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ORIGINAL RESEARCH

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"I also take my car to a specialist garage." factors that facilitate treatment entry among men with depression: a qualitative study

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Abstract

Background: Men with depression seek professional treatment less frequently and at a later stage than women. Previous studies have primarily focused on barriers to accessing treatment, which is why the present study investigates factors facilitating therapy initiation in men with depression. **Methods**: Semi-structured interviews were conducted online with men with depression (n = 60). Transcripts were evaluated using qualitative content analysis, which included deductive pre-structuring, inductive coding, and consensual validation. **Results**: Improving one's own crisis situation and restoring one's agency are key motivations for entering treatment. Men often initiated treatment after abandoning their own coping strategies in favor of professional help, or when no other option remained. Men follow the recommendations of those working in the professional care system and recognize psychotherapists and psychiatrists as "professionals" who, in contrast to personal contacts, are able to provide more adequate support. Patients' private spheres also play a crucial role in the decision to start treatment. Respondents noted that those in their personal lives may demand that treatment be started, but mentioned that their personal lives can also become a point of reference for seeking treatment independently. Treatment experiences of people from the private environment can facilitate therapy initiation by enabling normalization and access to the support system. **Conclusions**: By restoring men's agency, conventional masculine norms can be adapted to assist treatment entry. There is also evidence that normalizing mental illness is having an immediate effect on men's perspectives. Professionals from the healthcare system can play a mediating role in helping men undergoing treatment by actively addressing mental health in a broader context. **Clinical Trial Registration**: This study is registered in the German Clinical Trial Register (DRKS) and the WHO International Clinical Trials Registry Platform (ICTRP) under registration number DRKS00031065 (https://trialsearch.who.int/Trial2.aspx?TrialID=DRKS00031065).

Keywords

Depression; Men; Help-seeking; Mental health; Qualitative study

1. Introduction

Persons who experience mental health problems, such as depressive symptoms, are faced with the decision of whether to seek professional help. Studies show that the gender of people with depression can have a strong influence on their help-seeking behavior. Compared to women, men with depression seek professional help less often and at a later stage [1–7]. The results of a study conducted in Germany show that only half of men suffering from major depression have sought professional help [8]. In addition, the figures for psychotherapeutic (16.5%) and (partial) inpatient treatment (13.7%) participation are far lower for men when compared with women [8].

Qualitative studies concerning men's help-seeking have examined a number of barriers to treatment. Their results show that self-stigmatization and anticipated or actually experienced stigmatization by others represent a significant barrier [1–4, 9, 10]. Men describe more frequent and more severe experiences of stigmatization in the context of depression than women [11–13]. Seeking help, like the diagnosis itself, can be seen as the opposite of conventional masculine norms such as strength, assertiveness, self-confidence, insensitivity, and autonomy [1, 2, 9–11, 14, 15]. In addition, external stigmatization observed in their social environments, especially that expressed by other men, is often mentioned as a barrier to entering treatment [2, 16, 17].

Other studies describe barriers that can be attributed to a different experience of illness and to differences in coping

with illness among men when compared with women. These findings indicate that men want to deal with their own issues themselves [4, 18], for example by trying to develop their own coping strategies without treatment or by trying to wait until their depression symptoms improve without treatment [9]. Self-management may also be more typically chosen as a treatment option due to men taking depression less seriously than women [19]. Subsequently, several studies have shown that men might not perceive the risk of a given illness, notice symptoms at a later stage, or might not understand them as a type of depression at all [10, 14, 20, 21]. A lack of knowledge about the disease and insufficient information regarding treatment options may also play a role [5, 8, 22].

Another barrier to treatment for depression that has often been examined in previous studies is prejudice against the professional care system. Qualitative studies have shown that men experience difficulties in talking to professionals about feelings, emotions, and psychological issues in psychotherapy [1, 4, 17, 23, 24]. One possible reason for this is normative gender concepts that associate talking about emotions with being feminine [9]. Psychotherapy is often regarded as an ineffective waste of time [8, 25]. In addition, study results have also shown prejudices against the professionals themselves, with men seeing professionals as incompetent and unable to treat depression [24, 25], or viewing treatment as a means for clinics to maximize profits [22]. Further, structural barriers can make it difficult for men with depression to enter treatment. These include the lack of availability and long wait times for appropriate treatment [19, 26] and regional differences in the provision of healthcare [8]. The complex administrative organization that has to be dealt with in order to be admitted to treatment is also a significant barrier [21].

To date, general motivations have been examined in the context of constructions of masculinity, such as men associating treatment entry with autonomy, responsibility, and strength [18, 27]. In addition, the role of relatives who demand treatment entry is discussed as a facilitator [3, 9, 10, 21, 28]. Similarly, a supportive attitude among the men's peers can encourage treatment entry [3, 9]. However, research on help-seeking among men with depression has focused primarily on barriers [14], often without considering supportive factors for treatment entry [3, 17]. Moreover, many studies have examined help-seeking behavior across illnesses and not on a gender-specific basis. Studies have also utilized different definitions of help-seeking. Pederson [10] and Mahalik and Dagirmanjian [9] view the use of help as an active form of seeking support from others when their own life situation is perceived as challenging. In this context, help-seeking refers to both professionals and a person's social environment. However, specific support factors may be missing in the general definition of help-seeking. Considering the low treatment rates among men, more knowledge of factors that facilitate treatment access is crucial to facilitate better healthcare outcomes for men with depression. Therefore, this study aimed to examine the factors that lead men with depressive symptoms to seek psychiatric or psychotherapeutic treatment.

2. Materials and methods

2.1 Data collection

This study is part of the research project "Transformation of masculinity orientations and work-related attitudes among depressed men (TRANSMODE)", funded by the German Research Foundation. The aim of this project is to investigate the manner in which gender roles evolve over time, as well as the influence of psychological and psychiatric treatment on this process. This study was approved by the ethics committee of Ulm University (Nr. 347/21). Semi-structured interviews with 60 men with depression were conducted between July and September 2023 by three experienced researchers (MS, GK, PN) via encrypted video calls. The research team consisted of one woman and two men. At the time of the interviews, all of them were working exclusively in psychiatric research: two of them with a background in sociology and one with a background in medicine. The average length of the interviews was 63 minutes. The interviews were conducted in German and later translated into English by the research team. In a second step, the translations of all relevant quotations for the analysis of treatment entry were reviewed by an external language editor in order to be able to conduct a qualitative analysis despite the translation. Prior to the interviews, all participants were informed about the study via phone by staff members, and signed a written declaration of consent. After each interview, a short documentary report was written. The interview guidelines were developed by three members of the research team and reviewed by academic peers in a qualitative research workshop. The guidelines aim to provide a comprehensive picture of the way men cope with their depressive illness after being admitted to treatment. They are divided into five topic areas: (1) treatment entry and subjective theory of illness; (2) process of treatment; (3) social environment and disclosure, (4) work and (5) gender and attitudes towards society. The present study is concerned with the men's entry into treatment and their subjective theory of illness, with specific consideration reserved for supporting factors, barriers, and the role of patient's social environment. With regard to the patient's social environment, an occasional question about treatment entry was added after two test interviews. If other people were reported to be relevant for treatment entry, the interviewers then asked whether the said people had treatment experience, as this aspect was found to be significant in the initial interviews.

2.2 Sample

The sample for the qualitative study was drawn as a subsample of a larger quantitative study (N = 323) that was recruited from eight psychiatric clinics in southern Germany (53.5%), as well as via social media (38.3%), the German Depression League, newspapers, and radio. Selection criteria for the study were: identification as male, being aged between 18–65 years, having self-reported a depression diagnosis, and having received some form of treatment for depression from a psychotherapist/psychiatrist or other specialist in the last 12 months. Exclusion criteria were: a primary diagnosis of an addiction-related disorder, a lack of proficiency in the German

language, and intellectual disabilities. All participants agreed to be contacted again for an interview. A total of 113 men were asked to participate in an interview in order to reach 60 interviews. The numbering was retained for continuous anonymization, which is why the transcripts were numbered between 1 and 113. In the quantitative study, a latent class analysis was performed, resulting in three classes based on masculinity orientations, work-related attitudes, and health behavior. For the qualitative interviews, approximately 20 representatives from each class participated in order to obtain a heterogeneous sample. Among the representatives of each class, men with the shortest treatment duration were selected. Since these participants had only recently begun treatment, they were able to provide detailed accounts of their experiences. The duration of treatment for the participants ranged from one month to a maximum of 30 months. Thirty-six men were receiving treatment for the first time. Participants' age ranged from 19 to 63 years (mean age = 40.6). At the start of the study, 40 were employed, 12 were unemployed, and eight were unable to work. Twenty-three participants held a college degree, 25 had completed an apprenticeship, six were still in training or studying, and six had no formal qualifications. Twenty-nine participants were in a relationship, while 31 did not have a steady partner.

2.3 Data analysis

The analysis was conducted using qualitative content analysis according to Kuckartz [29, 30]. First, all interviews (n = 60) were coded on the basis of deductive categories from the guideline using MAXQDA software (MAXQDA2020, VERBI Software, Berlin, BE, Germany). For this purpose, nine interviews (15%) were coded independently by three researchers. The interdisciplinary research team has members with both a social science and medical background. In the next step, differences in the coding were discussed and adapted until consensus was reached. Using the resulting coding system, the remaining 51 interviews were coded by one person each and cross-coded by one other person. For the analysis of treatment entry, the categories "Motivations to seek treatment", "Obstacles to seeking treatment" and "Importance of patient's environment at the time of treatment entry" were further analyzed inductively by two authors, and, following consensual validation and based on the research question, the category system was developed for "Factors that facilitate treatment entry".

3. Results

Four main categories were developed: Crisis Situation Leads to a Willingness to Change, Regaining Agency, Role of Social Environment, and Influence From Healthcare Professionals. Within the category Role of Social Environment, three additional subcategories were identified: Not Wanting to Be a "Burden on Their Surroundings", Social Environment Requires Treatment Entry, and Social Environment as Role Model.

3.1 Crisis situation leads to a willingness to change

The interviews show that the decision to start treatment is typically a response to severe suffering and depressive symptoms. A central motivation behind men seeking treatment is to change the level of suffering caused by their depression. To this end, they refer to specific symptoms that they would like to overcome, such as anxiety, insomnia, mood instability, and a lack of perspective. In addition, the respondents generally describe wanting to develop personally and improve their quality of life. Moreover, for several men, one reason for seeking treatment was to overcome suicidal thoughts:

"*On the one hand, there was a very big trigger in December, when I uh began to feel suicidal (...) and then a kind of will to survive set in or, not quite that, but I then realized, no, I don't want that and I have to change something, because otherwise everything will simply become very... intense.*" (Interview_04)

In this case, the person only entered treatment at a time when their state of health was so severe that there was no other option left. The deterioration became the trigger for considering treatment as necessary and thus changed the way they had dealt with their depression up to that point. The high level of suffering and the pronounced symptoms the patient was experiencing before the start of treatment had become clear:

"*But at some point, I couldn't cope with the whole thing any more. That had already become apparent over the past year and I was becoming more and more, how should I describe it, mentally… "restricted" (...) I then just sat at home for two or three weeks and was crying and had no way out because I just couldn't get out of this thought loop. That was the biggest motivation for me.*" (Interview_14)

"*The downward spiral just keeps on going.*" (Interview_09)

"*I was just experiencing very low points, where I was, where I had um very dark thoughts too.*" (Interview_46)

The men's reports point to a long process of symptoms worsening before a decision is made to enter treatment. Participants described obstacles to entering treatment as irrelevant after experiencing severe suffering and pronounced depressive symptoms. One participant reported that he started treatment despite stigmatizing attitudes in the family environment:

"*I think there was definitely a lot of prejudice from how I was raised towards mental health treatment (...) And that didn't necessarily make it easier for me. But I think at that point I was already in a place where I didn't really care about any of that.*" (Interview_46)

The interviewees report their entry into treatment after realizing that they themselves no longer know how to deal with the depression. One participant describes how entering treatment undermined the gender role expectations he had held for himself:

"*And I realized that I needed help now, because as a man you always think, ha, you have to be strong, and yes, you can do it and you have to be careful and you have to do it for others and all that sort of thing. And that's when I realized that I'd reached the point where I couldn't go on any further. (...) That I couldn't handle it on my own.*" (Interview_101)

For another participant, the turning point for seeking help

was reached when he noticed significant limitations in his previous work abilities. While he was "*used to telling other people what to do*" due to the leadership position he held in his professional environment, and his depression meant that he "*was no longer capable of helping himself*" (Interview_14). In both cases, depression led to a changed perception of the patient's own agency. The motivation for seeking treatment was both being "*unable to cope with this on their own*" (Interview_16) and at the same time to be able to regain their pre-illness state of health. This motivation outweighed any prejudices towards the treatment, such as "*being hypnotized by the psychotherapist(s)*" (Interview_56).

3.2 Regaining agency

With the depressive illness restricting their agency, men hoped to be able to regain their agency by entering treatment. Accordingly, they emphasized their "*intrinsic motivation*" (Interview_33) for entering treatment. It was "*the right thing to do*" (Interview_69) with the aim of being "*actively involved in escaping this situation*" (Interview_54). As a result, the need for "*external help*" (Interview_29) or "*outside help*" (Interview_101) was explicitly emphasized. In this way, the individual's own attitude becomes a facilitating factor that encourages them to seek professional treatment. In addition, from the perspective of many interviewees, very few men would actually seek professional treatment "*out of their own free will*" (Interview_64).

Nevertheless, it is emphasized that "*capacity*" (Interview_72) is required in order to commit emotionally and organizationally to the treatment. In addition, motivation to improve the crisis situation can be associated with the fear of not receiving adequate treatment or suitable therapists:

"*How can I deal with this? Somehow by finding a point of view, uh, an approach to solving the whole issue (...) Hopefully they believe me. Hopefully. Hopefully the people I meet won't be so prejudiced. Hopefully they have enough time [to understand my issues].*" (Interview_72)

On top of this, some men claim that it was their own decision to seek professional help. This relates to the identification of symptoms, the organization of treatment entry, and the active participation in treatment:

"*And that was the reason I actually looked up the phone number on Google, called up, and said: Hey there.*" (Interview_103)

"*It was already clear in my head that I HAD to do something to get out of this hole. (...). So I really wanted to actively get out of it and I also discussed it with the psychiatrist and he said, well, there's the possibility of this home, uh, assistance, and after that I really sat down and tried to gain access to it immediately.*" (Interview_54)

For these men, it does not seem possible to "*deal*" with depression on their own, however, they were able *to* "*make the decision*" to enter treatment. Thus, entering treatment on their own becomes an opportunity to re-claim agency in the context of the depressive illness itself. In their narrative, the admission to treatment then follows as a logical consequence in a process of rational consideration: "*So in my case, the logical side of my brain had not yet been switched off*" (Interview_14). "*Not starting treatment would make no sense to me at all*" (Interview_01).

3.3 Role of social environment

For many of the men interviewed, their social environment played a decisive role in them entering treatment. However, the nature of this role and its specific impact varied across participants.

3.3.1 Not wanting to be a "burden on their surroundings"

Some of the men sought treatment in order to protect their social environment from suspected or existing stress caused by their depression:

"*It was my social environment, because I realized that I was putting a lot of strain on it and I was afraid that if I didn't change anything, I would lose all of that in the long term. And in this state that I was in, I couldn't imagine losing my social environment.*" (Interview_04)

For others, there was a concern about "*always feeling like a burden*" (Interview_48) or "*not wanting to hurt others*" (Interview_81) and thus overwhelming their social environment with the support they need. In contrast, the interviewees sought professional treatment with the aim of relieving the perceived burden on their social environment so that social relationships could be maintained in the long term. One man also reported a motivation of not wanting to disappoint those close to him, which helped him "*access treatment*" (Interview_57). Another factor that encouraged some of the men to start treatment was their desire to be able to participate more in their social networks:

"*My family was also a reason why I went into treatment, because I was simply no longer able to participate in the familial environment and became more and more withdrawn.*" (Interview_92)

Some men also hoped that the treatment would enable them to be more available/helpful (Interview_65) with their children again. With regard to their partners, the focus was on improving or maintaining the relationship. The men emphasized that they had recognized the challenging situation that had been created and that they entered treatment by themselves:

"*No, it was all my own initiative, because I knew that if I stayed in this hole, with my wife also being so seriously ill, that we'd both have no future.*" (Interview_54)

Many other participants reported that a change in their social environment was also a motivation for entering treatment. The reason for entering treatment was the desire to leave the private or professional environment. Inpatient treatment offers the temporary opportunity to be "*away from home*" (Interview_64) or to be "*released from work-related pressure*" (Interview_15). They also described the desire to be able to talk about their own state of health "*away from their family circle*" (Interview_62) in a "*confidential setting*" (Interview_62) as a motivation for entering treatment.

3.3.2 Social environment requires treatment entry

In contrast to other supporting factors, in this instance treatment entry was not initiated by the men themselves, but by close contacts instead:

"*So my wife and my children said that I had to get external help because they didn't feel able to help me... to help me beyond a certain point*." (Interview_07)

For nearly half of the interviewees, the influence was largely from their partners, whereas family and close friends also had an influence on starting treatment. The environment was the "*decisive factor*" in this case (Interview_91) and provided the "*final push*" (Interview_21); treatment entry was based on "*advice*" (Interview_78) or at the "*request of a friend*" (Interview_56). In addition, entering treatment was the result of a process that the patient's social circle had been "*working on for some time*" (Interview_60):

"*Well, as I said, I think it took me a year to make up my mind and only then did I have the motivation to start doing anything about it. She kept asking me, 'Don't you want to finally actually contact someone?'*" (Interview_57)

According to the men interviewed, their environment demanded that they enter treatment at a time when they no longer felt capable of providing adequate support themselves. The participants reported that, from the perspective of their social environment, they "*simply could not continue like this*" without treatment (Interview_27). In addition, the interviewees assumed that their own coping strategies (*e.g.*, aggression, work, alcohol) were no longer "*accepted*" (Interview_75). In this context, some men reported being "*strongly urged to do something by their friends*" (Interview_81):

"*Um, well, my wife also said, I can't do this anymore. I want a divorce. This is the end. Just like that. Um, and then I said, okay, understood. I'm going to a counseling center right now, I'm going to find some family counseling.*" (Interview_64)

In this case, while the impetus to enter treatment came from the partner, the participant emphasized afterwards that he had pursued and implemented the entry "*on their own*" (Interview_91). Other interviewees, in contrast, described their social environment as being the key factor to actually enter treatment:

"*It was all due to my grandma. That was actually the most important factor. That I managed to get there. Um. (...) Yes, you could say that. She basically organized the whole thing so that I could do it. I did almost nothing myself, on my own initiative.*" (Interview_75)

From the perspective of the interviewed men, their social environment enabled them to start treatment because they did not have the necessary resources themselves. In some cases, it may have even been that men's social environment acted against their own will:

"*Then she [wife; GK] just said: 'We're going now, no ifs, ands, or buts, come on, let's go', and then 'No, we don't need it', 'Come on, come!'. The suitcase was packed, and we drove there.*" (Interview_91)

3.3.3 Social environment as role model

A person's social environment can act as a role model for starting treatment. It is evident in several aspects that a patient's social environment is of particular importance for treatment entry if someone within it is familiar with psychiatric or psychotherapeutic treatment or works in the field of psychiatry themselves. In such instances, this initially influenced the men's perspective on illnesses and treatment options. One man described how witnessing his brother's psychosis influenced his own perspective on mental illness:

"*If you have a mental illness, you simply must get treatment. And [understand] that mental illness really is a serious matter too.*" (Interview_57)

Another participant mentioned that his mother's borderline disorder and depression "*sensitized*" him (Interview_59) to symptoms of mental illness. For another interviewee, a friend's plan to seek treatment was a sufficient motivator for him to start his own treatment:

"*And in any case, to return to [FRIEND 1], he has problems with panic attacks and is therefore already being treated by a psychologist as an outpatient. And um he told me six months ago that he would like to receive inpatient therapy, a planned course of therapy (...) that would last about 7 to 8 weeks,... and that's when I knew. And that's why I would say that [FRIEND 1] supported me at that point in time, even though he was entirely unaware of it.*" (Interview_02)

Even if there is no personal contact, both knowledge about mental illness and the perception of there being a specific way of dealing with it are crucial. In their descriptions, men refer to mental illnesses in general. It seems less relevant whether those in their social environment are specifically affected by depression.

In addition, the participants described positive experiences with treatment in their social environment as having a positive and encouraging effect on them seeking treatment themselves. The respondents also referred to a noticed improvement in the person's state of health:

"*Today she [mother; GK] is happily living in old age, and it's wonderful to see, uh, how she's ultimately managed to deal this very positively in terms of herself over the years, the decades (...) And let's say, that's certainly made it easy for me to understand that I'm dealing with something I don't understand, which means that I just need to get experts to help me.*" (Interview_01)

Furthermore, several men reported that their social environment supported them in contacting professionals:

"*Um, when I came to this understanding for myself, it was also with the help of my girlfriend at the time, and I first came across this, this um, overwhelming number of organizations [that you have to deal with], something that is simply a part of the process of dealing with seeking a therapist or a psychologist or psychiatrist or whatever. And, um, luckily for me at the time, my girlfriend, um, found several psychologists for me and, um, that of course removed a lot of the barriers for me.*" (Interview_20)

This illustrates a process in which the decision to enter treatment has already been made and is subsequently supported by the patient's social environment. The difference is also

evident in the case of another man:

"*That's why I don't think everyone around me said, hey, you absolutely have to talk to a therapist. But, um, they just supported me so that I could just… um, my sister told me where could I find a therapist, and what should I perhaps look out for.*" (Interview_59)

If the environment demands treatment entry, the process is described in reverse (see above). In addition, one participant reported that he was able to enter treatment at a psychiatrist because "*my girlfriend at the time*" (Interview_69) was receiving treatment there herself and he could therefore be referred to the specialist. Specific support from other affected persons is also described in other areas. The men are supported by other affected persons in their social environment who have specific "*prior knowledge*" (Interview_27) of the illness and of treatment. This can facilitate their own entry into treatment if "*experiences (...) with therapy*" (Interview_60) or about mental illness are shared, "*good tips*" (Interview_79) are given on how to deal with the illness, information is provided about medication, or advice is given on how to take sick leave. Other people affected can also help identify symptoms and communicate them at an early stage.

Equally, other affected persons can support the start of treatment through their specific understanding: "*I had a particular amount of trust in him and I think he also knew how urgent the situation might be*" (Interview_25). In addition, people in a patient's social environment with and without experience of treatment can have a crucial influence on the start of treatment through their attitude towards both treatment and the illness itself:

"*So my environment really played a (...) major role in my decision to seek treatment, but it had also played a major role in my decision not to seek treatment [previously]. (...). Um, for example, talking about it with my sister or my girlfriend at the time, who was also in therapy with a psychologist, it was absolutely not a taboo subject. (...). And, uh, on the other hand, when talking to my father, it was always such a taboo topic. But then I also just, uh, simply avoided it. And in terms of my mother, it was of course very difficult, because she was always very afraid. That I would, yes, become just like her, and that always made me very uncomfortable. But of course that also created a bit of extra pressure, where you then think, no, no, no, I'm just going to deal with it myself somehow.*" (Interview_20)

The environment can help normalize the illness and break down surrounding prejudices. It becomes possible to integrate professional treatment into the patient's previous methods for dealing with their depression:

"*I also knew a nurse who worked in a psychiatry clinic. I talked to her too. And that also helped me a lot, of course. The two people I spoke to were just there for me and said, 'hey, there's nothing bad about going into a clinic, and it will help you, so just get yourself there and get some treatment.'*" (Interview_64)

The following quote shows that entry into treatment is supported if the disease is normalized in the environment with reference to its social prevalence:

"*I'm nothing special and my boss also said that he doesn't think it's a particularly dramatic thing, because it's had an impact on a lot of people, and now I'm in the process of dealing with it too.*" (Interview_01)

In general, the results show that many participants refer to the social prevalence and normalization of mental illness in their explanation of their willingness to seek help. With regard to the prevalence of mental illness in society, one participant refers to being like a "*leaf (...) an enormous pile*" (Interview_01). The men see depression as a "*much more serious problem*" (Interview_66) in society "*that affects one in five people at some point*" (Interview_14). As a result, their own entry into treatment appears to be more common and less stigmatized. Some men also refer to celebrities from public life:

"*I listen to a lot of audiobooks generally, and then I listened to Kurt Krömer's audiobook [famous German comedian; GK] and heard about his experience (...) and then I decided that I might give inpatient psychiatric care at a hospital a try. Because the description was quite appealing.*" (Interview_09)

3.4 Influence from healthcare professionals

Healthcare professionals motivated the interviewed men to make use of psychiatric and psychotherapeutic treatment. This is based on recommendations from general practitioners and cross-sectoral counseling centers, such as "*the university*" (Interview_33), "*the school psychologist*" (Interview_63), "*the social counselor at work*" (Interview_79), and pastoral care. General practitioners in particular are the first point of contact for men with depressive symptoms and psychological stress. They take on both a supportive and mediating role:

"*Then it tended to be the case, the GP said, that the wife said that she could no longer deal with it on her own because she wasn't an expert, she wasn't a specialist and she would really like else someone to take a closer look at it (...) Yes, and then I it simply became clear to me: Okay this is how it is, and I want to move forward again. I don't want to just, um, grope around in the fog forever.*" (Interview_88)

This quote shows that the family doctor calls for "*clinical-psychiatric*" (Interview_88) treatment. As a result, a change in understanding is described and the advice is accepted and implemented. Another interviewee also reports that his sister and his GP initiated residential treatment after a "*suicide attempt*" (Interview_02). On the other hand, another participant reported that contact with a counseling center was sought "*intrinsically*" (Interview_33), which then referred the person concerned. For almost all of the consulted men, their social environment first urges professional treatment before contact is made with the GP or psychiatric specialists.

In addition, most interviewees expressed a fundamental trust in mental health professionals, which had a positive influence on treatment entry. The "*professional(s)*" (Interview_62) and "*specialists*" (Interview_101) are assumed to be able to provide specific support due to the fact of being "professional" and are seen as having the competence required to improve their own state of health:

"*Now I have something I don't know anything about, and so then you just consult with experts: it's just like I always say, I take my car to a specialist garage when I have no idea what's wrong with it, so I don't fiddle around with it myself either.*" (Interview_01)

This comparison symbolizes a rational and responsible approach to health. At this point, the participants contrast the competence and knowledge of the professionals with their own powerlessness in dealing with the illness. The responsibility for their state of health can be delegated to the professionals as experts, which, ultimately, is conducive to seeking treatment.

Equally, mental health professionals are seen as being outside of the men's own social environment. Professionals thus offer a form of support that the men believe is not guaranteed in their private environment:

"*Because no friend or family member can help you, you have to find someone who is a bit external and to whom you can tell anything or who can perhaps tell you something that you might not take so seriously if it were to come from a family member.*" (Interview_91)

Moreover, the desire to gain information about the disease encouraged treatment initiation:

"*And I think that was also important to me, to understand things in this way. Why am I like this? Why do I feel so down right now? (...) Because for me, depression isn't like that, I don't know, it's not like I'm going to fall down at some point and break my arm. I think everyone, even if they don't have medical expertise, have a kind of rudimentary understanding of this. But, but with depression I've always found that, I still don't think it's understand it completely, it's not quite tangible for me.*" (Interview_59)

This is where insecurities about their own emotional state and state of health became evident. The men hoped that professional treatment would help them understand and make sense of their condition. The desire for clarification is expressed both when their social environment demands treatment, when treatment successes have been experienced by other affected persons, and also in situations without external influence.

4. Discussion

This study examines factors that encourage men with depressive disorders to enter psychological and psychotherapeutic treatment. Men often start treatment at a time when they have given up on their own coping strategies in favor of external experts. At such a point in time, self-management [4, 18], which is often described as a barrier, is no longer sufficient. This moment, described as a tipping point by McKenzie *et al*. [31], is defined as the point of time when there is no other option for the men but to enter treatment, due to the severity of their symptoms. The results confirm previous findings that many men only enter treatment as a "last resort" and after reaching a tipping point [21, 31, 32]. Like the quantitative longitudinal study referred to in note [13], the intensity of the symptoms is of greater significance than the duration of the illness.

Previous studies have already discussed motivations for treatment entry in the context of conventional constructions of masculinity. Here, treatment entry is presented by the affected men as a sign of autonomy and strength [27]. Nevertheless, in previous analyses of motivation, it remains unclear which specific factors that facilitate treatment entry emerge as a result. The present study provides evidence of a connection between motivations and specific facilitating factors.

In concepts of masculinity such as hegemonic masculinity [33], control, autonomy, and independence are understood as identity-forming factors for masculinity. Previous studies suggest that men associate entering treatment with a loss of control—and thus a loss of agency [2, 9]. This study does not attempt to maintain the male identity factor of agency without treatment, but rather to restore men's agency by entering treatment. By referring to agency in this way, it is possible to establish connections to conventional expectations that masculinity places on men and adapt these to facilitate treatment entry. These connections are reinforced when entering treatment appears to the participants to be a rational and solution-oriented course of action, while not receiving treatment is perceived as not taking responsibility for one's own handling of the illness [34].

Furthermore, in contrast to other studies [1, 21, 34], the results show that treatment entry is not legitimized by physical illnesses, but that the affected men merely refer to them in order to normalize treatment admission. Also, in contrast to other study results, the naming of depressive symptoms or a depressive illness is not bypassed for treatment admission [12]. Instead, respondents acknowledged both diagnosis and treatment.

The men also described more self-initiative than previous research suggests. This is evident in their motivation to provide relief to their social environment. Caperton *et al*. [18] describe a desire to protect the family from their own psychological stress and taking responsibility for the family environment as a factor that promotes treatment entry for stay-at-home fathers. The results of the present study also confirm this result. In addition, men begin inpatient treatment on their own in order to become functional again in their social environment. They also explicitly seek professional forms of support away from their existing environment.

At the same time, this study confirms that treatment entry can also occur at the urging of relatives [9, 21, 28, 35]. As in other studies, the findings show the decisive influence of partners on treatment entry [3, 9, 10, 20]. However, participants do adopt a positive attitude towards treatment admission after being convinced by their social environment. According to the study by Scholz *et al*. [34], practical support can also have a conductive effect on treatment entry. In this study, it was also shown how decisive the social environment can be as a role model for treatment admission. The findings of Mahalik & Dagirmanjian [9] and Staiger *et al*. [3] support the hypothesis that accepting attitudes in the patient's social environment can facilitate treatment entry. The perception of not being alone with depression may be equally beneficial. This refers specifically to both other people affected by depression and to a general social prevalence of the illness [15, 21, 23, 34]. Our results suggest that it is not the specific clinical image of depression that is decisive, but psychological distress in general. In addition, the interviewed men did not necessarily have to be in contact with other affected persons; simply having knowledge of their experiences with treatment may be sufficient. Finally, it is crucial for the acceptance of treatment among men that mental illness is normalized in both their particular social environments as well as in the social discourse around mental health as a whole [11, 17, 24].

The specific influence of other affected persons on the treatment entry of depressed men has scarcely been investigated in studies beyond the naming of other affected persons as trusted confidants [17] or experts [32]. Our findings emphasize the various roles and functions of other impacted persons and the importance of experiential knowledge passed on by trusted persons as well as professional knowledge for treatment entry. Other affected persons provide advice on therapy, illness, and coping strategies, and gain a specific level of trust due to their shared background of experience. In addition, treatment successes experienced by those around them motivate people to seek treatment themselves.

Furthermore, previous studies have seen a lack of knowledge about depression and treatment options as being the primary barriers to treatment entry [5, 8, 22]. This study shows that the desire to obtain information about the illness can also help to establish contact with professional care systems. This fits in with the fact that professionals are considered to have the expertise to know about the condition and to be able to treat it in a way that promotes improved health. In that case, the frequently mentioned prejudices against those providing treatment and the professional care system [1, 4, 17, 23–25] are less relevant. Furthermore, our findings suggest that men with depression can be motivated to seek psychological and psychotherapeutic treatment through contact with other professionals from the healthcare system. The study supports views that men accept and implement the recommendations they are given.

Following a social constructionist perspective from Connell [33] and, in the context of help-seeking behavior, one should not assume a universal masculinity that is associated with a specific form of help-seeking. Rather, we should assume masculinities that are influenced by other structural positions [36, 37]. In this study, no differences in age, employment status, or educational level were found in relation to help-seeking behavior. However, the high educational level of the participants and the associated higher resources in health literacy [38] could lead to a greater likelihood of seeking treatment for depression. Similarly, a qualitative study with older men (mean age 52) shows that for the men surveyed, seeking treatment is less consistent with their own image of masculinity [3], which could indicate that younger men have fewer reservations about seeking treatment for depression.

5. Limitations

For this study, only men who had already received psychotherapeutic or psychiatric help were surveyed. The participants' accounts may be retrospective rationalizations that potentially downplay the initial difficulties or resistance to seeking help. As mental health treatment can shift perspectives, help to reduce prejudices against support systems, and support mental health literacy [21], respondents may be more likely to emphasize facilitating factors, while earlier ambivalence or barriers may recede into the background or have already been overcome. Positive experiences with therapy can also influence the views of respondents. Furthermore, the perspectives of partners and the social environment were only considered from the perspective of men, while the direct perspective of partners was not taken into account. Focusing on entering psychiatric or psychotherapeutic treatment does not allow conclusions to be drawn about help-seeking in private contexts. In addition, potential recall bias is possible in the men's reports, as treatment entry may have been some time ago at the time of the interviews.

6. Conclusions

Professionals from the healthcare system can play a mediating role in helping men undergoing treatment by actively addressing mental health as a standard health issue. Standardized and regular checks of mental distress could be helpful in identifying depressive symptoms at an early stage. This could also prevent a potentially severe acceleration of symptoms and mental health crises, and facilitate earlier psychological or psychiatric treatment. To achieve this, other professionals need to have adequate knowledge about depressive illnesses and receive targeted training. In addition, education strategies should aim to make it easier for men to articulate mental health issues and express them during low-threshold contacts with the healthcare system. Moreover, destigmatizing and normalizing mental illness and help-seeking through specific campaigns seems to have a direct influence on the health behavior of those affected and can thus promote treatment entry. This can be achieved by involving the patient's social environment, alongside other affected persons and professionals.

AVAILABILITY OF DATA AND MATERIALS

Data will not be shared due to difficulties in the anonymization of qualitative data. Access to data will be granted to researchers for appropriate use.

AUTHOR CONTRIBUTIONS

SK—supervised the study. SK and RK—developed the study design. MS—coordinated the team. MS, GK, PN and FM—recruited and pre-screened participants. NL and MP—managed and prepared the data. MS, GK and PN—conducted the interviews. GK, MS, PN and KS—analyzed the interviews. GK—drafted the manuscript. MS—revised the manuscript. All authors read the manuscript several times, suggested significant changes and approved the final version of the manuscript.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The study was approved by the Ulm University ethics committee (Nr. 347/21). Participants received detailed information and provided written informed consent. All participants have given written consent for anonymized publication of results.

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CONFLICT OF INTEREST

The authors declare no conflict of interest. Maja Stiawa is serving as one of the Editorial Board members of this journal. We declare that Maja Stiawa 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 SYY.

REFERENCES

[1] Gosling R, Parry S, Stamou V. Community support groups for men living with depression: barriers and facilitators in access and engagement with services. Home Health Care Services Quarterly. 2022; 41: 20–39.

[2] DeBate R, Gatto A, Rafal G, Bleck J. A qualitative assessment of mental health literacy and help-seeking behaviors among male college students. Discover Mental Health. 2022; 2: 23.

[3] Staiger T, Stiawa M, Mueller-Stierlin AS, Kilian R, Beschoner P, Gündel H, *et al*. Masculinity and help-seeking among men with depression: a qualitative study. Frontiers in Psychiatry. 2020; 11: 599039.

[4] Cramer H, Horwood J, Payne S, Araya R, Lester H, Salisbury C. Do depressed and anxious men do groups? What works and what are the barriers to help seeking? Primary Health Care Research & Development. 2014; 15: 287–301.

[5] Klineberg E, Biddle L, Donovan J, Gunnell D. Symptom recognition and help seeking for depression in young adults: a vignette study. Social Psychiatry and Psychiatric Epidemiology. 2011; 46: 495–505.

[6] Möller-Leimkühler AM. Barriers to help-seeking by men: a review of sociocultural and clinical literature with particular reference to depression. Journal of Affective Disorders. 2002; 71: 1–9.

[7] Galdas PM, Cheater F, Marshall P. Men and health help-seeking behaviour: literature review. Journal of Advanced Nursing. 2005; 49: 616–623.

[8] Nübel J, Müllender S, Hapke U, Jacobi F. Epidemic of depression?: Development of prevalence and help-seeking behaviour. Der Nervenarzt. 2019; 90: 1177–1186. (In German)

[9] Mahalik JR, Dagirmanjian FR. Working-class men's constructions of help-seeking when feeling depressed or sad. American Journal of Men's Health. 2019; 13: 1557988319850052.

[10] Pedersen SC, Maindal HT, Ryom K. "I wanted to be there as a father, but I couldn't": a qualitative study of fathers' experiences of postpartum depression and their help-seeking behavior. American Journal of Men's Health. 2021; 15: 15579883211024375.

[11] Reczek C, Thomeer MB, Gebhardt-Kram L, Umberson D. "Go see somebody": how spouses promote mental health care. Society and Mental Health. 2020; 10: 80–96.

[12] Johnson JL, Oliffe JL, Kelly MT, Galdas P, Ogrodniczuk JS. Men's discourses of help-seeking in the context of depression. Sociology of Health & Illness. 2012; 34: 345–361.

[13] Rice SM, Aucote HM, Parker AG, Alvarez-Jimenez M, Filia KM, Amminger GP. Men's perceived barriers to help seeking for depression: longitudinal findings relative to symptom onset and duration. Journal of Health Psychology. 2017; 22: 529–536.

[14] Seidler ZE, Dawes AJ, Rice SM, Oliffe JL, Dhillon HM. The role of masculinity in men's help-seeking for depression: a systematic review. Clinical Psychology Review. 2016; 49: 106–118.

[15] Sierra Hernandez CA, Han C, Oliffe JL, Ogrodniczuk JS. Understanding help-seeking among depressed men. Psychology of Men & Masculinity. 2014; 15: 346–354.

[16] Staiger T, Stiawa M, Mueller-Stierlin AS, Kilian R, Beschoner P, Gündel H, *et al*. Men and depression: illness theories and coping—a biographical narrative study. Psychiatrische Praxis. 2020; 47: 65–70. (In German)

[17] Hoy S. Beyond men behaving badly: a meta-ethnography of men's perspectives on psychological distress and help seeking. International Journal of Men's Health. 2012; 11: 202–226.

[18] Caperton W, Butler M, Kaiser D, Connelly J, Knox S. Stay-at-home fathers, depression, and help-seeking: a consensual qualitative research study. Psychology of Men & Masculinities. 2020; 21: 235–250.

[19] House J, Marasli P, Lister M, Brown JSL. Male views on help-seeking for depression: a Q methodology study. Psychology and Psychotherapy. 2018; 91: 117–140.

[20] Davenport CJ, Swami V. Getting help as a depressed dad: a lived experience narrative of paternal postnatal depression, with considerations for healthcare practice. Journal of Psychiatric and Mental Health Nursing. 2023; 30: 1–7.

[21] Wirback T, Forsell Y, Larsson JO, Engström K, Edhborg M. Experiences of depression and help-seeking described by young Swedish men. Psychology of Men & Masculinity. 2018; 19: 407–417.

[22] Seidler ZE, Rice SM, Oliffe JL, Fogarty AS, Dhillon HM. Men in and out of treatment for depression: strategies for improved engagement. Australian Psychologist. 2018; 53: 405–415.

[23] Tang MOT, Oliffe JL, Galdas PM, Phinney A, Han CS. College men's depression-related help-seeking: a gender analysis. Journal of Mental Health. 2014; 23: 219–224.

[24] Rochlen AB, Paterniti DA, Epstein RM, Duberstein P, Willeford L, Kravitz RL. Barriers in diagnosing and treating men with depression: a focus group report. American Journal of Men's Health. 2010; 4: 167–175.

[25] Brownhill S, Wilhelm K, Barclay L, Parker G. Detecting depression in men: a matter of guesswork. International Journal of Men's Health. 2002; 1: 259–280.

[26] Kravitz RL, Paterniti DA, Epstein RM, Rochlen AB, Bell RA, Cipri C, *et al*. Relational barriers to depression help-seeking in primary care. Patient Education and Counseling. 2011; 82: 207–213.

[27] Emslie C, Ridge D, Ziebland S, Hunt K. Men's accounts of depression: reconstructing or resisting hegemonic masculinity? Social Science & Medicine. 2006; 62: 2246–2257.

[28] Chuick CD, Greenfeld JM, Greenberg ST, Shepard SJ, Cochran SV, Haley JT. A qualitative investigation of depression in men. Psychology of Men & Masculinity. 2009; 10: 302–313.

[29] Kuckartz U, Rädiker S. [Qualitative content analysis: methods, practice, and computer-assisted analysis]. 5th edn. Beltz Juventa: Weinheim. 2022. (In German)

[30] Kuckartz U, Rädiker S. [Focused interview analysis with MAXQDA: step by step]. 2nd edn. Springer VS: Wiesbaden. 2024. (In German)

[31] Mckenzie SK, Jenkin G, Collings S. Men's perspectives of common mental health problems: a metasynthesis of qualitative research. International Journal of Men's Health. 2016; 15: 80–104.

[32] Gough B. Men's depression talk online: a qualitative analysis of accountability and authenticity in help-seeking and support formulations. Psychology of Men & Masculinity. 2016; 17: 156–164.

[33] Connell RW, Messerschmidt JW. Hegemonic masculinity. Gender & Society. 2005; 19: 829–859.

[34] Scholz B, Crabb S, Wittert G. "Males don't wanna bring anything

up to their doctor": men's discourse of depression. Qualitative Health Research. 2017; 27: 727–737.
[35] Skärsäter I, Dencker K, Häggström L, Fridlund B. A salutogenetic perspective on how men cope with major depression in daily life, with the help of professional and lay support. International Journal of Nursing Studies. 2003; 40: 153–162.
[36] Courtenay WH. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. Social Science & Medicine. 2000; 50: 1385–1401.
[37] Griffith DM. An intersectional approach to men's health. Journal of Men's Health. 2012; 9: 106–112.
[38] van der Heide I, Wang J, Droomers M, Spreeuwenberg P, Rademakers J, Uiters E. The relationship between health, education, and health literacy: results from the Dutch Adult Literacy and Life Skills Survey. Journal of Health Communication. 2013; 18: 172–184.

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