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COMMENTARY

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Cross-cultural perspectives on mental health shame among male workers

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Abstract

Globally, awareness of workplace mental health problems has increased rapidly. Employees need to be able to reflect on their wellbeing and ask for help if needed. Previous research has indicated mental health shame (or shame associated with mental health problems) is a barrier toward self-reflection and help-seeking. Our previous research identified that levels and types of mental health shame vary greatly across cultures, highlighting a need for a cross-cultural understanding of mental health shame. Accordingly, this perspective paper will focus on shame associated with mental health problems among male workers across cultures, and discuss differences among them in relation to cultures. Consistently, mental health shame in male workers is reported high in many cultures. Mental health literacy and wellness activities such as self-compassion training, organisational approaches to encourage connectedness and safety are recommended. Insights from our perspective can help the human resources staff and managers identify helpful approaches for mental health shame in a diverse workplace.

Keywords

Mental health shame; Workplace mental health; Male employees; Men's mental health; Help-seeking; Self-reflection; Masculinity; Perspective

1. Workplace mental health problems as a global concern

Mental health problems, such as depression, anxiety, burnout, and stress, are a general growing global concern, reportedly exacerbated by the coronavirus disease 2019 (COVID-19) pandemic [1–4]. Mental health in the working population is important for a healthy workforce and high productivity [5–8]. However, research has demonstrated a decline in employees' mental health [9, 10], with mental health issues becoming more common [11–14] and with rates of reported mental health problems increasing [15–18].

Recent global research has highlighted the high rates of workplace mental health problems. For example, in 2019/20, an estimated 17.9 million working days were lost due to work-related stress, anxiety or depression in the UK. This figure accounted for 51% of the reported work-related ill health [19]. Additionally, the mental wellbeing index (World Health Organization-5 (WHO-5)) [20] found that about a quarter (23%) of the workers in Europe reported low levels of wellbeing. In Singapore, 56.5%, 45.8% and 38.3% of workers reported having mild to severe levels of anxiety, depression and stress respectively (N = 308) [21]. 56.1% of Australian workers reported high emotional exhaustion (burnout) (N = 310) [22]. This was echoed by the Chinese nonprofit employees (N = 233) [23], reporting high levels of stress (29.8%), depression (13.5%) and anxiety symptoms (24.1%) [24]. Furthermore, in South Korea, a qualitative study highlighted high levels of negative emotions were reported in hospital workers (156 short notes from 59 department heads) [25]. An American Psychological Association survey identified that 59% of US employees (N = 1501) reported work-related stress that negatively impacted their wellbeing [26]. Additionally, high prevalence rates for anxiety (47%) and depression (48%) were reported in a systematic review in Africa (N = 62,380 from 78 studies) [27]. The high rates of mental health problems in the working population were echoed throughout the global research [14].

There has been a growing awareness of mental health problems in the workplace and in response, workplace interventions [28, 29] and initiatives have been developed to support the workforce's mental health—such as in Europe, the To-REACH project (producing research evidence supporting healthcare services and systems in Europe [30]) and the WHO European Programme of Work (initiative supporting better health of people [31]). Further, cost-effective interventions, best practices and a focus on prevention and support are needed for a healthier workforce [32]. However, countries in regions such as Eastern Europe and Central Asia need greater investment to improve the mental health of the workforce [33], and in comparison, received a small portion of global resources for mental health [34].

2. Mental health shame as a great barrier for help-seeking

One reason for poor mental health is the shame associated with mental health problems. This type of shame is referred to as mental health shame [35]. Mental health shame is often measured using scales such as the Attitudes Towards Mental Health Problems Scale (ATMHPS) [36]. ATMHPS is a validated, reliable and established scale for this purpose, used in many studies [37]. There is much evidence regarding the negative effects of shame. Shame contributes to developing and maintaining mental health problems [38–40]. Shame can lead to an individual feeling isolated and disconnected [41], and many individuals will choose not to seek help for their mental health problems because of stigma [37, 42]. The stigma associated with depression and other mental health problems is a barrier to help-seeking in many cultures [43], but there is still a lack of research examining the links between shame, mental health and culture [38].

South Africa is considered one of the countries with the most challenging mental health problems [44]. Recent studies compared the mental health of South African workers with German workers and reported South Africans have higher levels of mental health problems and mental health shame than German workers [45]. Similar observations were found in the United Arab Emirates (UAE): the UAE had the highest depression rate of any country in the Eastern Mediterranean. Of 341 participants, 58.9% named shame as the most critical obstacle to seeking help [46]. Likewise, in Asia, many cultures value conformance to norms, emotional self-control, and family recognition through achievement, which can cause stigmatisation of mental health problems leading to a sense of shame [47, 48].

Gender roles are entrenched in culture and often prevent male workers from seeking support for their mental health problems [49]. Historically in many cultures, men are expected to be dominating, strong, and in control, so many will be reluctant to tell their employers about mental health problems [50, 51]. Data from 15,000 workers across 30 organisations in the UK shows that 1 in 3 men are less likely to seek help compared to 2 in 5 women, and only 29% of men take time off because of their mental health problems, compared to 43% of women [52]. Men tend to feel a higher level of mental health shame than women.

Cultural differences have multiple implications for shame in mental health, from mental health perceptions to help-seeking behaviour [8, 43]. Therefore, it is crucial to understand mental health shame from a cross-cultural perspective.

3. Mental health shame and cultures

Culture plays a significant role in many aspects of mental health across the world [43]. Cultures affect the ways in which mental illness and mental health are perceived, hence can shape the attitudes of mental health service users, their help-seeking behaviours, and how the mental health support system is created [43, 53]. Shame is a potent negative emotion, associated with mental health problems [54, 55]. Understanding cultural variances and drivers of mental health shame bears clinical importance as a predictor of mental health problems [36]. For example, for Japanese workers, family-reflected shame (*i.e.*, worries that one's own mental health problems might damage their family reputation [56]) was a significant predictor of mental health problems; whereas for UK workers, self-reflected shame (*i.e.*, worries that one's family member's mental health problems might damage one's own reputation [57]) was a significant predictor [58]. Considering the impact of cultures can be helpful when understanding the difference in mental health status [59, 60].

A systematic review shows that within a 12-month period across 155 general populations conducted in 59 countries, one in five persons experienced a common mental health problem [61]. Specifically, men's mental health problems often go untreated because men are less likely than women to seek mental health treatment [62]. Suicide, strongly related to mental health problems [63], is one of the leading causes of death in men. Men's suicide rate in the US is four times higher than women's [62]. Drug misuse, another strongly related phenomena [64], is two to three times higher in men than women [65]. Alcohol misuse-related death among men is more prevalent than among women (about 62,000 men *vs.* 26,000 women in 2016) [65]. Men's mental health shame is attributable to these serious poor mental health outcomes and negative consequences.

4. Mental health shame in the West

Mental health shame is present among male workers in Western countries. Male-dominated industries such as construction are good examples. In the UK construction industry, male workers had limited awareness of mental health issues and lacked self-compassion, and did not seek help because of shame related to mental health problems [39]. We conducted consultation research work at a large UK construction organisation regarding their employee mental health. At their senior management meeting, we reported self-compassion was the strongest predictor of mental health among employees, to which the meeting chairman responded "We don't do self-compassion. We don't do self-pity." Self-pity is one common misunderstanding of self-compassion. Consequently, we took this opportunity to explain to the chairman that his initial reaction may be indicative of the issue of mental health shame in this industry.

Further, a report on Australian construction, a male-dominated industry, revealed male workers have a low level of self-stigma but also uncovered they had minimal awareness of mental health problems due to a low level of mental health literacy [66]. The study also revealed that male construction workers in Australia had a lower understanding of mental health in comparison to the general population [67]. The shame associated with mental health problems, and lack of self-compassion also prevented American industrial workers from seeking support due to the precarious manhood theory, a belief that manhood must be demonstrated by emphasising toughness and dominance consistently, which is lost by showing weakness and softness [68]. Furthermore, a German study revealed that shame and being classed unmanly weakened the motivation to seek help [69]. In brief, western

male workers in many contexts have limited awareness of mental health and lack self-compassion. These can deter them to seek help for mental health problems as that means a failure to be a man to them.

5. Mental health shame in the East

It is argued mental health shame is prevalent across Asia, as Asian employees tend to hide or ignore early signs of mental health problems. This is supported by research that demonstrates Asian employee burnout rates are higher than the global norm [70].

45% of Asia-Pacific employees suffering with mental health issues such as anxiety, stress and depression keep it to themselves, and 33% have either personally, or know someone who has, experienced mental health workplace stigma [71]. One Singaporean study [72] found 86.5% of employees would not seek mental health help due to shame or stigma; whilst in another study [73] 46% said being diagnosed with mental health issues was embarrassing; 50% did not want to work with individuals with mental health issues and, 60% felt individuals with mental health issues should have reduced responsibilities in the workplace. More concerning is that 25% of younger Singaporeans (under 18) believe mental health issues do not exist, it is just weak individuals who lack self-control or self-discipline [74]. These sentiments are reflected in other Asian countries such as Japan where workers have high levels of mental health shame [58]. Mental health shame across Asia is thought to be due to powerful traditional, yet prevalent cultural, and religious beliefs such as Confucianism, which encourages mental health issues to be kept within the family to protect the family reputation and honour; or Buddhism which sees mental health issues as a punishment for past life transgressions [72, 75, 76]. When these beliefs intersect with traditional Asian views of masculinity such as being the family provider; to be honourable; being in control; showing emotional restraint, and not to display mental or physical weakness [56, 77], it creates a situation where the mental health issues are viewed and trivialised by male workers as a sign of personal weakness, and shame for the family [43, 78]. These notions make male workers less likely to disclose issues or seek help [79, 80], as it can result in a loss of 'face', affect job reputation and prospects, social standing and credibility, even negatively impact marriage prospects and bring overall family shame [43, 81].

6. Mental health shame in Arabic countries

Shame towards mental health problems in Arab males is high. One reason is the values and traditions held in this culture have been identified as an obstacle to receiving mental health care. Of 1236 men surveyed, 22% believed mentally ill people to be unintelligent and 26% believed mental illness was a punishment from God [82]. In a study conducted in Jordan, the stigma associated with mental illness is one of the primary reasons that discourage Arab men with mental illness from disclosing issues related to their mental health at the workplace [83]. Arab men with mental illness often somatise their psychiatric symptoms to avoid others' unfavourable responses to their mental health status. Because of this stigmatised perception, job recruitment for mental health workers in Arabic countries struggles, which negatively impacts mental health outcomes [84].

However, mental health awareness has increased little by little. Recently, initiatives to address the stigma associated with mental health problems in Arab workplaces have been launched introducing mental health clinicians to Arab employees [85]. Input from mental health clinicians was found helpful to reduce negative views towards mental health problems in the organisation. A systematic review identified organisational knowledge-sharing of, and education about, mental health problems was helpful in reducing the stigma and shame associated with them [86].

7. Mental health shame in Africa

Mental health shame is deemed high in African male workers as well [45]. One factor may be mental disorders are not considered as diseases in many African countries [87]. Men from African countries have a different understanding of depression than the WEIRD (Western, educated, industrialised, rich and democratic) country cultures, especially the perception towards mental disorders portrayed in western medicine models. African views in general regard sickness as being caused by invisible forces like spirits, demons, or curses [88]. Therefore, having depression is thought to be attributable to the spiritual or cultural domain. Mental distress is seen as a sign of weakness, failure, or immaturity, rather than as a valid illness that should be accepted and treated. This may help explain why many Nigerian men experienced difficulties connecting with negative emotions such as bereavement, grief or depression [87]. In two studies carried out during the COVID-19 pandemic, male workers (34% of participants) were found to be at an even higher risk for anxiety [89], whilst in another study, almost 9% of male workers were found to be depressed [90]. There are many cultural and social barriers to accessing mental health services [91]. Stigmatised views towards mental illness are strong in Africa and especially so among men. This impedes mental illness recovery [87].

8. What workplaces and clinical practices should do

In light of these findings, it is clear that concerted cultural-competent action at an organisational level is needed in order to meet the mental health needs of male employees. This can be realised by using multifaceted approaches. Firstly, organisations should improve the mental health literacy of all male employees with campaigns that challenge gender stereotypes and the stigma around mental illness in a gender-sensitive way. This can be achieved by using role models to convey information about the issues. It can also be achieved by providing psychoeducational materials which can enable employees to recognise and signpost services using positive male traits such as responsibility and strength [92]. Secondly, male-dominated industries should include paid time for all their employees to engage in wellness activities such as self-

compassion training, cultivating kindness and care towards themselves [17, 93, 94]. Self-compassion has been shown to have a strong association with improved mental health across cultures [95, 96]. Thirdly, organisations can also do more to build a culture where men's social connectedness (a sense of belonging to a social relationship [97]) is promoted, as this has also been shown to contribute to improved mental health [98]. Finally, organisations need to undertake a systemic investigation of their workplace culture and environment and proactively address any racial workplace microaggressions and discrimination, as this has also been linked with poor mental health outcomes in black men [99].

Health, social care and public sector providers also have a responsibility to ensure considerations are taken to address the cultural nuances which can interplay for male staff and patients. Cultures are pertinent to mental health shame [100]. Male staff in these sectors need to be encouraged to talk openly about their experiences of mental health difficulties in the workplace [101, 102]. Likewise, male patients are also supported to feel safe to talk about their mental health experiences. For example, sharing narratives of mental health experiences and recovery has been reported effective to normalise the experiences, reducing mental health shame [103]. Similarly, having a peer support worker can counter shame, leading to hope that patients believe they too can overcome the difficulties as the peer support worker did [94]. These approaches can benefit both male staff and patients [104], and should be considered in those sectors.

9. Limitation

While this perspective paper offers helpful insight into male workers' mental health shame across different cultures, limitations should be noted. First, our literature searches were limited to English. Considering the contents of this prospective paper, multilingual searches would have yielded more meaningful findings. Second, a systematic literature search was not employed for this perspective paper, as the feasibility of such type of study was uncertain before this work. Our findings suggest a more systematised review is possible, and could offer helpful findings. Third, many of the studies reported employed self-report measures to capture shame towards mental health problems. Self-report measures can suffer from response biases [105]. Especially high masculine cultures can cause repressive coping, unconsciously denying the existence of socially unfavoured emotions [51]. This may help explain that these types of mental health studies often recruit more female participants than male ones (as demonstrated in synthesised works such as [14]), suggesting that male workers' mental health shame is a hard-to-reach topic. Future research should consider a male worker recruitment method which allows participants who have high mental health shame feel comfortable and safe. The method should also consider cultural nuances.

10. Conclusion

As the awareness of mental health increases worldwide, the negative impact arising from mental health shame on people's mental health are highlighted. Mental health shame is present in male workers across cultures. Though the types of mental health shame may differ by culture, a solution is needed to protect male workers' mental health. Improving mental health literacy, wellness activities such as self-compassion training, social connectedness and safe workplace culture can address this problem. The healthcare sector has the responsibility of sending the right messages to organisations about mental health. Insights offered in this perspective paper can help the human resources staff and managers who work at a multicultural workplace identify effective approaches for male workers' mental health shame.

AVAILABILITY OF DATA AND MATERIALS

Not applicable.

AUTHOR CONTRIBUTIONS

YK—designed the research study. YK, JJ, MA, AME, CV, KB, MAK, HA and AK—performed the research. YK, JJ, MA, AME, CV, KB, MAK, HA and AK—wrote the manuscript and contributed to editorial changes in the manuscript. YK, JJ, MA, AME, CV, KB, MAK, HA and AK—read and approved the final manuscript.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Not applicable.

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CONFLICT OF INTEREST

The authors declare no conflict of interest. Yasuhiro Kotera is serving as one of the Guest Editor of this journal. We declare that Yasuhiro Kotera had no involvement in the peer review of this article and has no access to information regarding its peer review. Full responsibility for the editorial process for this article was delegated to ALA.

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