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Men's Experiences of Mental Illness Stigma Across the Lifespan: A Scoping Review

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Abstract

The stigma of men's mental illness has been described as having wide-reaching and profound consequences beyond the condition[s] itself. Stigma negatively impacts men's mental health help-seeking and the use of services amid impeding disclosures, diminishing social connection and amplifying economic hardship. Although men often face barriers to discussing their struggles with, and help-seeking for mental illness challenges, research focused on men's lived experiences of mental illness stigma is, at best, emergent. This scoping review explores men's mental illness related stigmas synthesizing and discussing the findings drawn from 21 published qualitative articles over the last 10 years. Four thematic findings were derived: (a) the weight of societal stigma, (b) stigma in male-dominated environments, (c) inequity driven stigmas, and (d) de-stigmatizing strategies. Despite evidence that stigma is a common experience for men experiencing diverse mental illness challenges, the field remains underdeveloped. Based on the scoping review findings, research gaps and opportunities for advancing the field are discussed.

Keywords

mental illness, stigma, men, masculinities, qualitative

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Introduction

Research consistently shows that individuals with mental illness are subject to stigma and treated, or thought of, less favorably than others due to their mental health challenges (Gaebel et al., 2017). The detrimental impacts of stigma are far-reaching, impacting access to education, employment, housing, social support, and health care, adding to and amplifying the burden of mental illness (Corrigan & Watson, 2002; Sharac et al., 2010). Similarly, being on the receiving end of stigma can lead to loss of hope and self-esteem, shame, and disempowerment (Corrigan et al., 2016; Livingston & Boyd, 2010). Perhaps most significantly, mental illness stigma is a major barrier to participation in mental health care, leading many to avoid help-seeking (Clement et al., 2015; Corrigan et al., 2014). While mental illness stigma has been extensively researched among the general population, and those with severe and/or chronic mental illness, gender as an influencer of men's mental illness stigmas has rarely been addressed (Gaebel et al., 2017). It remains unclear how mental illness stigma is experienced by diverse groups of men and in different settings.

There are compelling reasons to distinguish the mental illness stigma experiences of men and describe the gendered

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dimensions of men's mental illness stigma (Chatmon, 2020). Globally, men are more than twice as likely to die by suicide than women (World Health Organization, 2021). Despite these higher rates of suicide, men have lower reported rates of depression, a significant suicidal risk factor (Kilmartin, 2005). Implicated in this discordant relationship is the stigma around mental illness, which can restrict men's help-seeking, hinder treatment adherence and deter men from disclosing their depressive symptoms and/or suicidal thoughts (Oliffe et al., 2016; Mackenzie et al., 2019). Furthermore, men may be more vulnerable to stigmatized attitudes and beliefs toward mental illness because experiencing a mental illness transgresses gender ideals including masculine strength and self-reliance, by assigning weakness and dependence to men who disclose a mental illness (Boysen, 2017). Finally, while mental illness is associated with stigma, not all conditions are stigmatized in the same way. Research indicates that gender and mental illness stereotypes intersect resulting in the perception of specific gendered conditions (Boysen et al., 2014). For example, substance use and antisocial behavior are stereotyped as masculine mental health problems and have been shown to elicit more stigma than eating disorders which are stereotypically perceived as feminine (Boysen et al., 2014).

Stigma is a complex social process which is challenging to define. The concepts of stigma applied in mental illness research have been influenced by the early work of Goffman (1963, p. 3) who described stigma as a discrediting "mark" or "attribute which is deeply discrediting" and reduces the status of the person in the eyes of society. According to Link and Phelan's (2001) theory, this is achieved through *labeling* (where particular human differences are singled out), *stereotyping* (where labeled differences are linked to dominant cultural beliefs about mental illness), and *separating* (where those experiencing mental illness are separated "us" from "them"), which in turn leads to *status loss and/or discrimination* (where those with mental illness are devalued, rejected and excluded). To understand the impact of mental illness stigmas, researchers have distinguished between *public stigma* and *self-stigma* (Corrigan & Watson, 2002). *Public (social) stigma* refers to the negative stereotypes, attitudes, and prejudices directed at those with mental illness by society (Corrigan et al., 2012). *Self-stigma* refers to the reactions of individuals with mental illness who turn the publicly endorsed stigmatizing attitudes against themselves (Corrigan & Rao, 2012; Corrigan & Watson, 2002).

Sex difference studies suggest men hold more stigmatizing attitudes toward those with depression (Cook & Wang, 2010; Wang et al., 2007), anxiety (Batterham, Griffiths, et al., 2013), and those who die by suicide (Batterham, Calear, & Christensen, 2013) in comparison to women. Furthermore, young men (Clark et al., 2020) and men with lower mental health literacy (Oliffe et al., 2019b) are more likely to hold negative views toward those with mental illness suggesting increased stigma may stem from having less exposure to, and knowledge of mental illness. Two recent studies addressing sex differences in social and self-stigma related to men's depression and suicide further support these findings (Oliffe et al., 2016; Mackenzie et al., 2019). A survey of Canadian adults reported men with no personal experience of depression or suicide held more stigmatizing attitudes toward men's depression and suicide compared to women (Oliffe et al., 2016). Likewise, men were more likely to agree with the statements, "men with depression are dangerous," "depression is a sign of personal weakness in a man" and men who die by suicide can be described as "pathetic" and "irresponsible" (Oliffe et al., 2016). Among those with personal experience of depression or suicide more men reported self-stigma and embarrassment about seeking help for depression (Oliffe et al., 2016). Expanding on these findings, Mackenzie et al. (2019) reported age differences with younger men having the highest levels of social stigma toward men's suicide and depression.

In terms of the influence of gender on men's mental illness related stigmas, the men's depression and suicide literature has begun to draw attention to men's stigmatizing experiences when discussing the gendered subjectivities of these struggles with mental illness, including help-seeking (Johnson et al., 2012, Coen et al., 2013; Cleary, 2012). Fear of being judged and shamed for transgressing masculine ideals are common stigmatizing experiences. For example, suicidal young men in Cleary's (2012) study concealed their mental distress for fear of being judged as weak for disclosing their emotional vulnerability. Similarly, Canadian based men with depression avoided help-seeking because it was considered emasculating, stigmatized, and further marginalizing (Johnson et al., 2012, Coen et al., 2013). Men's reticence to disclose their mental health challenges is shrouded in fear, influenced by a critical public gaze that encourages men to appear strong, stoic, and unemotional (Johnson et al., 2012, Coen et al., 2013; Cleary, 2012). Collectively, these studies suggest many men are prone to internalizing mental illness stigma through adopting messages about what is, and what is not appropriate behavior for men in relation to their mental health. The purpose of the current scoping review is to provide a synthesis of existing qualitative studies exploring the gendered nature of men's mental illness stigma experiences to identify opportunities for addressing knowledge gaps to advance the field.

Methods

Scoping reviews offer unique contributions by systematically searching and synthesizing existing research

knowledge within emergent and narrowly defined issues (Colquhoun et al., 2014; Levac et al., 2010). A scoping review provides a "snapshot" of the research landscape, allowing researchers to assess the state of the existing literature, determine its breadth and depth, identify gaps, and make recommendations for future research. The current review utilized Arksey and O'Malley (2005) stepped approach to scoping reviews comprising outlining the research question and criteria for inclusion, designing, and implementing search strategies, selecting relevant studies, data extraction, and analysis of included studies.

Identifying the Research Question

The current scoping review addresses the following research question: What does the published qualitative research tell us about the mental illness stigma–related experiences of men ? We inclusively defined "men" to encompass men of all ages across the lifespan and their direct and indirect experiences of mental illness stigma.

Identifying Relevant Studies

Given qualitative research in men's mental illness is emergent (McKenzie et al., 2016) and the complexities inherent in defining stigma (Link & Phelan, 2001), the initial search was broad to thoroughly search the literature. We also focussed search terms to find the high prevalence disorders of depression and anxiety where sex differences in rates have been consistently reported, rather than the low-prevalence mental disorders such as schizophrenia and bipolar disorder where no consistent sex differences have been reported.

The search strategy was developed iteratively using broad keywords and terms to strategically harvest from the available literature (Arksey & O'Malley, 2005). The final set of search terms reflected the three main topic components: (a) terms related to mental health and illness ("mental health" OR "mental illness" OR "suicide" OR "depression" OR "anxiety" OR "mental disorder" OR "distress"); (b) stigma related search terms ("stigma" OR "discrimination" OR "shame" OR "stereotype" OR "prejudice"), and (c) terms for men ("man" OR "men" OR "male") which were combined using Boolean operators. Free text terms were mapped to relevant subject headings and where possible Medical Subject Headings [MeSH] were employed. An electronic search strategy was iteratively devised for use with Medline and adapted for PsycINFO, CINHAL, SCOPUS, Embase, and PubMed and limited articles published 2010 to 2020 inclusive.

Selecting Relevant Studies

Records were screened against the following inclusion criteria: (a) article reported primary research using a qualitative study design, (b) study participants were male (any age), or results were disaggregated and reported separately by gender, (c) study was focused on men's mental illness, and (d) mental illness stigma featured as the study focus OR emerged as a discrete finding. Studies were excluded where mental illness was not the focus of the stigma related findings, for example, studies of stigma specifically due to sexual orientation or HIV. Only empirical peer-reviewed journal publications reporting original research in English were included (i.e., discussion papers, invited book chapters, dissertations, expert opinions, and editorials were excluded). A total of 953 records were generated through the search process, of these 283 duplicates were removed. Of the remaining records, 603 were excluded following the first stage screening by title and abstract. The remaining 67 articles were read independently in full by 2 authors, leaving 21 articles deemed to meet the inclusion criteria for review (see Figure 1). Any uncertainties or disagreements were resolved through iterative discussions.

Charting the Data and Analysis

Data from the 21 articles were extracted and charted using the study characteristics and relevant findings (Table 1). The findings from each study were analyzed to distill patterns and explain variations on those themes (Braun & Clarke, 2006). We used QSR NVivo 11, a software program used to manage and code the relevant stigma related findings in each study. This consisted of harvesting all participant quotations and authors' interpretations/summarizing statements relating to stigma and men's mental illness findings. Terms related to the concept of stigma were included. For example, the experience of shame and embarrassment in relation to men's self-stigma was included (Link & Stuart, 2017). Data were annotated line-by-line with the relevant findings of each study using constant comparative methods to compare study results (Gibbs, 2007). This process informed initial codes which represented common concepts and/or phrases relating to aspects of stigma associated with men's mental illness. As each new study was coded, the list of codes was revised and added to, ensuring all relevant data were encapsulated. Nodes were examined and discussed several times among the first two researchers, to ascertain similarities, differences and drive consensus for the coding schedule and allocation of study data. Coded data were subsequently sorted into preliminary themes which were then reviewed to check the fit of the theme label and the coded data assigned to it. Preliminary themes were reviewed, and consensus reached through iterative processes among authors.

Results

The 21 studies included in this review used the following data collection methods: semi-structured interviews (n = 14), photo-elicitation interviews (n = 5), and interviews

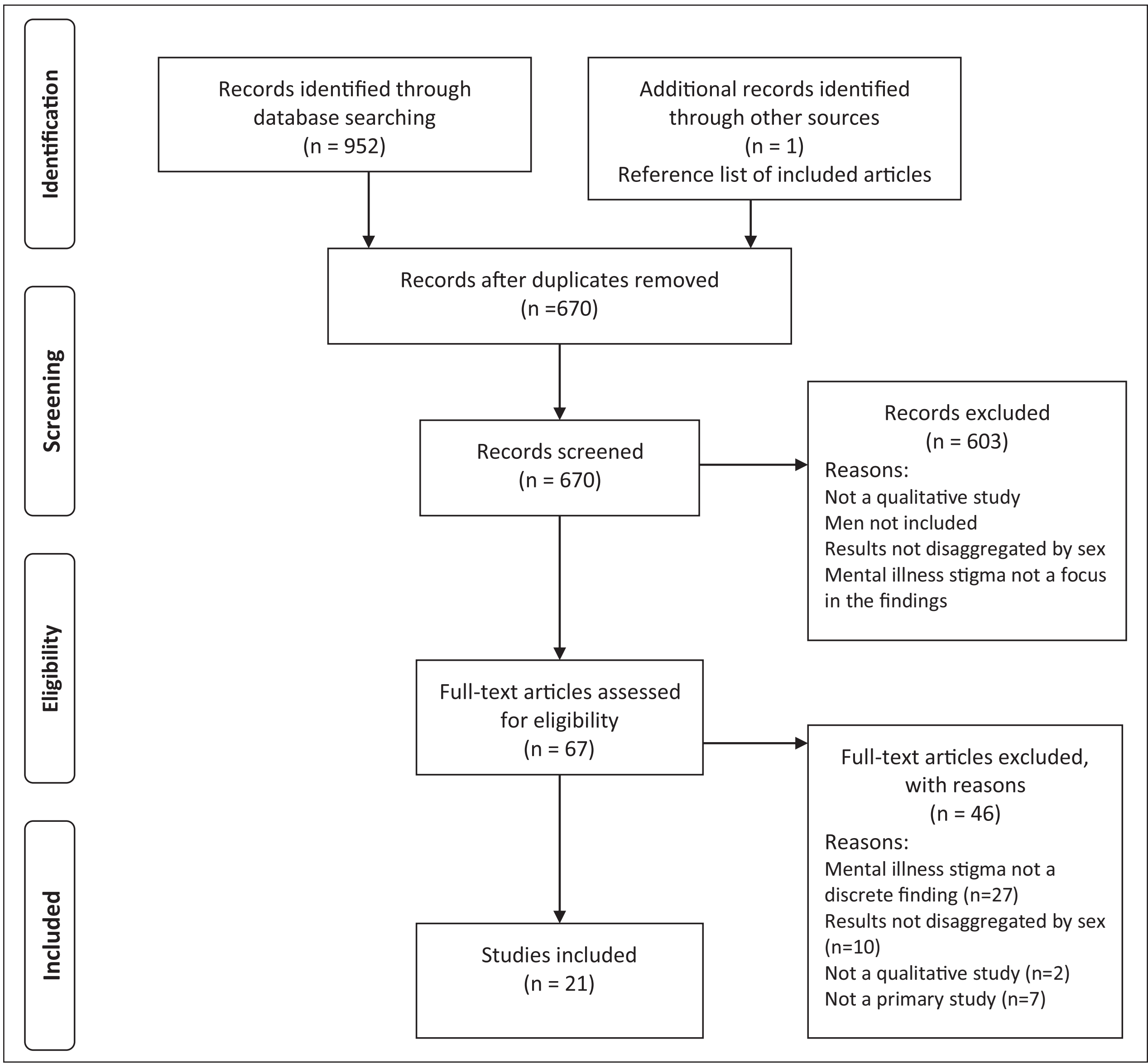

Figure 1. Pathway of Articles Identified and Excluded.

and focus groups ($n = 2$). Studies were conducted in Canada ($n = 8$), the United States ($n = 5$), Australia ($n = 4$), the United Kingdom ($n = 2$), Germany ($n = 1$), and Norway ($n = 1$). The majority of studies included samples of men across wide age ranges. Two studies included younger men aged 12 to 18 years (e.g., Clark et al., 2018; Samuel, 2015) and one study included older men aged 55 to 79 years (e.g., Oliffe et al., 2011). A caveat of our review is that while the findings shared reveal what prevails across these wide age ranges, a comparison by age was not completed as that analysis resides outside the research question for the current scoping review.

The primary objective of most articles included in this review was to examine men's subjective accounts of a range of mental health difficulties and related behaviors including depression, suicidality, mental distress, anxiety, mental health service use/engagement, and formal help-seeking. Few articles explicitly defined or conceptualized stigma, but the terms societal stigma, external stigma, public stigma, social stigma, and internalized stigma were used within the study findings. This reflects the fact that only three articles had the primary objective of examining stigma in relation to men's mental illness (Ferlatte et al., 2019c; DeLenardo & Terrion, 2014; Ward & Besson, 2012). For most articles, mental illness stigma emerged inductively either as a thematic or a descriptive finding in the analysis of men's accounts. Four distinct though interconnected themes concerning stigma were derived from

Table 1. Summary of Included Articles.

Author/year/ country	Primary objectives	Theoretical framework	Data collection methods	Study population	Relevant findings
Clark et al. (2018), Australia	To explore the barriers and facilitators of help-seeking for anxiety among adolescent males	None	Focus groups and individual interviews using vignettes	29 adolescent males with/ without clinical anxiety recruited from mental health services and the community (age 12–18)	Perceived stigma was a significant barrier to young males disclosing their anxiety to peers or seeking help from school counselors. Having a mental illness which required professional help was seen as weak, unmacho and resulted in fear of being bullied or excluded by peers. Help-seeking threatened their masculine social status and they would rather deny experiencing symptoms than leave themselves open to being stigmatized by others.
DeLenardo & Terrion (2014), Canada	To explore the stigma associated with mental illness for athletes and the difficulties they may face in seeking help for mental health problems	Link and Phelan's stigma framework	Interviews with stimulus text	8 male varsity football players (mean age 22)	Players described the stigma around mental illness as weakness, a lack of mental toughness and were fearful of being associated with mental illness. Negative labels and stereotypes were commonly used for those with mental illness. Players were also fearful of being rejected by their peers if they disclosed mental health difficulties. The use of famous sportsmen in campaigns to de-stigmatize mental illness in a masculine-dominated sport was reported as a positive strategy.
Ferguson et al. (2019), Australia	To understand men's experiences of using ambulance services for mental health and/or alcohol and other drug problems	None	Semi-structured interviews	30 men who used ambulance service for mental health and /or alcohol and other drug concerns (including anxiety, depression, self-harm, suicidal ideation/attempt, anxiety, intoxication, overdose, and psychosis) (mean age 40)	Men described negative experiences of care from ambulance staff including shame, embarrassment, a lack of professionalism and compassion and judgmental communication that their mental health crisis was not as legitimate a reason for ambulance care as physical health concerns.
Ferlatte et al. (2019b), Canada	To explore the drivers of suicidality from the perspectives of gay, bisexual, and Two-Spirit (indigenous) men (GBTSM)	Intersectionality framework	Semi-structured photo-elicitation interviews	21 GBTSM with a history of suicidal thoughts, plans and/or attempts (age 23-71)	Participants described how multiple intersecting forms of stigma and oppression related to their sexual identity, class, ethnicity, having a mental illness, homophobia and biphobia were drivers of their suicidality. Men described feeling disconnected, socially isolated, and excluded.
Ferlatte et al. (2019a), Canada	To explore suicide prevention from the perspectives of gay, bisexual, and Two-Spirit men (GBTSM)	None	Semi-structured photo-elicitation interviews	21 GBTSM with a history of suicidal thoughts, plans and/ or attempts and 8 who had lost a GBTSM friend, partner or family member to suicide (age 23-71)	Participants described the double stigma of being GBTSM and having a mental illness, but also the enduring effects that homophobia, biphobia and mental illness stigma had on their everyday lives. Suicide and mental illness continued to be seen as taboo subjects which reinforced stigma. Peer support from those with similar experiences helped in addressing stigma.
Ferlatte et al. (2019c), Canada	To explore how stigma shapes gay men's bereavement after the loss of a partner to suicide	Link and Phelan's stigma framework	Descriptive case study approach using semi-structured photo-elicitation interviews	Two gay men who lost a partner to suicide (age 40-49)	Gay men described a number of stigma-related challenges during and after the loss of their partner to suicide: thwarted efforts to connect their partners to professional help, maintaining silences and secrets about partners due to mental illness, HIV and sexual minority stigma; complicated grieving process, and loss of support during their own bereavement journeys.

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Table 1. (continued)

Author/year/ country	Primary objectives	Theoretical framework	Data collection methods	Study population	Relevant findings
Harding & Fox (2015), Australia	To explore factors which enable men to seek help for their mental health	None	Semi-structured in-depth interviews	9 men who were currently or had received counseling in the past 12 months (age 23-65)	Men described how help-seeking was supported or enabled by a number of factors: challenging their own understandings and perceived stigma of mental illness through interactions with mental health professionals, disclosing within social groups where help-seeking was normalized and less likely to be stigmatized, seeing sportsmen's disclose mental health issues.
Hassouneh & Fornero (2020), United States	To explore the experience of depression in men with physical disabilities	None	Focus groups and interviews	24 men with physical disabilities (e.g., spinal cord injury, multiple sclerosis, traumatic brain injury) and depression (age $>$ 18)	Men experienced stigma and social marginalization as a result of having a visible physical disability, a mental illness and being unable to meet traditional gendered expectations of men as breadwinners, successful in paid work, strong and muscular. Depression was described as 'another weakness and failing' in addition to physical disability and not disclosed in order to avoid further stigma.
Johnson et al. (2012), Canada	To explore men's discourses of help-seeking for depression	Connell's theory of masculinities	Semi-structured interviews	38 men with depression (formally diagnosed or self-reported) (age 24-50)	Men described fear of being judged for seeking help for their depression. To avoid the additional potential stigma of seeking help from professionals, men reframed their help-seeking behavior in a number of ways: manly reliance, as responsible independent action, guarded vulnerability, desperation and genuine connection. These different discourses enabled men to circumvent or buffer the stigma attached to treatment seeking and maintain their masculine identities.
Kour et al. (2020), Norway	To explore the mental health treatment experiences of immigrant men living with co-occurring disorders	None	Semi-structured interviews	10 immigrant men (from Middle East, South Asia, East and West Africa) diagnosed with co-occurring substance use and mental disorders (age 25-53)	Men experienced stigma from within their own immigrant communities due to the cultural stigma around seeking psychiatric help. This deterred them from engaging in mental health care. Those who did seek help experienced discrimination within the health system because of their status as an immigrant which led to them dropping out of treatment
Mahalik & Dagirmanjian (2019), United States	To explore working-class men's constructions of help-seeking when feeling depressed or sad	Connell's theory of masculinities	Semi-structured interview	12 men working in manual/ industrial labor (age 21-70)	For many men, the fear of being rejected, shamed, shunned or stigmatized by work colleagues led men to deny or hide mental illness symptoms. To avoid being stigmatized or seen as being weak for having mental health difficulties, men avoided disclosure and help-seeking. Men did not want to be seen to fail the masculine ideal of being strong, stoic and self-reliant which meant "toughing things out" when suffering.

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Table 1. (continued)

Author/year/ country	Primary objectives	Theoretical framework	Data collection methods	Study population	Relevant findings
Oliffe et al. (2011), Canada	To explore suicide from the perspectives of older men who experience depression	Connell's theory of masculinities	Semi-structured interview	22 men who self-identify or have been formally diagnosed with depression (age 55-79)	The stigma associated with suicide was a significant barrier to men's self-harming or acting on their suicidal thoughts. Underpinning this was the desire to protect family and friends from the shame and stigma that would likely accompany their suicide. Some men reported thoughts of how they might take their own life without attracting the stigma that accompanies it.
Oliffe et al. (2017), Canada	To understand the connections between masculinities and men's experiences of suicidality	Connell's theory of masculinities	Semi-structured photo-elicitation interviews	20 men with a history of suicidality (age 20-62)	Men self-isolated and distanced themselves as a protection strategy- a way of hiding their vulnerability and avoiding public stigma- and to avoid troubling others. This not only took men away from potential sources of social support but also left them at heightened risk of suicide
Oliffe et al (2019a), Canada	To explore how social isolation is experienced among men with a history of suicidality	Connell's theory of masculinities	Semi-structured photo-elicitation interviews	35 men with a history of suicidality (age 20-68)	Men's self-isolation was driven by the stigma of mental illness and/or being part of a minority sexual group, estrangement from families, a lack of belonging at work and a sense of being judged and ex-communicated by others for their life choices. Men's accounts of mental illness revealed their internalization of stigma and a focus on their failure to meet societies gendered expectations of men to be productive and capable male citizens.
Samuel (2015), United States	To examine the beliefs and attitudes of African American male adolescents toward mental health issues and mental health service utilization	None	In-depth interviews	54 African American adolescent males currently or formerly receiving mental health treatment following release from juvenile detention (age 15-17)	Participants described stigma, shame, fear and mistrust of the service providers they interacted with. To avoid further potential stigma, many disengaged from mental health services. Communities were less tolerant of those with mental illness and there was shame and stigma in being an African American man with a mental health issue. Young men experienced shame and ridicule amongst their peers for their involvement with mental health services.
Scholz et al. (2017), Australia	To explore men's discourses of depression	None	In-depth interviews	10 men with previous experience of high levels of depressive symptoms (age 45-88)	Participants described the embarrassment of being a man with depression as a barrier to disclosure of depression and seeking help. Men rejected this public stigma by (i) reframing their depression as "normal" rather than men who were facing a crisis and (ii) reframing their help-seeking as a rational and desirable masculine practice

(continued)

Table 1. (continued)

Author/year/ country	Primary objectives	Theoretical framework	Data collection methods	Study population	Relevant findings
Siegel & Sawyer (2019), United States	To explore the experiences of men with eating disorders in the workplace	None	In-depth interviews	14 men who self-identify or have been formally diagnosed with an eating disorder (mean age= 27.8)	Men reported fear of potential stigmatization, shame and backlash for revealing their eating disorder (ED) to colleagues in the workplace, especially in male dominated workplaces. To avoid stigma, many men chose not to disclose their ED and to blend into the culture of the organization. This included avoiding social events, finding ways to manage the ED and in extreme cases, leaving their job meaning they were unable to receive workplace benefits. The stigma of EDs was seen as more stigmatizing and shameful for men given Eds are typically viewed as a feminine disorder.
Staiger et al. (2020), Germany	To explore men's experiences and attitudes toward depression, help-seeking, and service use	None	Semi-structured interviews	12 men diagnosed or self-identified as having depression (age 16-64)	Men described feeling stigmatized and, in some cases, shunned by work colleagues for not being unable to cope with mental distress, and for failing to meet the norms relating to paid work. Men's depression-related incapacity to work and being labeled left them feeling further stigmatized. In terms of help-seeking, some avoided accessing treatment out of fear of being further stigmatized, while others found safe spaces among men-only groups where they could disclose their condition without the shame or stigma of being labeled as 'unmanly'.
Wagstaff et al. (2018), United Kingdom	To explore the experiences of black men with schizophrenia who disengage from mental health services	None	In-depth interviews	7 men with a diagnosis of schizophrenia and a history of disengagement from mental health services (age 31–64)	Men had a complex relationship with mental health services of which the social stigma of being involved in services contributed to. Not only did men feel that their association with services had a negative impact on their social identity, but it also impacted their relationships with their families, community and wider society.
Ward & Besson (2012), United States	To examine African American men's beliefs about mental illness, stigma, and barriers to help-seeking	Psychological Common-Sense Model	In-depth interviews	17 men who self-identify as African American with and without personal experience of mental illness (age 24-75)	Most men were aware of the stigma and negative stereotypes associated with having a mental illness, but did not endorse these ideas, nor did they consider stigma to be a barrier to help-seeking. Rather mental illness was perceived as a 'normal', 'everyday' occurrence, synonymous with physical illness.
Wood et al. (2017), United Kingdom	To understand the mental health experiences and help-seeking of male professional footballers	None	In-depth interviews	7 male professional footballers with self-reported experience of mental health difficulties and help seeking (age 32-41)	Men avoided stigma by concealing their mental health difficulties and putting on a 'brave face'. They described the fear of rejection if they disclosed to their peers due to the competitive, macho culture associated with being in the male-dominated world of football. The perceived lack of safe spaces to share their difficulties contributed to feelings of helplessness, isolation and sense of being trapped. Internalization of this stigma and shame was a barrier to seeking help, and men relied on female partners and mothers for support where the risk of rejection was lower.

the reviewed articles: (a) the weight of societal stigma, (b) stigma in male-dominated environments, (c) inequity driven stigma, and (d) de-stigmatizing strategies.

The Weight of Societal Stigma

Seven studies reported internalized stigma experiences of men with mental illness (Oliffe et al., 2011, 2017, 2019a; Clark et al., 2018; Ferguson et al., 2019; Samuel, 2015; Wagstaff et al., 2018). Participants' narratives revealed a variety of stigmatizing experiences including feelings of fear, shame, embarrassment, guilt, and isolation. This self-stigma was driven by the stigmatizing attitudes of peers, work colleagues, family, health professionals, and members of the wider community. A common experience was that men believed people negatively stereotyped those with mental illness as weak and failures. In studies focused on young men, feelings of fear and shame were common, not only for having a mental illness but for being seen to engage with mental health professionals (Clark et al., 2018; Samuel, 2015). Young men with diagnosed anxiety who reported having a mental illness and seeking help from a school counselor were seen as "weak" and "not macho" (Clark et al., 2018). Many were fearful of their peers finding out about their anxiety or that they were receiving help, and that their social status would be compromised, and they would be subjected to bullying, derision and exclusion. Likewise, young men recently released from juvenile detention experienced shame, embarrassment, and were ridiculed by peers for their involvement with mental health services (Samuel, 2015). Young men could be labeled as "lazy," 'crazy "nut-head" 'freak "sissy" and "wuss" by their peers, which served to categorize them as subordinate to everyone else (Clark et al., 2018; Samuel, 2015). To save face, young men would lie and deny their experience to their peers.

Shame and embarrassment also arose from men's stigmatizing encounters with health professionals (Clark et al., 2018; Ferguson et al., 2019; Samuel, 2015). Men with mental illness and/or alcohol and other drug problems described a range of stigmatizing experiences during their interactions with ambulance staff called out for a mental health crisis (Ferguson et al., 2019). These included judgemental comments, lack of empathy, and compassion, delays in service response and a focus on restraint and sedation. These experiences left men feeling judged as less worthy of care, perpetuating men's self-stigma and shame around their mental illness. Similarly, young men described their encounters with mental health staff as shameful, uncomfortable, and embarrassing (Clark et al., 2018; Samuel, 2015). Being labeled with a mental illness and asked to talk about their emotional lives by service providers left many men feeling vulnerable, ashamed, and reluctant to engage further (Clark et al., 2018; Ferguson et al., 2019; Samuel, 2015).

For many men struggling with mental illness and suicidality, their buy-in to societal stereotypes about mental illness drove social isolation and alienation from friends, family, and society. Men in Oliffe et al.'s (2017, 2019a) studies described this isolation as "a lack of belonging," "outsiderness," being "a loner," "a burden", "an island", "separate" and "different". For some, this isolating behavior was self-driven to protect others from their low affect or suicidality, as well as self-protection from social judgments (Oliffe et al., 2017). For others, isolation was a result of being distanced and shunned by family (Oliffe et al., 2019a). This internalized stigma heightened men's suicide risk wherein they focused on their failures and inability to meet societal expectations around being a productive and capable man within society (Oliffe et al., 2019a). Men's sense of isolation could also be driven by the stigma of being a service user. The stigma of being a long-term mental health service user, combined with lack of control and choice over their care, was described by men with schizophrenia as detrimental to their social connection with families and their community (Wagstaff et al., 2018).

Finally, two studies emphasised how men's internalization of public stigma can act as a barrier to self-harming or acting on suicidal plans (Oliffe et al., 2011, 2017). Rather than stigma and shame being a precedent to men's suicide, the stigma associated with mental illness and suicide deterred men from taking their own lives through a desire to protect their families from the distress, shame, guilt, and stigma of losing a family member to suicide.

Stigma in Male-Dominated Environments

Six studies reported how mental illness stigma and men's fear of transgressing masculine cultures normed by strength, independence, and invincibility, can play out in male-dominated environments such as places of paid work and professional sport (DeLenardo & Terrion, 2014; Hassouneh & Fornero, 2020; Mahalik & Dagirmanjian, 2019; Siegel & Sawyer, 2019; Staiger et al., 2020; Wood et al., 2017). Consistently reported by men in these studies was the fear of being perceived as weak, incapable of coping with distress, and failing to fulfill the masculine norms deemed mandatory for specific male dominated jobs and sports. The fear of being stigmatized for having a mental illness was a constant threat, leading many to avoid disclosing their distress in the workplace or off the sports field. Moreover, men masked symptoms in order to avoid backlash and further stigmatization. Wood et al. (2017) highlighted the intolerance for mental illness in the "competitive macho culture" of masculine football milieus where those with mental illness were seen as weak, vulnerable and unable to handle stress. Players hid their struggles due to shame and fear of rejection. Underlying

the camaraderie of the dressing room was fear of discrimination, and a lack of safe space to disclose rendering it safer for men to conceal their distress and put on a "brave face" (Wood et al., 2017). Similarly, university football players feared being shunned by peers and expelled from the team if they disclosed a mental illness (DeLenardo & Terrion, 2014). Mental illness was perceived as weakness and incompatible with a highly competitive masculine game like football where mental and physical toughness were paramount. Derogatory labeling and stereotyping by teammates toward anyone with mental illness was a survival strategy in a highly competitive group setting and served to separate "them" from the group's identity. Players with mental illness were left fearful of being ostracized and losing their status within the team—an example of the power dynamics that can feed the stigma process (DeLenardo & Terrion, 2014).

Men with depression working in manual or industrial labor occupations (e.g., construction, factory workers) were fearful of being perceived as weak by others, particularly other men, and of being shunned by colleagues for failing to meet masculine ideals of being strong and invincible (Mahalik & Dagirmanjian, 2019). They avoided disclosure and help-seeking in order to protect themselves from being stigmatized or labeled in ways that would hinder future professional relationships. For men in Staiger et al.'s (2020) study, their incapacity to work due to depression left them feeling stigmatized by colleagues who labeled them as "loser," "lazy" or "incapable." A workplace culture of "not being sick" was associated with masculine norms such as being strong, successful, and self-reliant. Subsequently, men who took sick leave were made to feel ashamed, weak, vulnerable, and their masculine status was threatened. To safeguard their career options and employability, men avoided seeking help or taking time off work.

The challenge of having a mental illness in the workplace was particularly evident where men's conditions were seen to overtly violate ideals in relation to masculinity. Siegel and Sawyer (2019) documented men's shame and fear of backlash for having an eating disorder, a condition stereotyped as feminine. Men were fearful work colleagues would look down on them, not take them seriously, ridicule or worse still, that they may lose their jobs if they were to reveal details about their condition. The "invisibility" of eating disorders was also emotionally exhausting for men to manage in the workplace with some avoiding work functions and social events. The decision to disclose was complicated—while there was fear of backlash for disclosing, without disclosure men could not access workplace benefits and entitlements or make changes to their roles in order to support recovery. In contrast, men in Hassouneh and Fornero's (2020) study struggled with experiencing a very visible physical disability that undermined their masculine status, as well as depression. The pre-existing marginalization these men endured due to their physical disability was exacerbated by what they perceived as "another weakness or failing" as a man with depression. The stigma of mental illness and physical impairment impacted men's success at work and their ability to fulfill idealized masculinities associated with breadwinner roles, and the embodiment of muscularity and strength. Disclosing their depression was out of the question, even in the context of friendships with other men with physical disabilities. Maintaining silence and resisting the internalization of negative stereotypes around depression and disability was exhausting, further perpetuating their depression (Hassouneh & Fornero, 2020).

Inequity Driven Stigma

Mental illness stigma was also expressed in relation to other forms of social marginalization. Three studies described the intersection of mental illness stigma with minority sexual orientation (Ferlatte et al., 2019a, 2019b, 2019c). A commonly reported experience was the impact that multiple stigmas—being gay, non-binary, having a mental illness, HIV—had on men's lives. Men expressed feelings of not belonging, outsiderness and social exclusion, describing life as hard, challenging, and tough. Suicide and mental illness continued to be shrouded in silence which served to reinforce the stigma and shame these men internalized in relation to both their sexuality and mental illness (Ferlatte et al., 2019a). These stigmatized identities were further impacted by the persistence of homophobia, biphobia, and fear of violence which many men had endured over their lifetime. Ferlatte et al. (2019a,b) further highlighted how men experience stigma and marginalization from within their own communities. Multiple intersecting identities and related stigmas, including sexual orientation, class, race, HIV/AIDS, and depression/suicidality served to ostracize and outcast men from the very communities they had belonged to. Ferlatte et al. (2019c) also demonstrated how gay men's experiences with grief after the loss of a partner to suicide were shaped by sexual and mental illness stigmas. Before their partner's death, men's unsuccessful attempts to connect their partners to professional help left them feeling powerless to quell the shame and internalized stigma their partners endured regards their mental illness. After their partner's death, men's bereavement was marked by guilt, loyalty, betrayal, and silence as they tried to avoid the layering stigmas of the deceased being gay, having a mental illness, HIV, and dying by suicide.

Two studies highlighted the co-occurring stigmas related to mental illness and race. For young African American men, the stigma, shame and fear of mental

illness, combined with mistrust of service providers led them to disengage from mental health services (Samuel, 2015). Underlying these decisions lay cultural norms shunning mental illness in the African American community and thus being "a black person in a black neighbourhood" was more stigmatizing. The authors note that African Americans have historical trauma experiences in relation to mental health care services which prevails as mistrust and suspicion. Similarly, Kour et al. (2020) described how immigrant men (Middle Eastern, Asian, African) with co-occurring substance use disorders and mental illness were fearful of being stigmatized and ostracized in their small cultural communities wherein being known to seek psychiatric help would lead to them being labeled as "mad." Similar to Samuel (2015), treatment adherence among men was low due to the shame and stigma for using mental health services. For immigrant men, disengagement with services was further swayed by family pressure and the stigma they faced in having a loved one using psychiatric services.

De-stigmatizing Strategies

Several de-stigmatizing strategies which men engaged to mitigate the negative effects of mental illness stigma were described. These included peer support, increasing mental health literacy and reframing mental illness and help-seeking (Johnson et al., 2012, Ferlatte et al., 2019a, 2019b; DeLenardo & Terrion, 2014; Harding & Fox, 2015; Scholz et al., 2017; Ward & Besson, 2012). For some, connection with peers experiencing similar mental illness challenges was key to countering stigma by enabling disclosures in safe spaces where such issues and talk were normed (Ferlatte et al., 2019b; Harding & Fox, 2015; Staiger et al., 2020). Peers with similar illness experiences were perceived as more empathetic, trusted, and able to understand. Mutual awareness of mental illness and help-seeking, knowing they were not alone and opportunities to reciprocate and authentically share experiences afforded destigmatising avenues. Men in Harding and Fox's (2015) study were more likely to disclose mental illness challenges in informal peer groups where their experiences were normed and affirmed. Peer groups could be enablers, positively influencing men's help-seeking efforts. For example, on-line forums where mental illness experiences were openly shared, reinforced men's decision to seek counseling, enabling them to counter the associated stigma (Harding & Fox, 2015). For men with depression and a history of mental health service use, interactions with fellow services users provided valuable peer support and a destigmatizing "sheltered space" (Staiger et al., 2020). Men who participated in group counseling were not subjected to questions or made to feel weak and felt accepted by men with similar illness experiences. For many, inpatient services were a safe space offering shelter from stigma and societal expectations which felt unattainable. Peer support and community connections were also key in countering mental illness stigma for sexual minority men struggling with suicidality (Ferlatte et al., 2019a). Peer support groups within the gay community provided men opportunities to make safe and meaningful friendships, a sense of belonging and new skills to manage their suicidality.

Increasing mental health literacy and exposure to positive mental health messaging enabled some men to challenge stigmatizing messages about mental illness (DeLenardo & Terrion, 2014; Harding & Fox, 2015). For some, accessing professional help assisted participants to better understand and accept their mental illness (Harding & Fox, 2015). This increased knowledge ameliorated men's self-stigma and the stigma they perceived in others' mental illness challenges. The role of high-profile sporting identities openly discussing their mental illness struggles was also credited with influencing men's knowledge and acceptance of mental illness (DeLenardo & Terrion, 2014; Harding & Fox, 2015). Seeing elite sportsmen disclose their illness experience, and success on the field despite this, made them credible, and de-linked mental illness from passivity and failure.

Finally, reframing mental illness and help-seeking enabled men to circumvent stigmas. Johnson et al. (2012) reported masculine discourses that explained and justified men's help-seeking practices thereby countering stigma. Herein most men accessed services for their depression by contextualizing and reframing their behaviors as strength-based practices. For example, the discourse of genuine connection enabled men to describe their need to be heard, accepted and helped whereas the discourses of help-seeking as responsible, independent and rational enabled men to buffer the stigma attached to being helped. Across the findings, legitimizing and preserving masculine status were evident as effectual destigmatizing avenues. Similarly, reframing mental illness issues by likening them to physical health issues or as part of everyday life enabled some men to destigmatize the ailment and access potential remedies (Scholz et al., 2017; Ward & Besson, 2012).

Discussion

This scoping review reports themes and gaps in the published research addressing mens' experiences of mental illness stigma. Our review reveals three qualitative papers directly examining mental illness stigma among men published between 2010 and 2020. Nonetheless, aspects of stigma prevailed as findings across men's mental illness experiences in the research reviewed for the current scope. Synthesizing the literature makes available common threads

of stigma experiences among men across the lifespan going through diverse mental illness challenges and serves as a useful entry-point into the field for men's mental illness researchers and practitioners. Men's narratives highlighted aspects of public (social) stigma which in turn drove their experiences of self-stigma. Those who anticipated, perceived, and internalized mental illness-related stigma faced a range of consequences including reluctance to access and engage with mental health services, poor treatment adherence, employment issues, social disconnection, intensifying suicidal behavior, and heightened risk for severe mental illness. These findings align with the wider stigma literature in demonstrating the deleterious effects of public stigma on the lives of men with mental illness (Clement et al., 2015; Corrigan & Watson, 2002; Sharac et al., 2010).

While the wider stigma literature has drawn attention to the complexities of co-occurring social identities and stigma (Jackson-Best & Edwards, 2018), the social construction of gender as an influencer of men's experiences of mental illness stigma has rarely been addressed (Gaebel et al., 2017). The current scoping review findings confirm the links between gender, masculinity and mental illness stigma. Hegemonic masculinities that idealize men as strong, self-reliant and healthy also subordinate men with mental illness as weak, inadequate and unmanly. For men struggling with mental health difficulties, this subordination amplifies stigma, particularly internalized stigma, for failing to embody hegemonic masculinities. Hence, masculinities are interwoven with mental illness stigma, and stigmatization in turn has detrimental consequences for men including, limiting their disclosure, reducing opportunities for social support, hindering help-seeking and interfering with treatment adherence. Men's fear of transgressing dominant masculine ideals, particularly within male-dominated environments where these norms are prescribed and policed influenced many men's experiences of internalized stigma. Implicated in this are mental illness concerns which are perceived as feminine (e.g., eating disorders).

Reflected in the review findings is how mental illness stigma also intersected with other axes of marginalization and disempowerment (e.g., across race, class, sexual orientation, HIV/AIDS) in ways that resulted in some men being profoundly disadvantaged. In terms of race, the review highlights a knowledge gap relating to the mental illness stigma experiences specific to racial and ethnic minority men. The intersection of historical trauma and mental illness stigma for African American men was raised in one study (Samuel, 2015). Mental health and Indigenous researchers have consistently associated disproportionate rates of mental illness with historical experiences of colonization (Gone, 2013). Employing a trauma informed framework to future research with Indigenous men could help to contextualize mental illness stigma and the devastating legacy of colonization, thereby informing stigma interventions that better meet the needs of Indigenous and racial minority men (Gone & Kirmayer, 2020). For those men who embody multiple stigmatized social positions, the findings confirm the value of employing an intersectionality lens to understand mental illness stigma (Oexle & Corrigan, 2018). Identifying and unpacking multiple stigmas, and wider structural determinants such as homophobia and racism, is key to understanding mental illness stigma in men's lives.

Applying a macrolevel theory of stigma such as Link and Phelan (2001) to future research would also enable concepts such as labeling, stereotyping, separating "us" from "them," status loss and discrimination to be explored within the specific social contexts of dominant masculine cultures and power that excludes men with mental illness from social and economic life. Utilizing a stigma framework could provide the empirical foothold for better understanding mental illness behaviors and addressing those challenges through gender transformative destigmatizing avenues.

In terms of addressing the drivers of internalized stigma for men, the workplace, school and mental health services are important settings in which interventions targeting mental illness discrimination are important. However, this review suggests a key challenge for combating men's mental illness stigma and discrimination is to address the subtle everyday ways in which particular gendered attitudes and expectations of men curb their help-seeking and heighten the risk for severe mental illness. This requires addressing gender norms and structures that host and house stigma at multiple levels—institutions, the general public, health professionals, family and men themselves. A view of gender and corresponding ideals, norms, and beliefs as socially constructed (Connell, 2020), and therefore malleable to change, calls for efforts focused on identifying and critiquing negative and harmful messaging around men, masculinity, and mental illness.

Reflected in our findings and echoing the wider mental illness stigma research (Gaebel et al., 2017), is the need to address key knowledge gaps in relation to masculinities and men's mental illness stigma. Employing an explicit masculinities lens could provide researchers with the means to theorize and unpack important links between gender, stigma and men's mental illness practices (Connell, 2005). It also provides the means to explore the diversity among men, including those sub-groups who despite being marginalized by dominant masculine ideals are complicit in sustaining many harmful gendered norms. Understanding the intersection of masculinities and mental illness stigma will provide further insights into inequities in men's access and engagement with

professional mental health care to inform tailored interventions and resources.

To date, stigma research has focused predominately on ways to reduce public stigma. Given the complexities of this work there is growing interest in stigma management strategies that support those experiencing mental illness (Stuart, 2017). Our review points to some promising stigma management strategies for men. First, the value of peer support as a way of managing self-stigma and encouraging disclosure was raised by many men (Ferlatte et al., 2019b; Harding & Fox, 2015; Staiger et al., 2020). Formalized peer support services, that is men with mental illness being supported by other people with similar illness experiences, has been proposed as a way to promote recovery and is increasingly found in voluntary settings and as part of secondary mental health care (Lloyd-Evans et al., 2014). Second, improving men's mental health literacy through interactions with mental health professionals and being exposed to positive messaging is key to reducing the negative impact of stigmatizing messages (Harding & Fox, 2015). Third, reframing men's help-seeking as a strength-based practice can norm men transgressing masculine ideals to courageously address their mental illness challenges and is central to norming men's engagement with services as a bridge to effective self-management (Johnson et al., 2012; Ward & Besson, 2012).

Limitations and Future Directions

The review findings should be viewed in light of several limitations including the paucity of studies explicitly designed to examine men's mental illness stigma and corresponding lack of conceptualization of stigma. Methodological limits for conducting scoping reviews including the absence of evaluating the quality of the studies likely limits the interpretation of the findings in regard to the empirical weight and methodological rigor in men's qualitative mental illness stigma studies. Furthermore, the restriction of studies to empirical peer-reviewed journal publications reporting original research in English likely explains the reviews focus on research from Western nations and excludes men from outside these areas. That said, by providing a synthesis of previous and recommendations for future studies our scoping review reinforces the need to challenge mental illness stigma and provides important directions for future research. We also recognize the limitations of reporting review findings for small qualitative studies conducted with diverse men. However, we suggest empirical understandings of men's mental illness stigma are needed to thoughtfully guide the design and implementation of tailored destigmatizing interventions. Within the broader mental illness stigma literature there remains limited evidence of interventions that are appropriate and effective among certain population subgroups including men (Thornicroft et al., 2016).

Future qualitative research is needed to uncover the nature and mechanisms of mental illness stigma for diverse groups of men and across the life course. Stigmatization is complex and demands layered nuanced methodological approaches (Stutterheim & Ratcliffe, 2021) inclusive of interviews, focus groups, and visual methods (e.g., photovoice) to make audible and visible men's shifting experiences of mental illness stigma. Related to this we need greater connection between theory applications (both stigma and gender) and men's mental illness experiences. There is also great potential for extending our understandings of what prevails across and differentiates men's diverse social identities (e.g., sexual orientation, race and ethnicity) as a means to further advancing the fidelity and reach of tailored destigmatizing avenues. Specifically, future research might explore the different types of stigma as they related to men—public stigma, self-stigma, the impact of stigma on families of men and structural stigma within the workplace and the health care system (Sheehan et al., 2017). Finally, given the focus in this review on research from Western nations, further research including the voices of men from broader geographical locations, low-income countries and non-English speaking countries is important.

In conclusion, there are important gains to be made but this will require researchers to engage and advance the wider stigma and mental illness literature to discern and address the intersections of masculinities and men's mental illness stigma. Only through a deeper understanding of men's diverse lived experiences can de-stigmatizing interventions be developed that are relevant, appealing and effective for men living with mental illness.

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