., 2014; Lynch et al., 2016). Open discussions about mental health are less prominent with male social groups, thus resulting in a stigma surrounding men's mental health (Corrigan & Watson, 2007; Latalova et al., 2014).

Importantly, research shows a disengagement pattern from mental health services during adolescence (Mason-Jones et al., 2012). This is valuable information as first instances of mental illness typically surface in adolescence (Kessler et al., 2007). Providing sufficient and positive experiences of intervention and treatment from the onset may not only prevent problems in the future but in the event of further instances of mental ill-health, those who have had a positive experience of health services in the past are more likely to seek help in the future (Birchwood & Singh, 2013; Patel et al., 2007). This leads to recommendations of increased education of young men about the signs and symptoms of mental illness. The research suggests further investigation into more suitable intervention methods for young men that coincide with their everyday lives, such as through sport, music and gaming, to remove boundaries to mental health education and treatment (Rice et al., 2018). School programmes are shown to reduce mental illness social stigma (Pinfold et al., 2003), and parental intervention, particularly the engagement of fathers, has been suggested as crucial for cultural change and setting the tone for young boys' attitudes towards mental health (Panter-Brick et al., 2014).

With regards to treatment, research shows that men responded better to more action-focused treatment, such as Cognitive Behaviour Therapy (CBT) (Emslie et al., 2007). A recurring finding amongst the research was that men will seek help for depression if it is engaging, practical, solution-focused and accessible (Spendelow, 2015). Some studies also suggest that men may be more likely to seek help through online services rather than in person (Burns et al., 2013).

While the current research contains a lot of beneficial data, it is not without its limitations. Firstly, there is a lack of longitudinal data which would be useful to determine intervention and treatment effectiveness. Secondly, the majority of samples used for both quantitative and qualitative studies are largely deficient of diverse demographics, mainly

consisting of convenience samples of middle-class, Caucasian men, often university students, from wealthy countries. The data for varying age groups, ethnicities, socioeconomic backgrounds and cultures is virtually non-existent. While reduced prevalence of help-seeking for depression is consistently lower in men across all countries and cultures (Addis & Mahalik, 2003), there is some variance in rates amongst men with different backgrounds. Rates of male suicide vary largely throughout the world. For example, Europe has the highest rates of male suicide with 24.7 per 100,000 people per year, and the Eastern Mediterranean has the lowest rates with 5.1 male suicides per 100,000 people per year (WHO, 2016). In addition, Irish males suicides between 20 and 24 years of age were 30 per 100,000 people per year (Griffin et al., 2016). There has been little discussion of why Irish male suicide rates are so high, or what may be influencing low rates of help-seeking behaviour.

Furthermore, a large portion of studies rely on self-report measures, essentially excluding the very data needed from men who struggle to identify depression symptomology. Another common theme amongst the research is the simplistic view of masculinity as a shortcoming, suggesting it is something that is "wrong" with men, therefore focusing on changing views of masculinity rather than adapting diagnostic tools and treatments to accommodate perceived masculinity. Ballinger et al. (2009) discuss the importance of moving away from the idea of men as limited and blaming men and boys for their lack of help-seeking and suggest instead promoting health and wellness in men through encouraging engagement in mental health discussions through activities that are enjoyable to them, such as Men's Shed programmes.

Overall, research has shown traditional norms of masculinity play a significant role in attitudes towards help-seeking and treatment for depression. There is encouraging suggestions that altered treatment options may be more successful for men. Action-based, practical approaches, such as CBT, seem to be more appealing to men than other talk-based

therapies, and incorporating approaches that play to men's strengths and ideas of masculinity may also be successful. However, this doesn't solve the issue of men's reluctance to seek help in the first place. Reframing how we talk about masculinity and men's mental health is crucial to increase instances of help-seeking amongst men. Increased awareness and discussion around depression symptomology, and depression as a universal illness, not just a women's illness, may lead to less resistance. The research to date has been limited and tends to focus on narrow demographics. More research is needed with more inclusive demographics to get a better understanding of the reality of men's attitudes towards help-seeking and treatment for depression.

The present study aims to investigate the factors that influence Irish men's help-seeking for depression. It aims to conduct online, remote interviews with men of various ages and backgrounds throughout Ireland to gain an understanding of the attitudes and influencing factors that may encourage or prevent help-seeking. The data will be analysed using Braun and Clarke's (2006) Thematic Analysis approach to determine any recurrent themes that point to specific influencing factors. It is hopeful that results may allow for the formulation of potential prevention, intervention and treatment options that are realistic and accessible to all men. The study also aims to lay the groundwork for much-needed longitudinal research in the future into the long-term effectiveness of various male-centred interventions and treatments. The research question being asked is, what are the factors that influence help-seeking behaviour for depression in Irish males?

Methods

Study Design

A cross-sectional qualitative analysis was the appropriate method for this study as it is interested in understanding and opinions of a specific population (Irish males) at a specific point in time (Silverman, 2020). This analysis was based on Braun and Clarke's (2006) thematic analysis. The flexibility of the semi-structured, open-ended format allowed for a more in-depth analysis of the participants' experiences (Sutton & Austin, 2015). The interview questions aimed to explore participant's opinions and feelings about seeking help for depression and the factors that might encourage or dissuade them from doing so. The interview guide (Appendix 1) was used to avoid any potentially leading questions.

Ethical Considerations

Ethical approval for this study was sought from and approved by the National College of Ireland. Prior to being interviewed, participants were emailed an information and consent sheet (Appendix 2). Here they were also advised of their right to withdraw from the study. Participants were informed that to maintain their anonymity, we are unable to retract their data once they had completed and submitted the interview as all data collected is non-identifiable. Participants were not asked to provide any identifying information. Before providing consent, participants were informed that there would be questions regarding depression, but that they would not be asked to disclose any specific information, such as the circumstances that lead to the depression. A list of available mental health services and helplines were provided on the debriefing page (Appendix 3).

Although the questions regarding participants' experiences of depression were general, there was a minimal risk of distress which required a contingency plan should this occur. The researcher was aware that, should a participant become distressed, i.e., explicitly stating that they are feeling upset or distressed, or by displaying physical signs of distress

such as crying, the interview would be stopped immediately. The participant would be asked if they needed additional support (such as mental health services) and should they require it, they would be provided with appropriate details, such as helpline or emergency service numbers. If the participant was comfortable with proceeding, the interview would resume, if the participant was unable to continue, the interview would end, and the participant would be released from the study without penalty. The participant would be encouraged to engage with their mental health provider or general practitioner, and the researcher would follow-up with the participant in the days following the interview, if the participant consented. However, none of the participants became distressed during any of the interviews.

Participants

Purposive sampling was used to select participants. This method was chosen as the research was interested in the specific perspective of Irish males. As this is a non-probability method, there was not an equal probability of participant selection (Luborsky & Rubinstein, 1995). The recruitment criteria included men living in Ireland between the ages of 18 and 65 across a variety of demographic variables. Data was collected for age, location type (rural, suburban, urban), ethnicity, religion and employment status. The sample included 8 participants, allowing for an in-depth analysis of each participant's views on seeking help for depression. Based on a report by Eynon et al. (2018), data saturation, or where "no new information or themes are observed in the data" (Guest et al, 2006), is after 8 transcribed interviews.

Measures

As the interviews were semi-structured, guide questions were created by the researcher to work from (Appendix 1). The discussions varied based on the context and flow of the interviews. A pilot study was conducted with one of the participants to ensure the

questions, timing and materials were sufficient and appropriate for the study. The participant was made aware of this before the interview. No changes were made following the pilot study, therefore the results were included in the analysis

Materials

The researcher's MacBook Pro was used throughout the interviews for recording and transcribing. Interviews took place over Microsoft Teams and were recorded using the record feature on this platform. The researcher's laptop webcam and the participants' personal computer or laptop webcams were used in all interviews. The researcher used earphones with a microphone while conducting interviews to ensure privacy. Once recorded, the interviews were saved to Microsoft Stream until the transcriptions were completed, when they were then permanently deleted. The interviews were transcribed using Microsoft Word. The interview guide was saved to the researcher's iPad so that the researcher could easily access the questions throughout the interviews.

Data Collection

Information about the study, such as the general theme, the inclusion criteria (men living in Ireland between the ages of 18 to 65) was posted on social media sites Facebook, Instagram and LinkedIn by the researcher. Potential participants were advised through the social media post that if they wished to participate, they may contact the researcher via the email address provided. Upon emailing the researcher, participants were sent an information and consent sheet (Appendix 2) and times and dates were arranged to conduct the interview. Once suitable arrangements had been made, participants were sent an invite to join a meeting on Microsoft Teams.

At the time of the meeting, the participant and researcher both joined the call. The researcher reminded the participant what the study is about and that the interview would be recorded. The researcher reaffirmed that the participant was comfortable to continue with the

interview. The participant was reminded that once the interview has concluded, the recording would be transcribed and anonymized, and as a result, it would not be possible to retract the data.

Eight interviews were conducted as part of the data collection process and each took place separately. Before the interview, participants were asked to complete a brief demographic survey (Appendix 4). Following this, the researcher asked a series of questions regarding the participant's experiences with seeking help for depression and their thoughts on mental health services (Appendix 1). The structure was flexible so that the interview flowed and adapted naturally. The participant was given the right to end the interview at any time for any reason, as per the information and consent sheet (Appendix 2) prior to the interview.

The interview times ranged from 30 minutes to 74 minutes (m = 46 minutes) and took place over five weeks. Following the interview, the researcher reiterated that the data collected would be anonymised, and as such would not be able to be retracted after January 2021 when the interviews would be deleted following transcription. The participant was also sent a debriefing sheet (see Appendix 3) which included a list of mental health services and helplines that were available if needed. Once the interviews were completed, they were transcribed into a Microsoft Word document for further analysis.

Data Analysis

Braun and Clarke's (2006) thematic analysis was used for analysing the data. Inductive analysis was used to allow themes to emerge naturally from the data rather than relying on an existing framework. This method of thematic analysis involves six phases. The first phase involves the researcher becoming familiar with the data that has been collected through verbatim transcription of the interview recordings and repeatedly re-reading the data. Following this, preliminary codes are generated by highlighting and noting relevant and interesting features of the transcripts to be sorted into groups. These groups of codes are

then sorted into themes and sub-themes and are then further analysed, refined, and altered as needed.

Results

Demographics

The demographics for all participants are presented in Table 1 below. 8 participants took part in the interviews. They were aged between 28 and 49 years old (m = 33.5, SD = 7.8)

Table 1

Descriptive statistics for depression, gender, employment, ethnicity, location, religion, and relationship status

Variable	Frequency	Valid %
Experienced depression		
Yes	6	75
No	2	25
Gender		
Male	8	100
Female	0	0
Employment		
Employed	5	62.5
Unemployed	1	12.5
Student	1	12.5
Self-employed	1	12.5
Ethnicity		
White Irish	8	100
Other	0	0
Location		
Rural	2	25
Urban	1	12.5

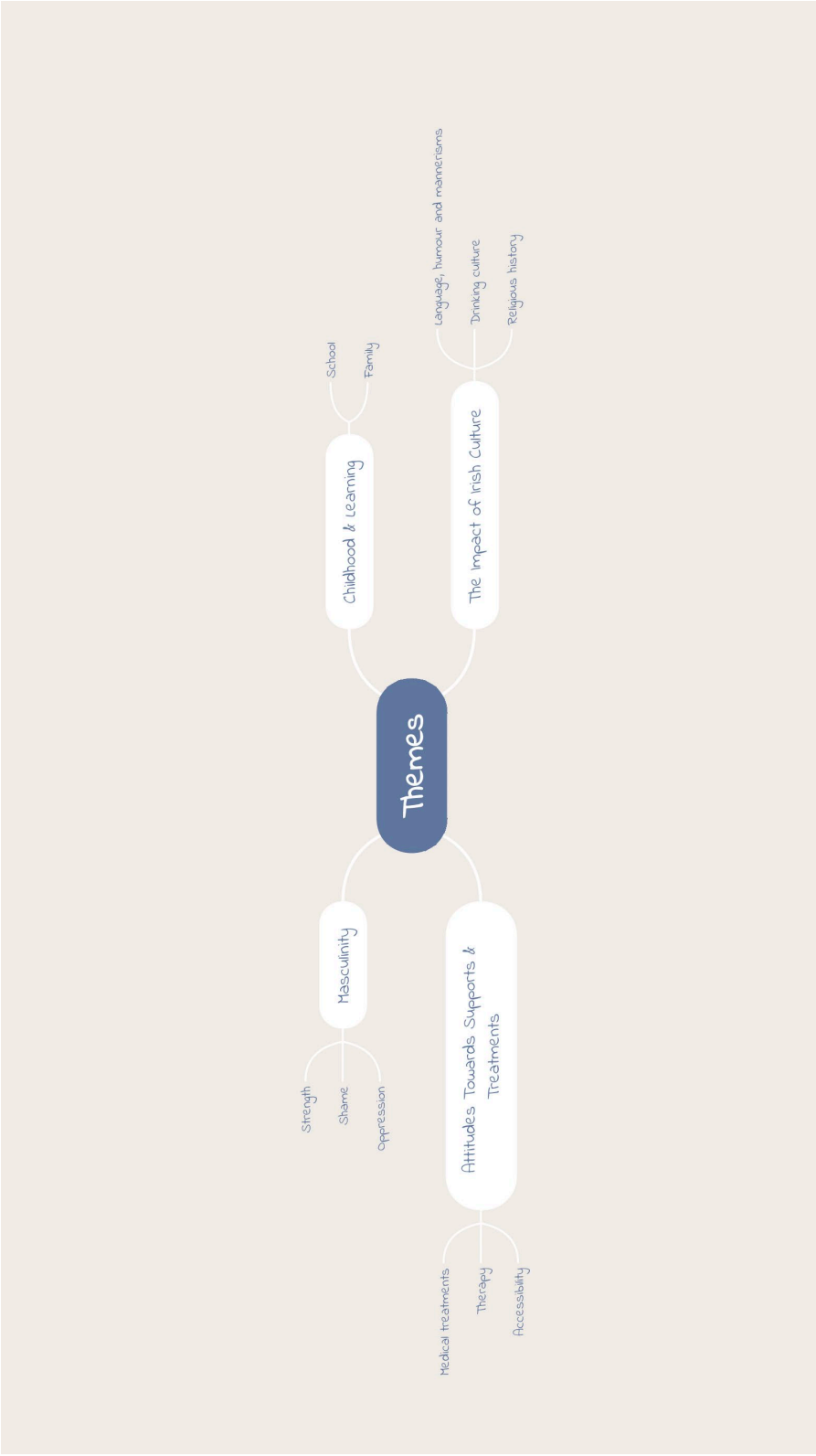
Suburban	5	62.5
Religion		
Non-religious	3	37.5
Roman Catholic	2	25
Spiritual	2	25
Other	1	12.5
Relationship		
In a relationship	5	62.5
Single	3	37.5

Themes

The interview transcripts were analysed using Braun and Clarke's (2006) thematic analysis method. Following the analysis of the data, four main themes were developed as follows: (i) "Childhood and Learning" identified the role that families and education play in the attitudes and beliefs surrounding mental health (ii) "The Impact of Irish Culture" explains elements that are unique to Irish culture that contribute to mental illness, such as Irish humour and mannerisms, Irish drinking culture, and Ireland's religious history (iii) "Attitudes Towards Supports and Treatments" explores the opinions of participants towards treatment options such as visiting their doctor or a private therapist, and the issue of accessibility of services, and (iv) "Masculinity" discusses the potentially damaging effect of traditional views of masculinity on men's mental health (Figure 1).

Figure 1

Themes



Childhood and Learning

When participants were asked about the signs of depression the men all correctly identified some commonly known signs such as low mood and withdrawal. However, throughout the discussions, it became apparent that while the men felt they had a general awareness of depression and increased suicidality in men, they also felt the knowledge they had was vague and predominantly from their own experiences. A prominent theme throughout each of the interviews was the role of education, both at school and home, and the influence that the participants' families and school learning had on their attitudes and understanding of mental health.

School

When discussing the role of school education it was frequently mentioned that mental health education is limited and undervalued in the Irish school system: "Throughout your schooling, emotional health isn't viewed as important really (…) You're not really taught about who to talk to." (P1). A common feeling amongst the men was that early intervention is critical in preventing future mental health problems through learning how to identify and talk about emotional wellbeing: "People need to be taught how to talk about how they feel. If from a very young age we are able to verbalise or write how we're feeling, we can identify those issues at a much earlier age." (P1). In particular, concerning the role of education in men's mental health awareness, Participant 3 felt that learning from a young age to normalise male emotions could be an important factor in influencing men's attitudes towards mental illness in later life: "Boys need to be taught that it's okay to talk about mental health and be aware that you're not always expected to be strong and macho." (P3).

Many of the participants felt that they did not know where to go for help if they felt depressed: "I think there's a general lack of awareness about what's available. I wouldn't know who to seek help from." (P5). Based on the comments from participants, it is clear that

mental health awareness education is lacking in the Irish curriculum, as this was mentioned in every interview by each participant. There was a recurring sentiment of a missed opportunity by the participants, that schools may have a protective role and a preventative responsibility to educate children about mental health and mental illness, including how to identify mental illness and where to seek support.

Family

> *"It's where you learn everything from the start. I think they have a huge impact. If your parents were open about mental health from an early age, you'd probably be able to cope a lot better when you're older." (P2)*

In addition to school education, participants mentioned the influence of family and upbringing on how they perceive mental illness. Several participants felt their parents and siblings had a strong impact on their negative attitudes towards depression and mental illness in general. Some participants felt they first became aware of feeling shame about their mental health at home. When asked to expand on this, Participant 4 replied:

> There's a lot of this "someone always has it worse" attitude that we got from our parents (...) So, we're taught to feel ashamed of ourselves when we feel hurt or upset by something when in reality, our feelings are no less valid just because someone might have it worse. Someone always has it worse.

Another recurring factor was the influence of participants' families in their attitudes towards seeking help: "I haven't really grown up being heavily involved with the GP. It's kind of an 'if your arm's not hanging off, you'll get over it' type of thing." (P1). There was a general dismissal of mental health concerns in many of the participants' experiences. Some

participants discuss how their attempts to talk about their mental health were sometimes belittled, and how this impacted their ability to talk about their feelings in later life: "I was expected to get over it and was never really given the time to feel it out and talk about it." (P8). The role of family is undoubtedly a significant and meaningful contributor for the participants in their perception of mental illness, help-seeking and shame. Many of the participants felt their attitudes and behaviours in adulthood were strongly influenced by what they learned from their families in childhood.

The impact of Irish culture

While there appears to be many influencing factors for men's help-seeking behaviours that are not specific to Irish culture, several elements of Irish culture do seem to be recurring themes in what participants viewed to be contributory to their attitudes towards mental health and mental illness. Most commonly discussed amongst the participants was Irish mannerisms, the Irish drinking culture, and the impact of Ireland's history with Catholicism.

Language, humour, and mannerisms

> *"I think it makes it harder to talk. Sometimes when you share something there's a tendency to take the mick out of each other. That's great sometimes because it can be a bit of fun and can lighten the mood and cheer you up, but other times when you just want to talk about something that's been painful it can be more challenging to be taken seriously or really heard." (P5)*

Irish humour was frequently mentioned with regards to how mental health is discussed in Ireland and the impact it has on the ability to disclose mental health concerns: "I think the type of banter we have – if you have a vulnerability, you're slagged over it. That probably hinders how we talk about mental health." (P3). When discussing Irish humour, it was widely understood by participants that "slagging" and "teasing" was expected in

interactions amongst peers. Participants discussed how they were prepared for these conversations and often engaged in this type of humour themselves. This was seen as normal and predictable behaviour and part of Irish culture. It was discussed as being "harmless" in most cases, however, the men acknowledged that it can sometimes have a negative impact when discussing serious issues. When asked about such experiences, Participant 4 describes an instance where he felt this type of humour was damaging to him:

> I recently went through [painful experience] and was chatting with my mates about it and they were slagging me off, trying to make me laugh, but it just wasn't what I needed then. I think me talking about it just made them uncomfortable. That's a very Irish thing, when we're uncomfortable we make jokes, but I felt embarrassed then and didn't want to talk about it anymore, so I had to sit with those feelings alone.

Participant 8 talks about how their ability to seek help was directly impacted by his interactions with his friends in his teenage years:

> Fear of the slagging from friends would definitely have prevented me from seeking any help as a teenager, and I would often downplay how I actually felt to not arouse suspicion or seem weak.

There was a distinct correlation demonstrated between Irish humour and how participants discuss issues that are important to them. While this type of interaction is seen as normal and expected in Irish interactions, it appears to be hindering in some cases where men wish to share their feelings and experiences with peers, but are either dismissed, rejected, or reluctant to share these feelings from the onset for fear of teasing, however well-intentioned:

"We're expected to behave a certain way, to laugh and joke along and not say when someone's touched a nerve." (P1).

Another point that arose through the course of the interviews was the reluctance to explicitly state when one is feeling depressed: "I think I've probably said, 'I'm feeling a bit off' or 'not well', but I don't think I've ever used the term 'depressed'." (P2). When discussing their own experiences with depression and whether they sought support at that time, many of the men described how their close friends or partners brought the issue to them first. Often the participants used terms that they viewed as more masculine to implicitly disclose their depression, such as "being under a bit of pressure" (P3). This suggests an inability to articulate feelings of depression or concern about mental health.

Drinking culture

Ireland's relationship with alcohol consumption is mentioned in all of the interviews. Amongst the men, it was generally accepted that socialising and alcohol consumption go hand-in-hand. While alcohol consumption in itself was not viewed as problematic, the overall feeling was that alcohol is often over-consumed and used to placate negative emotions: "We definitely have a culture of drinking instead of getting professional help. We self-medicate with alcohol, and it's acceptable because we're Irish, and it starts so young." (P6). Participants believed that Ireland's attitudes towards drinking are at times problematic. Each was aware of the negative impact that alcohol can have on mental health, and also the impact of the after-effects of alcohol consumption: "We joke about 'the fear'. We use drink as a coping mechanism to numb our feelings, but it also creates anxiety when we're hungover. If you're already depressed, that can have a really strong impact." (P5).

Some participants acknowledged that "normal" levels of alcohol consumption in Ireland would be seen as binge drinking in most other cultures, yet is acceptable in Ireland. Going against the grain with regard to Ireland's drinking culture is often met with criticism,

according to some participants: "You can't tell people not to drink because it makes your mental health worse because drinking is what we do, we can't wreck the buzz." (P1). It is clear that alcohol plays a strong role in how many people in Ireland cope with negative emotions. This also illustrates how non-conformity is treated in Ireland, with many feeling that drinking alcohol is expected, and to challenge that may be met with social exclusion.

Religious history

> *"Generational shame and guilt can have an aversive effect on what way you teach your children. So, you might do the opposite of what was done to you, or you might do the same because it filters down through the generations." (P1)*

When discussing Ireland's religious history, the subject was often seen as controversial. This was for several reasons, namely due to "The Troubles", controversies in the Irish Catholic church, such as Magdalene laundries and clerical sex abuse scandals, and the non-division of church and state in Irish law with regards to divorce, contraception, same-sex marriage, and abortion. Participants talked about how, even with the troubled religious history of Ireland, many still considered Catholicism to influence their life, albeit on varying scales. For instance, several participants mentioned christening their children and sending their children to Catholic schools, despite disagreeing with Catholic policies and beliefs, as it is seen as expected. While discussing the role of religion, Participant 2 states:

> I think even though very few of us still practice religion it's still a very big focus in schools and with our parents and grandparents. They would have influenced our beliefs and the things we're ashamed of and how we view others.

In general, participants viewed Ireland's religious history as being repressive and damaging to society: "Catholicism had a really negative influence on Ireland. I think it brought a lot of repression, guilt, and negative attitudes towards mental health." (P7). While religion may not play as significant a role today and it has in the past, it is evident that religion still influences the attitudes and beliefs of many of the participants. There was an acknowledgement amongst participants that Ireland's religious history is closely linked with family dynamics and upbringing. Several participants held religion accountable for much of the negative stigma surrounding mental illness and suicide. Participant 6 in particular described his frustration with the terminology used when discussing suicide:

> I think our society is very oppressive because of religion. Even terms like "committing suicide" – that came from the Church because suicide is committing a sin (...) I think historically we have this view of those who have taken their own lives as bad or selfish or sinful, to the extent that people would just lie about how they died, and then nothing gets talked about. We're so afraid of talking about suicide.

Shame and guilt were frequently mentioned while discussing religion and it is apparent that many participants attributed the overall societal stigma towards mental illness to the influence of the Church. However, some participants spoke quite positively about religion and the positive influence it has had in terms of morality and charitable organisations. Participant 5 discusses the potentially protective role of religion against suicide:

> I think maybe faith can be helpful in a lot of ways, it can help you through difficult times, give you some hope maybe. If you look at suicide, I wonder would as many

> people have killed themselves 50 years ago, probably not. They might have thought it was immoral.

Overall, religion is undoubtedly an important factor in the discussion of mental health attitudes in Ireland, whether it be protective against suicide or contributary to mental illness stigma.

Attitudes towards supports and treatment

A common theme while discussing the influencing factors for the men seeking, or not seeking, support and treatment for depression was the healthcare provided in Ireland. Overall, participants were vaguely aware that their options included visiting their general practitioner (GP) or attending private therapy. Further than this, there was little to no awareness of healthcare services or available treatments. Accessibility appeared to be a primary concern with regards to seeking mental healthcare.

Medical treatment

Participants considered their attitudes towards attending their GP for support with depression, and while they felt their GP should be their first port of call, there was an overall reluctance. Several participants felt that GPs were quick to prescribe medication rather than discuss therapeutic treatment options: "I think there's a lack of training with GPs to diagnose depression and offer appropriate treatment, so they tend to go straight to medication." (P5). Some participants felt dismissed by their GP when seeking treatments for depression. Participant 6 describes his experience with seeking support from his GP:

> At the start, I felt I was very brushed aside. You're made feel like you've just come in to waste time. It took 8 or 9 months for them to take it seriously, but once they realised that it was serious, they became more supportive. The therapy side has

> always been great, but the GPs didn't take me seriously until I couldn't go to work anymore.

In addition, several participants felt there was an absence of emergency mental healthcare, with mental health crises not being taken seriously or sufficiently managed. Participant 8 shared his feelings towards crisis management by the Irish healthcare system:

> I feel they're lacking in the way they handle cases of crisis. I feel as though you'd almost have to be ready to do something drastic in front of some of these places to actually get help from them in a time that you need it, and not pawned off until a later date, perhaps a time that's too late.

There is a noticeable mistrust amongst the participants towards the healthcare system in general. This shows an area that is preventing men from seeking help for depression. While participants believed their GP should be their first contact if concerned about depression, several felt that if they felt unheard at their initial consultation, they would not continue to seek help at all: "If you don't have a positive experience at the first step, you're not likely to keep going." (P1).

Therapy

The other option that participants felt was open to them was private therapy. While discussing this option, they spoke about different types of therapy and what they felt would be most accessible and appealing to them. When asked about his preferred therapy style, Participant 8 said:

> For me, talk-based therapy would be my go-to. I'd be better at talking through my problems than actioning through CBT. I feel that I'd let myself down if I committed

to actioning something every week, and if I didn't succeed then I'd feel a sense of anxiety going back the following week.

This opinion was shared by each of the participants, showing a preference for talk-based therapy over solution-focused therapy. Several participants felt that other men would disagree: "I think solution-focused therapies might be more accessible to men in general, probably because there's a target to being 'fixed'." (P2).

Some of the participants had attended therapy for depression in the past and had very positive experiences, despite an initial reluctance: "I was hesitant to go to a counsellor after [painful experience] but after 2 or 3 sessions I was totally comfortable." (P3). It is apparent that participants have a more positive attitude towards more holistic treatments such as talk therapy when compared with medical treatment options. The general feeling was a desire to be heard without judgement as opposed to "treated".

Accessibility

"Waiting lists are outrageous (...) Even the private system is tough because it's very expensive and you mightn't find someone you gel with for a while. In general, I think I'd just prefer not to interact with the mental health services in Ireland." (P7)

The accessibility of treatment options was a recurring issue for participants. The time and financial cost involved in receiving treatment was a concern shared across every interview. Participants spoke of lengthy waiting times for public healthcare services, including mental health services: "I haven't had much experience with the public mental health system, but I know the waiting lists are outrageous, even when the case is very serious." (P7). Several participants felt this would dissuade them from seeking help through the public healthcare system.

In addition, participants felt their only other option was to source a therapist privately. Some of the participants had attended private therapy and found it valuable, however, the participants all felt that the time commitment and financial cost of private therapy could be a significant burden that many would be unable to manage. While discussing this subject, Participant 2 said:

> I've been on antidepressants and I've been to a therapist before. I've thought about doing that again, but the problem is finances and time with work. I would have to *really* need it because it's expensive and I don't really have time.

This demonstrates that accessibility of services is a significant factor when contemplating the likelihood of seeking help for depression. Each participant felt their only options were to wait an unknown length of time to be seen publicly or to commit to a financial and time constriction in order to seek support privately.

Masculinity

The role of the participants' perception of masculinity was discussed at length with regards to the influence on help-seeking for depression. Participants consider the expectations placed upon men and the feelings associated with the pressure to conform to these ideals.

Strength

> *"There's an expectation that if you're a man, you suck it up and deal with it. It's the macho thing. There's something about exposing a vulnerability. You don't want to be seen to not be able to handle stress." (P3)*

Participants explained the pressure put upon them to act in a way that they feel is masculine. The primary pressure expressed by the participants is that of "strength", the

expectation for men to avoid showing weakness at all costs. This appeared to be due to the association of weakness with femininity: "I think worrying about seeming weak is what discourages men. I think talking about mental health, or pursuing mental health services, is considered a feminine thing to do." (P7). Participants felt they had to conceal their emotions to portray to others that they were strong and masculine which often limited their ability to openly discuss their mental health or seek support: "There is a pressure by society for men to get on with it and not seek help. We're expected to keep going, we can't let emotions control how we operate because it's not manly to have emotions." (P8).

Several participants expressed concern for other men, that their inability to seek help may increase their risk of suicide: "They're afraid to ask for help so it gets so bad that they can't manage it themselves and they commit suicide or attempt to." (P5). The need to appear strong seems to override the need for mental health support in many cases. Some participants admit to waiting until their depression was unbearable before eventually seeking support: "I nearly had to work myself into a pit before I decided to get professional help." (P6). Participants mentioned how they believed some men may see suicide as the only option: "I think a lot of us, if left to our own devices, just wouldn't bother unless we got to a really bad place, and even then, it's a choice between getting help and suicide." (P6). From this, we can see the important role that perception of masculinity plays in male attitudes towards mental health, mental illness, and help-seeking.

Shame

Participants who had sought help for depression admitted to feeling ashamed and embarrassed for doing so, but that after engaging in therapy felt comfortable sharing their experience with peers and even recommended therapy to others. Participant 3 shares his experience with this:

> I said to my wife at the beginning that I didn't want anyone to know I was going to counselling, even my own family. But once I actually started and knew what was involved, I was happy to admit to it and talk about it. I wouldn't hide it. I wasn't embarrassed anymore.

Similarly, participants shared instances of their friends also seeking help after hearing about the participants' experiences: "A lot of my male friends who are getting support now only started after I told them I did." (P6). This suggests some men are more open to seeking help if they feel they won't be shamed by their peers.

When discussing the source of the shame surrounding depression and masculinity, a lot of the men felt this came from other men, and that they generally didn't experience the same level of shame when disclosing their feelings to their female peers: "I think how society is built, the expectation's on men and not talking about feelings, like an oppression of men's feelings. I think it actually comes from other men." (P4). Several spoke about their desire to deconstruct the traditional concept of masculinity. When asked how he would prefer masculinity to be perceived, Participant 7 replied:

> I would prefer if we didn't have to think about things through a binary lens at all (...) Allow people to behave and express themselves in the way that they want to without having to put it through a prism of masculinity or femininity.

This view was shared by the other participants who felt the current view of masculinity is outdated and doesn't represent their views on what masculinity means to them. When asked how they would prefer masculinity to be represented, the responses were that

"men aren't all the same" (P7) and that "men do have emotions" (P8). Participant 6 shares what he would want masculinity to be perceived as:

> I guess just supportive. A shoulder to lean on. When people talk about femininity and girl power, having each other's backs – I think we can take a huge lesson from that. Whereas masculinity is all about being strong for yourself. I think if masculinity could be changed to being supportive to each other, that would be great.

These views shared by the participants show a desire for a shift in the current attitude towards men's mental health at a societal level.

Discussion

The aim of this research was to explore the experiences of men living in Ireland and to understand the factors that influence them to seek help or to not seek help for depression. Interviews were carried out and four themes were developed from the transcripts using thematic analysis. The themes constructed from the data were: (i) Childhood and learning, (ii) The impact of Irish culture, (iii) Attitudes towards supports and treatment, and (iv) Masculinity.

Consistent with the previously mentioned research carried out by Keneko and Motohashi (2007) and Jorm (2012), participants appeared to struggle to identify symptoms of depression or where to seek support. In "childhood and learning" participants shared their views that schools and families play a significant role in their understanding of mental health and mental illness. Participants felt that mental health awareness education was lacking in the Irish school system and as a result, they felt they had a limited understanding of mental health, including the signs and symptoms of common mental illnesses such as depression, how to articulate their feelings, and where to go for support. While mental health education may have improved since the participants were in school, there is no substantial evidence or research to suggest this. Oftentimes, the stigma surrounding mental illness is a result of negative stereotyping and miseducation (Harland, 2008). Pinfold et al. (2003) found that short educational workshops in schools can reduce stigma and discrimination against those suffering from mental illness. Furthermore, a larger focus on mental health education should be implemented across all school levels to improve literacy and empower children and adolescents to articulate and identify mental health concerns. Providing young people with these tools will improve mental health awareness and will likely increase help-seeking rates (Patel et al., 2007).

In addition to school education, participants felt their upbringing and families influenced their attitudes towards mental illness. Several participants felt less likely to discuss their mental health or to seek help for depression due to learning to hide their emotions, and that seeking medical advice was not for mental health concerns, but extreme physical ailments only. This is also in line with previously mentioned research that suggests that family engagement with mental health discussions, particularly with the father, is a critical influencing factor in young men's attitudes towards mental health (Panter-Brick et al., 2014). Early intervention programs within family settings may be useful in encouraging and engaging families to understand and openly discuss mental health and its importance.

"The impact of Irish culture" explores how cultural and societal norms in Ireland play a role in how mental illness is perceived and managed. Participants described the interactions that are common and expected amongst peers, and how the language and mannerisms used sometimes make mental health discussions difficult, if not impossible. "Slagging" was seen to dissuade participants from sharing feelings with peers, resulting in participants withholding their emotions and lessening their likelihood to seek support for depression. Research has shown men to conceal feelings of emotional upset amongst male peers in particular in anticipation of being made fun of (Harland, 2008; Seidler, 2007). National mental health awareness campaigns should be explored as an option to provide education on mental illness stigma, signs and symptoms, and support options.

Alcohol use was also frequently mentioned as a coping mechanism for managing symptoms of depression. Participants acknowledged the negative impact of using alcohol to self-medicate instead of seeking help for depression and felt that high rates of alcohol consumption in Ireland contribute to the high rates of depression and suicide. Ireland has a higher-than-average rate of regular heavy episodic drinking than other European countries at 46.5% of drinkers (WHO, 2019), and 37% of drinkers engage in binge drinking on a typical

occasion (Healthy Ireland Survey, 2018). In Ireland, alcohol is more involved in instances of self-harm in men (37%) than in women (33%) (Griffin et al., 2014) and is involved in more than half of male suicides (Alcohol Action Ireland, 2013). Participants also discussed how drinking often starts quite young in Ireland. The relationship between alcohol, depression and suicidality among adolescents can be explained by Problem Behaviour Theory (Jessor & Jessor, 1977) and is a phenomenon that must be addressed when examining preventative measures for suicide in this group. As such, adolescent education regarding the relationship between alcohol, depression and suicidality should be examined (Galaif et al., 2007).

Another interesting topic that emerged was the impact of Ireland's religious history. Participants discussed the damaging effect that the Catholic Church has had in Ireland in terms of repression and generational shame, guilt and trauma. Several studies show a correlation between higher levels of shame and guilt with higher levels of religiosity, particularly amongst Catholics and Protestants (Albertson et al., 2006). Generational trauma refers to trauma that subsequent generations (children, grandchildren, etc.) are affected by (Levine, 2001). Ireland is a predominantly Catholic country, with 78.3% of Irish individuals identifying as Catholic (Ryan, 2017). The history of the Catholic Church in Ireland is long and turbulent with many controversies such as clerical sex abuse scandals (BBC, 2012), the use of Magdalene laundries (McCarthy, 2010), and the discovery of several mass graves at various mother and baby homes (Dalby, 2014). There is currently a lack of research regarding the impact of Ireland's religious history concerning generational trauma in Irish families, however, it could be suggested that parents and grandparents have been impacted by their experiences with religion, which in turn may have influenced their parenting style. One suggestion for healing generational trauma in Ireland is to incorporate positive Irish cultural identity and practices such as music, dancing, sport and language, into mental health treatment to focus on positive elements of Irish history (Coll et al., 2012).

In contrast, some participants argued that the lack of religion is connected with the increased rates of suicide in Ireland in recent years. It was argued that religion provides hope, therefore reducing the likelihood of suicide. This would fit in well with Émile Durkheim's (1897) theory of religion's protective role against suicide. Thomas Masaryk (1881) also proposed an inverse relationship between suicidality and religiosity. While it is true that suicide rates have increased in Ireland in recent years, and also true that religiosity has declined (Central Statistics Office, 2016), it cannot be confirmed that the two events are directly related. A study by Kelleher et al. (1998) argues that, were religion as protective against suicide as suggested by theorists such as Durkheim and Masaryk, then it would be unlikely that suicide rates would be higher in rural areas in Ireland where rates of religiosity are higher, than in urban areas where levels of religiosity are lower, as is the case today (National Suicide Research Foundation, 2021).

The theme "Attitudes towards supports and treatments" shows participants' beliefs about mental health services in Ireland and their opinions about their different options. Participants felt their only options were seeking medical support or private therapy. There was an overall mistrust of GP competency amongst participants, with many feeling reluctant to attend their GP due to a tendency for GPs to be dismissive or to prescribe medication with no other treatment. There have been reports in Irish media that antidepressant prescription rates have drastically increased in the last 10 years (Corrigan, 2019), however, it has been argued that this is not so much a result of overprescribing, but rather a response to increasing prevalence and awareness of mental health issues (O'Rourke, 2019). Participants felt that urgent mental health support was insufficient, with many feeling that to be seen urgently they would have to self-harm or attempt suicide. Participants felt that this was a major influencing factor in their decision not to seek help for depression. Further research is needed to

determine if appropriate measures are being taken by primary care practitioners in managing mental health issues.

The participants all spoke positively about therapy and of those who had first-hand experience they found it valuable and meaningful. Participants discussed their preference for talk-based therapy rather than solution-focused treatments such as Cognitive Behavioural Therapy (CBT) due to wanting to feel heard without judgement and to have a safe space to express their feelings. Some participants felt that committing to CBT may present other challenges, such as feeling pressured to reach targets and shame and guilt for not doing so. This was an interesting perspective, and in contrast with research mentioned earlier which shows men to prefer CBT (Emslie et al., 2007; Spendelow, 2015). The insight into men's therapeutic preferences indicates a potential redirection of treatment that contradicts previous research. This provides an opportunity for therapists to understand the needs of clients without assumption based on gender.

A prominent topic for participants was the issue of accessibility. Each felt they would be less likely to seek treatment through their GP or hospitals due to the extremely long waiting lists for public mental health treatment in Ireland. Extremely long waiting lists in Ireland for mental health services for children, adolescents and adults are an ongoing and well-documented issue (O'Brien, 2019). Furthermore, participants felt the financial cost of private treatment was unsustainable and unachievable for many. The time commitment of private therapy was also a concern, with several feeling it would be too difficult to attend therapy regularly in addition to their working hours and family commitments. The issue of accessibility is clearly an influencing factor in the decision to seek help for depression as the participants indicate they would be more likely to approach their GP if they felt they would receive adequate and prompt treatment, and more likely to seek out private therapy if the cost was regulated at a lower rate. Increased government funding is essential to provide more

practitioners and services to limit waiting times for public treatments. In addition, urgent care facilities should be explored within communities for prompt treatment of mental health emergencies. Mental illness diagnostic and treatment protocols should be re-examined to ensure GPs are well-equipped to sufficiently manage patients disclosing mental health concerns.

The theme of "Masculinity" includes discussions about the role participants feel masculinity plays in their ability to seek help for depression. According to Harland (2008), westernised idealisations of masculinity leads men to reject any characteristics they perceive as feminine, and as a result, feeling obliged to withhold their emotions. Participants acknowledged that it is normal for men to experience emotions such as depression and anxiety, yet they still felt ashamed to admit these feelings to themselves and others. The association between emotions and seeking help with femininity was a common thread amongst participants. Participants shared how the shame attached to men's mental illness causes men to leave it too late to seek help, resulting in suicide. Participants felt the shame attached to male mental health is brought by other men. Research corroborates this, showing men often feel most berated about mental health by other men (Harland et al., 2006; Harland, 2008).

An interesting perspective is given by Harland & McCready (2007), who discuss the impact of the upheaval of The Troubles in Northern Ireland where men were seen as defenders of their communities. The aggression and violence expected of young men at this time was respected and warranting praise in Irish society, however, this behaviour is no longer commended in Ireland today, presenting a complex transition for men. Harland & McCreary argue that men are struggling to adapt to this period of relative peace resulting in the internalisation of aggression. In addition, Connell (1995) discusses masculine contradictions, where men are expected to be powerful, strong, in control, and brave, yet in

reality, they may feel weak, fearful, and unrestrained. To counteract these uncomfortable feelings, Connell refers to the phenomenon of "protest masculinity", where men attempt to prove their masculinity by appearing unemotional. Overall, participants felt they would like a shift in the current perspective of masculinity. Some felt that they would prefer if traditional binary concepts were deconstructed entirely, and others would prefer masculinity be seen as being supportive to others, rather than presenting as stoic and unemotional.

Educating practitioners may help provide a more supportive environment for men upon initial help-seeking for depression. Practitioners should be encouraged to reflect on their own binary biases about men and how they could or should manage their mental health whilst taking cognisance of the complexities and contradictions of "masculinity". Meaningful engagement with men by asking about their thoughts and feelings may be unexpectedly effective, as research has shown that men are rarely asked about such things (Harland, 2008). O'Neil (2008) recommends that practitioners explore positive masculinity traits, shifting the focus away from what is "wrong" with masculinity, and highlighting the strengths such as problem-solving, resilience, positive fathering, and generativity. In a study by McMahon et al. (2014), results found that Irish boys who had engaged in self-harm had a largely increased risk of suicide. This should be considered by practitioners when assessing suicide risk.

Finally, if only one thing is to be taken away from this study, it should be that there are a lot of complex issues underlying men's mental health. Masculinity is not a one-size-fits-all concept. It is clear that the men in this study felt hindered by traditional constructs of masculinity and with to be seen and heard as more than what society believes men ought to be. As such, interventions and treatments should be reflective of this. Men are all individuals with different preferences, ideas, circumstances, and backgrounds. No one treatment option, marketing campaign, or intervention is going to be appropriate for every man. While Men's Shed programmes have become popular in recent years (Ballinger et al., 2009), these will not

appeal to everyone. Incorporating options that are inclusive to the entire spectrum of men and interpretations of masculinity are crucial to ensuring men feel accepted and safe to be open about their mental health. As discussed by participants, when men become more open about their mental health journeys, their peers often follow suit. Providing men with the tools to become well-informed and open-minded about mental health should be the primary focus in preventing suicide.

Strengths and Limitations

The primary strength of this study was the depth of the discussions regarding Irish culture and its relationship to mental health. This was significant as, despite Irish male suicide rates are one of the highest globally (Griffin et al., 2016), there has been little research about why. The analysis identified several potential risk factors that are specific to Irish culture, such as religiosity, drinking culture, and peer interactions. This method of qualitative analysis allowed for a more in-depth analysis of the human experiences of the participants. The interviews' flexibility and fluidity allowed for a more natural flow which contributed to the ease of communication between researcher and participants.

While the study aimed to involve a more diverse group of participants, the participants who applied were all of White Irish ethnicities. There was no response from individuals under 25 years or over 50 years. However, participants that took part were diverse in their employment and relationship statuses as well as age, location and religions. This expanded on the traditional research that predominantly included affluent university-aged participants. A limitation that should also be considered is the sampling strategy used. It is likely that the participants recruited were already more open to discussing mental health issues and therefore the issue of accessing males who are unable to unwilling to discuss the potential factors discouraging them from seeking support remains unanswered.

The research highlighted several areas for improvement such as education, treatment, and accessibility. Obtaining a greater understanding of the factors influencing help-seeking in men allows for clear recommendations for future research. Therefore, the aim of the study was achieved. Time and resources were limited in recruiting participants and the study would have benefited from a longer recruiting period which may have allowed for a wider range of demographic variabilities, and therefore a more representative sample. Furthermore, due to COVID restriction in Ireland during the research period, the standard method of conducting face-to-face interviews was not permitted. This may have influenced participants' responses based on other individuals being within earshot of the participants during the interviews.

Conclusion

Overall, the research presented in this study has contributed to the understanding of men's mental health and the factors that influence Irish men to seek help for depression. The findings illustrate important influencing factors such as education, family, Irish culture, attitudes towards the mental healthcare system, and masculinity. This research highlights gaps in the literature, adds to the limited information available regarding men's help-seeking behaviours in Ireland, and provides several recommendations for further research in this area. The data collected should inform practitioners, policymakers, families, and educators on how best to support Irish men in their depression with the ultimate goal of preventing suicide.

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Appendix 1

Appendix 1: Interview guide

1. What, to your knowledge, are the signs of depression?
2. Without providing any specific details, do you think you have ever suffered from depression?

   If so:

   - What made you start to suspect you were feeling depressed? (Signs, symptoms)
   - Did you seek help or support for this?

     If so:

     - Did you know where to go for support?
     - Did you talk to friends/family?
     - Did you go to a GP/mental health service?
     - At what stage did you decide to seek help for your depression?
     - How did it feel to seek help for depression?
     - Were you happy with the response you got when you sought support?
     - What were you happy/unhappy about with the support you received?
     - Would you seek help again based on the support you received?
     - What would encourage you to seek help again?

     If not:

     - Was there any particular reason you can recall that made you decide not to seek help?

   If not:

   - Do you think you would seek help if you felt you were depressed?
   - What might encourage/discourage you to seek help for depression?
   - If you chose to seek help, where would be your first port of call?

3. What do you know to be the available mental health services in Ireland?
4. In your opinion, what, if any, are the strengths/weaknesses of mental health services in Ireland?
5. Do you feel that men in Ireland are more or less likely to seek help for depression than women? Why?
6. Do you worry about how you would be perceived if you sought help for depression?
7. What do you feel are the factors that might encourage/discourage men in Ireland to seek help for depression?
8. Do you think that there is anything specific about Irish culture that influences Irish men's decision to seek, or not seek, help for depression?
9. If you were suffering from depression and you could design your own treatment plan, what would that look like for you?
10. Is Ireland changing in terms of views on mental illness?
11. How do you think we, as a society, can improve the likelihood of men seeking help for depression?
12. Is there anything else you would like to add?

Appendix 2: Information and consent sheet

STUDY TITLE

Factors that influence Irish men to seek help for depression

INVITATION

You are being invited to take part in a study that aims to understand the factors that influence help seeking behaviours in Irish men. The researcher, Niamh Slevin, is a final year psychology student at National College of Ireland, IFSC, Dublin. The study is being supervised by Dr April Hargreaves and has been granted ethical approval by the Psychology Ethics Filter Committee.

WHAT WILL HAPPEN

If you choose to participate in the study after reading the information sheet and providing consent, you will be invited to arrange a suitable time and date to take part in an interview. Due to COVID-19 restrictions, unfortunately, interviews cannot take place face-to-face, therefore interviews will be conducted remotely via video conference using Microsoft Teams. The audio of the interview will be recorded so that the researcher can transcribe the interview for further analysis. Once the interview has been transcribed, the recordings will be deleted permanently.

The interview will involve a variety of questions relating to depression, mental health services, and factors that may encourage or discourage men to seek help for depression. There are no right or wrong answers to any of the questions, the answers are from your perspective and based on your opinions, any and all of which are valid, valuable and will be respected.

TIME COMMITMENT

Interviews will last approximately one hour

CONFIDENTIALITY

All of the data that is collected during the interview will be entirely anonymous. We will not ask for any identifying information such as your name, address or date of birth. This is to protect your privacy and to ensure that anything said during the interview cannot be linked to any individual. Since all of the data that is collected from all of the participants taking part in the study will be anonymous, once the interviews have concluded it will no longer be possible to retract your data. This is because the researcher will have no way of identifying what data belongs to any specific participant. Please note, however, that if you no longer want to participate in the study, you are free to withdraw at any point prior to the end of the interview. Once the interview is finished you will be reminded of this once more before ending the meeting.

YOUR RIGHTS AS A PARTICIPANT

It is your right to withdraw from the study at any time prior to the submission of your data. It is your right to decline to answer any of the questions in the interview. It is your right to have any questions answered regarding the procedures or any of the information provided on this sheet.

BENEFITS/RISKS

It is important to note that there are some questions about depression included in this study. This may include general questions about your experience with depression but will not include any specific details or information about the particular circumstances. However, if you do experience any distress as a result of the questions, a list of mental health services and helplines is provided below and will be provided again at the end of the survey.

FOR FURTHER INFORMATION

For further information, please contact Niamh Slevin (researcher) by email at niamhnci@gmail.com or Dr. April Hargreaves (supervisor) by email at april.hargreaves@ncirl.ie. If you are interested in the general results of the study, please contact Niamh and she will arrange to have a copy of the study sent to you following publication.

CONSENT
Please mark **X** beside all the following statements that apply to you:

I confirm that I have read and understood the information about this study that has been provided on this sheet [ ]
I confirm that all questions about this study have been answered satisfactorily [ ]
I confirm that I am aware of any potential risks of taking part in this study [ ]
I confirm that I am taking part in this study voluntarily and without coercion [ ]
I understand that to protect my anonymity, once submitted, my data cannot be retracted [ ]
I consent to the use of a recording device during the interview, as mentioned above [ ]
I consent to the use of the data that I provide in this study [ ]

HELPLINES
Samaritans: 116 123
Pieta House: 1800 247 247
Niteline: 1800 793 793
AMEN: 046 902 3718
HSE National Counselling Service: 1800 235 235
HSE Crisis Textline: Text "TALK" to 50808

Appendix 3: Debriefing sheet

Thank you for taking part in this study. This study aims to explore the potential factors that may influence Irish men's help-seeking behaviour for depression. Interviews will be conducted with several participants and the data will be examined and any themes that arise will be analysed. The final results will be included in my thesis which will be submitted to National College of Ireland and will go towards my final degree. I am also hopeful that I will be able to present this thesis in academic journals and conferences.

If you wish to withdraw your data from this study, you are free to do so at any time up until January 2021, at which point the data will have been fully anonymised and transcribed and will therefore no longer be identifiable or retractable. If you require any further information, do not hesitate to contact me or my supervisor using the contact details below. If you have found any part of this study distressing, a list of services and helplines has also been provided here.

Niamh Slevin (researcher) niamhnci@gmail.com
Dr April Hargreaves (supervisor) April.hargreaves@ncirl.ie

HELPLINES
Samaritans: 116 123
Pieta House: 1800 247 247
Niteline: 1800 793 793
AMEN: 046 902 3718
HSE National Counselling Service: 1800 235 235
HSE Crisis Textline: Text "TALK" to 50808

Appendix 4: Demographic questionnaire

Please answer the following questions, and return to niamhnci@gmail.com

1. What is your age? (Please state your age in years only, do not include your date of birth)
2. What is your ethnicity?
3. What is your religion, if any?
4. What county do you live in? (Please do not include any specific areas or towns)
5. Would you consider the area that you live in to be rural, suburban or urban?
6. What is your employment status? (For example, unemployed, employed, student, retired. Please do not include details of your place of employment or study)
7. What is your marital status?