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Mental health literacy among Arab men living in high-income Western countries: A systematic review and narrative synthesis

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ABSTRACT

While interest in mental health literacy (MHL) is growing rapidly, cross-cultural research focusing on MHL is developing more slowly. This inaugural systematic review explored the recognition and beliefs about the causes of mental health disorders amongst Arab men living in high income Western countries (HIWC), their help-seeking beliefs, behaviors, and sources of help, as well as barriers and facilitators to help-seeking. Six electronic database searches were conducted using Medline, Embase, ProQuest Dissertations & Theses Global, PsycINFO, Scopus, and Web of Science. These searches yielded a total of 9,460 citations. After applying inclusion criteria through both database and manual hand searches, 46 studies were identified. The findings corresponded with four of the socioecological model's five factors: intrapersonal, interpersonal, societal, and institutional. Intrapersonal factors included attributing mental health illness to life and migration stressors, and religious reasons. Interpersonal and societal factors included men favoring informal help-seeking sources as stigma was a barrier to formal help-seeking. Institutional factors around the perceived cultural competence of healthcare professionals and access difficulties were obstacles to seeking formal help. The growth in Arab migration to HIWC highlights the need for culturally tailored care. Research is needed to understand the perspectives of healthcare providers working with Arab men in addition to how men's stigmatizing attitudes are an obstacle to formal help-seeking. Interventions should be designed to address the unique mental health needs of Arab men, recognizing that some explanatory beliefs may not align with current Western models of mental health. Moreover, efforts should be made to integrate men's informal sources of support into treatment planning.

Mental health literacy (MHL) refers to knowledge and beliefs about mental health disorders that assist their recognition, management, or prevention (Jorm et al., 1997). This involves recognizing disorders, understanding their causes, and being aware of available help, including factors that facilitate or hinder help-seeking (Jorm et al., 1997). MHL is important because it underpins efforts to increase mental health knowledge, promotes help-seeking attitudes and behaviors, and assists with prevention and treatment (Anderson and Pierce, 2012; Kelly et al., 2007). Higher levels of MHL facilitate early detection and timely intervention which in turn are associated with greater wellbeing (Jung et al., 2017). Most evidence indicates men exhibit lower levels of MHL (Cotton et al., 2006; Hadjimina and Furnham, 2017), have lower health utilization and are less likely to seek professional help than women (Wendt and Shafer, 2016). Men also exhibit different coping strategies compared to women (Elliott, 2013; Robinson et al., 2009).

Gender differences in attitudes towards mental health among Arab samples are complex and contradictory. In Arab countries (22 member states of the Arab League in the Middle East and Africa), mental health disorders are often stigmatized (Fekih-Romdhane et al., 2022). These populations may have lower levels of MHL characterized by less positive attitudes towards mental health and counselling services than Western populations (Hamid and Furnham, 2013). Arab men show lower MHL, including recognition of disorders, causes, help-seeking, and stigma, compared to Arab women (Al-Krenawi et al., 2000; Fekih-Romdhane et al., 2021). A survey of 1,236 men in Jordan revealed many believed mentally ill people to be 'unintelligent' and attributed mental illness to divine punishment (Ghuloum et al., 2010). A study in Qatar found, among a sample of 2,514 adults, men had higher levels of MHL than

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women (Bener and Ghuloum, 2011). Other studies of Arab populations have found women report greater benefits from help-seeking and disclosing personal information to a counselor than men (Hamdan, 2009; Heath et al., 2016). A recent systematic review examining mental health help-seeking in Arab populations found more positive attitudes towards help-seeking among women than men (Khatib et al., 2023). However, other studies conducted in the Arab Gulf Cooperation Council, the United Emirates, and Qatar found no differences in MHL, stigma, and help-seeking intentions between men and women (Andrade et al., 2022; Elyamani et al., 2021).

This review answers the call to adapt Jorm et al. (1997) framework and definition to the Arab cultural context (Abo-Rass et al., 2023). Furthering research on Arab men is important for several reasons. First, despite a population of over 400 million, little is known about the mental health of Arab populations, with a scarcity of studies on MHL (Abo-Rass et al., 2023; Khatib et al., 2023). Second, globally, the number of Arab migrants increased from 19 to 34 million in the past 10 years (World Bank, 2022), with many moving to high-income Western countries (HIWC). According to the United Nations (2020), 15 million Arab men moved to HIWC between 2010 and 2020. As HIWC share similarities including being individualist societies, there are implications for resettling Arab men from collectivist societies. The burden of mental disorders in Arab populations is higher than the global average given continued regional instability and conflict (Charara et al., 2017). Arab immigrants in HIWC experience greater psychological distress than the general population (Samari, 2016), psychological distress among Arab immigrants may increase over time (Bulut and Brewster, 2021), and greater negative attitudes towards mental health services have been observed among Arab migrants than counterparts in their host countries (Hamid and Furnham, 2013). Third, Arab immigrant men are particularly at risk of mental health problems, with discrimination being linked to greater psychological distress (Assari and Lankarani, 2017) and the stigma associated with mental illness in Arab families making it difficult for men to seek assistance for mental health issues (Dardas and Simmons, 2015). Fourth, despite higher prevalence rates of mental illness and migration-related stressors, mental health service utilization by migrants and refugees from the Arab world is low (Kayrouz et al., 2015; Youssef and Deane, 2006). Fifth, MHL studies primarily focus on native-born populations in HIWC countries (Sweileh, 2021). Consequently, MHL in non-Western populations is less understood than (Furnham and Hamid, 2014). Therefore, we aimed for a broader scope, by including HIWC, to avoid a single-country focus. Recognizing the specific mental health challenges of Arab men is vital and addressing their needs is essential for promoting social inclusion and reducing health disparities (Minas et al., 2013).

This systematic review marks the first comprehensive examination of MHL among Arab men living in HIWC. It employed a multi-method approach, encompassing qualitative, quantitative, and gray literature analyses. While recent reviews have explored MHL in Middle Eastern populations, they have primarily focused on women (or not specifically considered men or gender), included non-Arab populations, centered on populations within Arab states exclusively, adopted restrictive approaches to considering MHL, or did not thoroughly review and include articles and dissertations concerning Arab men living in HIWC (Abo-Rass et al., 2023; Almutairi et al., 2022; Elyamani et al., 2021; Khatib et al., 2023; Tahir et al., 2022; Zolezzi et al., 2018). Notably, prevailing reviews have largely overlooked the gray literature and not adequately covered men's help-seeking attitudes and behaviors, which can significantly differ from those of women. This systematic review explored MHL among Arab men living in HIWC, as defined by the World Bank (2023). The aims of this review were to describe Arab men's; 1) recognition of mental health disorders, 2) beliefs about the causes of mental health disorders, 3) help-seeking beliefs and behaviors and sources of help, and 4) barriers and facilitators to help-seeking. We adopted the socio-ecological framework to understand the factors influencing health-related behavioral change (McLeroy et al., 1988). This framework describes (i) intrapersonal factors: knowledge, beliefs, education, perceptions, attitudes and behaviors related to mental health, (ii) interpersonal factors: the influence of men's partners, family, friends, and social networks, (iii) institutional factors: information from the healthcare system, healthcare workers and other organizations, (iv) societal factors: social norms, including culture, religious beliefs, and expectations and (v) public policy including government laws and policies pertinent to Arab men's mental health.

1. Method

1.1. Data sources and search strategy

Following recommendations (Johnson and Hennessy, 2019), the results of this systematic review are summarized according to PRISMA (Moher et al., 2009; see Fig. 1). The methods align with AMSTAR 2 (Shea et al., 2017; see Supplementary File 1). The protocol for this systematic review was registered *a priori* with PROSPERO (#CRD42022335159). A systematic search of six electronic databases (Medline, Embase, ProQuest Dissertations & Theses Global, PsycINFO, Scopus, and Web of Science) was conducted in July 2023. This included peer reviewed articles and gray literature (dissertations). Search terms were stratified into four categories: 1) mental health knowledge, 2) psychological problems, 3) population, and 4) country (Supplementary File 2). The search strategy was developed in consultation with a specialist librarian. Additional articles were sought by manually searching the reference lists of included studies.

1.2. Inclusion and exclusion criteria

The inclusion and exclusion criteria are outlined in Table 1.

1.3. Screening

The screening process was carried out using Covidence Reference Management Software according to the Cochrane Collaboration Guidelines (Lefebvre et al., 2019). Two independent reviewers (JM, HL) screened records for title and abstract, after which they undertook the full text screening. Differences were resolved through consensus with a third review (LJ) at both stages.

1.4. Data extraction and synthesis

The first author (JM) conducted reflexive thematic analysis (Braun and Clarke, 2006) from male participants quotes in each article to generate themes for each research question. The themes were then evaluated in terms of their alignment with the socioecological framework. Both the primary (JM) and senior authors (KK, LJ, SSY) refined, reviewed, and named the themes. Specific quotes were selected to illustrate these themes. Due to the studies heterogeneity, no formal meta-analysis of quantitative data was conducted. Results from the quantitative studies were collated as relevant to each research question.

1.5. Quality assessment

Three quality assessments were carried out: 1) quantitative, 2) qualitative and 3) levels of evidence. The rigor of the research study designs was assessed in accordance with the National Health and Medical Research Council (NHMRC) Evidence Hierarchy (National Health Medical Research Council, 2009). The National Institutes of Health Quality (NIH) Assessment Tool for Observational Cohort and Cross-Sectional Studies (National Heart Lung Blood Institute, 2018) was used to evaluate the quantitative studies, and the Critical Appraisal Skills Programme (CASP) Qualitative Research Assessment Tool (Critical Appraisal Skills Programme, 2018) was used for the qualitative studies. The gray literature dissertations were assessed using the

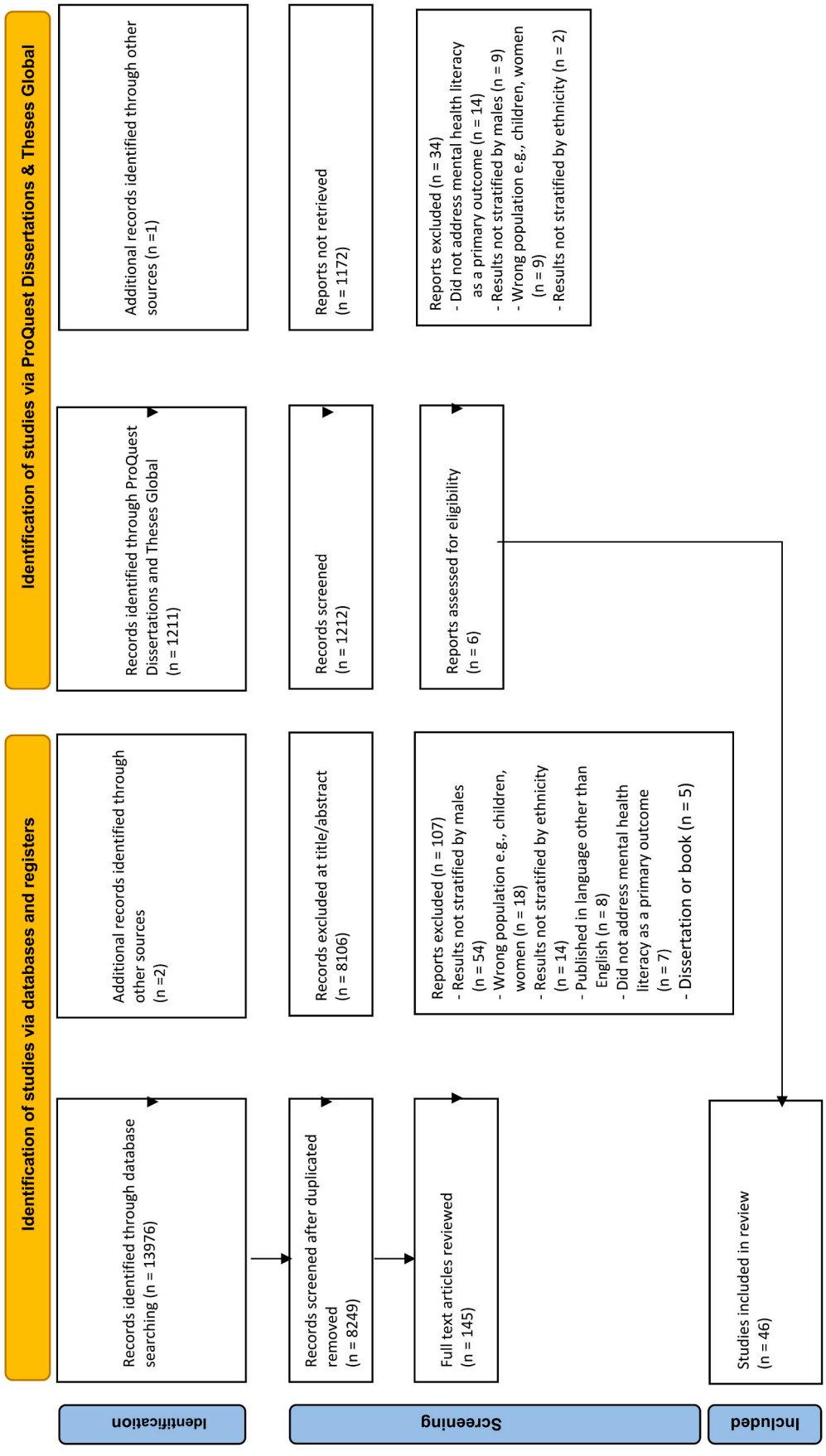

Fig. 1. Study selection PRISMA Flow Diagram.

Table 1
Inclusion and Exclusion criteria.

Inclusion criteria	(1) male/men only samples or mixed gender, where findings were reported for men (2) quantitative or qualitative data (3) addressing mental health literacy in relation to knowledge of mental health and psychological disorders including their causes and prevention, attitudes, and behaviors towards and sources of help-seeking and coping, and facilitators and barriers to accessing mental health services, (4) reporting on Arab men over 18 years of age living in high-income Western countries, (5) published in English, (6) peer- reviewed quantitative, qualitative, or mixed methods studies and dissertations and theses,
Exclusion criteria	(7) Case studies (1) women/female only samples, or those that did not provide aggregated results for genders (2) focused on those under 18 years of age, (3) living outside HIWC, (4) books, gray literature such as organizational reports or blogs

AACODS Checklist (Tyndall, 2008). Two reviewers (JM, HL) independently assessed study quality alongside data extraction, with a third reviewer (LJ) resolving any discrepancies.

2. Results

As shown in Fig. 1, the initial database search yielded 13,976 references, with 5,727 duplicates. After title and abstract screening, 9,460 were assessed, resulting in 145 full-text publications for review with 38 articles meeting the inclusion criteria. Of the gray literature, 1,211 dissertations were screened, with 5 dissertations meeting criteria after full-text review. Two additional publications and one dissertation were found through reference list searches.

2.1. Study and sample characteristics

A total of 45 publications were reviewed, which included 46 studies (one paper contained two studies; Markova and Sandal, 2016).

As shown in Tables 2 and 3, 29 studies (76%) were conducted in the last 10 years and 15 studies (33%) since 2021. Many were conducted in Australia ($n = 14$, 31%), the United States ($n = 10$, 22%) and the United Kingdom ($n = 7$, 16%). Qualitative study ($n = 31$) characteristics are available in Table 2 and quantitative study ($n = 15$) characteristics are outlined in Table 3 (See Supplementary Files 3 and 4 for unabridged data extraction).

11,435 men were included across all the studies. Of the 45 publications, many ($n = 14$, 31%) did not provide any age range but instead reported mean age (28–58.9 years). For those that included an age range ($n = 20$), a large proportion of samples were aged between 18 and 65 years (18/20, 90%). While a significant number of studies did not provide a breakdown by country of origin of participants ($n = 12$, 27%), many were focused on Somali samples ($n = 18$, 40%). Participants from Iraq represented the largest proportion of participants (83%).

2.2. Quality assessment

As shown in Tables 2 and 3, no study obtained Level I evidence in accordance with the NHMRC Evidence Hierarchy. Our review did not identify any systematic review or meta-analysis (Level I) among Arab men living in HIWC. The qualitative studies ($n = 26$) had an overall moderate-high level of research quality (Supplementary File 5). The published quantitative studies ($n = 14$) had poor to fair study quality, suggesting a potential risk of bias (see Supplementary File 6). The six dissertations rated highly according to the AACODS Checklist (Tyndall, 2008; supplementary File 7).

2.3. Synthesis of empirical findings

Findings from 46 studies were synthesized to address each of the four research aims and then aligned with four themes in the socioecological model (i.e., intrapersonal interpersonal, institutional, and societal factors) where relevant (see Table 4 for an overview). No findings related to the fifth theme of the socioecological model, public policy.

Q1. Rates of recognition of mental health disorders

2.4. Intrapersonal factors

Knowledge. Mond et al.'s (2021) study related to individual-level factors and focused on men's recognition of mental health disorders. Among Iraqi men with clinically significant posttraumatic stress disorder (PTSD) symptoms, 40% recognized PTSD or related issues. Iraqi women showed a slightly higher recognition rate of 60%, but the gender differences were not significant.

Q2. Beliefs about the causes of mental disorders

Twenty-three studies (51%) assessed men's attributions of mental health disorder causes, spanning intrapersonal, interpersonal, and societal domains of the socioecological framework.

2.5. Intrapersonal factors

Life stressors. This included fleeing war, facing discrimination and migration difficulties, e.g., economic pressures, looking for work, language difficulties (Aarethun et al., 2021; Amri and Bemak, 2012; Lindert et al., 2021; Linney et al., 2020; Pratt et al., 2016; Rae, 2014; Slewa-Younan et al., 2022; Wedel, 2012).

A man representing the experience of the wider Arabic-speaking community's encounter with social and political turmoil expressed:

> Whether they are Muslims, Assyrian, Chaldean, Mandean etc., they live in the same community, the same shell, and almost have the same mental health status. All of such happens as a result of wars consequences, forced displacement effects …
>
> 59-year-old from unidentified Arab country living in Australia (Slewa-Younan et al., 2022, p. 7).

Jinn and supernatural forces. The role of Jinn in causing mental illness appeared prominently, especially amongst Somali men (Abuzinadah, 2019; Alqasir and Ohtsuka, 2023; Boynton et al., 2010; Hussein, 2021; Johnsdotter et al., 2011; Kuittinen et al., 2017; Molsa et al., 2010; Rae, 2014; Youssef and Deane, 2006). Jinn are described as supernatural beings capable of good or evil (Dein and Illaiee, 2013): "My friend, (…) his wife had a problem. And he tells the social [social worker]. But they didn't believe him. (…) But they don't understand what is this problem. This is Djinn [spirit]." 25-year-old from Somalia living in Germany (Grupp et al., 2019, p. 11). Finally superstitious beliefs around the 'evil eye' that some individuals can cast harmful intentions through their gaze also appeared ""I think "Ayn" (evil eye) can affect people's health physically and mentally. As we know the evil eye can make you sad, anxious, or even crazy." 30-year-old from Saudi Arabia living in Australia (Alqasir and Ohtsuka, 2023, p. 8).

Religion. This theme involved the belief that Allah causes mental disorders because of insufficient faith and punishment for wrongdoing (Alqasir and Ohtsuka, 2023; Endrawes et al., 2007; Markova and Sandal, 2016; Mölsä et al., 2010; Pratt et al., 2016; Youssef and Deane, 2013): "As we all know, Allah brings this disease and brings us the cure or alleviates suffering, as we are His creation." Man from Somalia living in US, age unknown (Pratt et al., 2016, p. 19). Deviation from the teachings of the Qur'an and Bible, estrangement from Allah, and lack of faith were seen as contributing to mental health issues, as described: "Research

Table 2
Characteristics and key findings of qualitative studies ranked by quality rating.

Author, Year, Country	Study design	Study aims	Target population	Participant Characteristics	Key Findings	Quality Rating[a]
Lindert et al. (2021); Germany.	Focus groups.	To investigate the knowledge and understanding of substance use.	Syrian refugees.	$N = 19$ men, ages: 20–50.	• The accessibility and societal approval of alcohol and drugs, combined with their use to cope with trauma and escape monotony, contribute to mental illness. • Family support is most important. • Stigma and shame impede refugees' access to psychosocial services.	10/10
Omar et al. (2017); Australia.	Focus groups.	Examines men's perspectives on the underlying causes of emotional difficulties and barriers to help-seeking.	Djiboutian, Somali refugees.	$N = 36$ Muslim men from the Horn of Africa, ($n = 20$ men), ages: 18–50.	• Settlement and interpersonal relationship challenges can cause emotional difficulties. • Family and social support are crucial for Somali men relying on elders for problem-solving. Younger generation seeks mental health help, while those with addiction go to Somalia for cultural rehabilitation, emphasizing hope, faith, and God as treatments.	10/10
Paudyal et al. (2021); United Kingdom.	Individual interviews.	Explore mental well-being and coping mechanisms.	Syrian men.	$N = 12$ mixed gender ($n = 9$ men), Men aged: 18–69.	• Source of support includes seeking comfort in nature and faith, including reading the Qur'an. • Barriers to help-seeking include stigma, language difficulties and doctors not understanding their experience. • There was a recognition of the need to break taboos about mental health.	10/10
Youssef and Deane (2006); Australia.	Individual Interviews.	Explore perceptions of mental illness and preferred forms of support and treatment.	Arabic speakers in the community and community workers.	$N = 35$ mixed gender.	• Satanic power causes mental illness. • Anxiety and depression are very common, and not considered a form of mental illness. • Barriers to help-seeking include feelings of stigma and shame, lack of knowledge about health and mental health services and concerns about confidentiality.	10/10
Abuzinadah (2019); Australia.	Individual interviews.	Explored mental health literacy in the Arabic-speaking community.	Arab immigrants.	$N = 21$ mixed gender ($n = 6$ men).	• One's destiny, Jinn, and spirits responsible for mental disorders • Religious treatment is used. • Stigma is a significant barrier to help seeking.	6/6
Al-Owidha (1996). United Kingdom.	Individual interviews.	The perception of counselling amongst international students in Britain.	Saudis.	$N = 11$ men.	• Counselling considered useful to some. Others focus on informal supports, • including family and friends and using the Qur'an. • Young people more open to professional help than older individuals. • Barriers to counselling include lack of awareness and cultural fit.	6/6
Habhab (2016); United States.	Individual interviews.	Examining the effects of acculturation, perceived Family support, stigma, and gender on mental health recovery.	Mixed Arab American population.	Mixed nationalities, $N = 6$, ages: 31–63.	• Stigma is a significant barrier to getting help.	6/6
Hussein (2021); United Kingdom.	Individual interviews.	Somali refugees understanding and perspective of mental illness.	Somali refugees.	$N = 10$ mixed gender, ($n = 5$ men), ages: 31–63 (men).	• Jinn and spirits cause disorders. • Mixed attitudes towards help seeking that includes counselling and religious treatment. • Stigma, lack of awareness and distrust of professionals are barriers to help whilst more Somalis working in the health service would encourage help seeking.	6/6
Rae (2014); United Kingdom.	Focus groups and individual interviews.	Explore how Somali male refugees understand and perceive depression, coping and professional help in the UK.	Somali refugees.	$N = 12$ men, ages: late 20–59.	• Migration stressors, Jinn, and spiritual factors, interpersonal difficulties, and substance abuse cause disorders. • Religious and traditional treatments preferred.	6/6

(*continued on next page*)

Table 2 (*continued*)

Author, Year, Country	Study design	Study aims	Target population	Participant Characteristics	Key Findings	Quality Rating[a]
					• Stigma, concerns about cultural competence of professionals and resistance to medication are barriers to getting help. More Somalis working in the sector will encourage help seeking.	
Alqasir and Ohtsuka (2023); Australia.	Individual interviews.	Examine understanding of mental disorders and treatment.	Arab immigrants (Egyptian, Saudi, and Sudanese).	N = 12 mixed gender (n = 6 men), ages: 28–53 years.	• Magic, Jinn, God and the 'evil eye' cause mental disorders. • Religious treatment is the preferred source of treatment. • Stigma is a significant barrier to help seeking.	9/10
Bettmann et al. (2015); United States.	Individual interviews.	Investigate perceptions of mental illness and treatments.	Somali refugees	*N* = 20 mixed gender (*n* = 10 men), ages: 18–65 years.	• An unmet desire may cause mental problems. • Access to formal help is a family matter. • Preference for informal support (talking to family, friends and reading the Qur'an).	9/10
Blignault et al. (2019); Australia.	Individual interviews.	Explore the acceptability and clinical utility of mindfulness.	Arab community members, (Lebanese, Iraqi, Egyptians, Palestinian, Syrian).	*N* = 70, mixed gender (27.1% men), ages: 18–65 years.	• Help calm oneself through meditation.	9/10
Bridi et al. (2023); United States.	Individual interviews and focus groups.	Investigate the role of faith on mental health and cognitive health.	Syrian and Iraqi refugees.	*N* = 29 mixed gender (*n* = 12 men), (*M* = 55.1).	• Praying and reading the Qur'an are effective forms of self-help.	9/10
Ellen Selman et al. (2018); United Kingdom.	Individual interviews.	Understand the nature of stigma experienced by parents of children with autism.	Somali parents of autistic children.	*N* = 15 mixed gender (*n* = 3 men), ages: 28–56.	• Faith as a source of support and coping.	9/10
Endrawes et al. (2007); Australia.	Individual interviews.	To understand the experience of Egyptian families caring for a relative with mental illness.	Egyptian families caring for a relative.	*N* = 7 mixed gender, (*n* = 3 men). No age range provided.	• God causes mental health problems.	9/10
Grupp et al. (2019); Germany.	Focus group interviews.	Investigate help-seeking intentions and lay beliefs about cures for PTSD.	Asylum-seekers from Sub-Saharan Africa.	Mixed nationalities, *N* = 8 Somali (*M* = 25.6 years).	• Jinn cause mental illness, and religious treatments like reading the Qur'an are the most effective for PTSD. Preferences for informal sources of support. • Perceived health professionals' cultural incompetence hinders help-seeking.	9/10
Grupp et al. (2022); Germany.	Focus group interviews.	Investigate the coping intentions and lay beliefs about appropriate coping strategies.	Somali asylum seekers.	Mixed nationalities, *N* = 8 Somali (*M* = 25.6 years).	• Social support and distractions help with coping.	9/10
Johnsdotter et al. (2011); Sweden.	Focus group and individual interviews.	Explore traditional Somali concepts of mental ill health.	Somali migrants.	*N* = 23 mixed gender (*n* = 6 men), ages: 24–62 (men and women).	• Jinn and the supernatural cause mental disorders. • Religious treatment (reading the Qur'an, using religious endorsed amulets) are helpful.	9/10
Krstanoska-Blazeska et al. (2023); Australia.	Focus group and individual interviews.	To explore sources of help in Arabic communities.	Arabic speakers.	*N* = 18 mixed gender, (*n* = 12 men). No age range provided.	• GPs favored over mental health professionals. Second-generation migrants are more open to seeking mental health assistance. • Stigma amongst families of the mentally ill is common.	9/10
Lechner-Meichsner and Comtesse (2022); Germany.	Individual interviews.	To investigate illness and treatment beliefs regarding Prolonged Grief Disorder.	Syrian, Yemeni, Egyptian, Somali refugees.	*N* = 23 mixed gender, (*n* = 10 men), age (*M* = 29.70).	• Loss of bonds, adverse circumstances of death, and inability to perform rituals contribute to mental disorders. • Preference for informal forms of support (family and friends) • Self-help including finding a new way of thinking about the loss and having faith in God.	9/10
Linney et al. (2020); United Kingdom.	Focus groups.	Explore community beliefs about the causes and treatment of mental illness.	Somali community.	*N* = 23 mixed gender, (*n* = 12 men), ages: late 20s–60s.	• War, poverty, unemployment, homelessness, family breakdown, and loneliness cause mental disorders. Depression and anxiety are	9/10

(*continued on next page*)

Table 2 (*continued*)

Author, Year, Country	Study design	Study aims	Target population	Participant Characteristics	Key Findings	Quality Rating[a]
					often considered as part of everyday life. • Religious healing (reading the Qur'an, going to the mosque), medications, and taking the person out of the country can help. • Barriers to help-seeking - language difficulties, shame, lack of cultural competence amongst healthcare professionals, mistrust of authority figures. • Secondary healthcare viewed more positively than primary care.	
Markova and Sandal (2016); Norway.	Focus group interviews.	Investigate explanatory models of depression and preferred coping strategies.	Somali refugees.	$N = 10$ mixed gender, ($n = 4$ men), ages: 20–55.	• Depression caused by loneliness, lack of faith, evil spirits, drugs, family problems. • The community has a responsibility to provide support through treatment advice, financial aid, religious guidance, and other coping methods such as mosque visits, Quran reading, and physical exercise.	9/10
Pratt et al. (2016); United States.	Focus groups.	Perceptions of mental health.	Somalia community.	$N = 35$ mixed gender, ($n = 16$ men). No additional demographics provided.	• God, sleeping difficulties, anxiety, and war and trauma are responsible for mental problems. • God provides support, and some prefer religious figures as their primary source of support, while others hold a negative view of medication.	9/10
Slewa-Younan et al. (2022)); Australia.	Focus groups, interviews.	Explore how migrants understand mental illness and beliefs and experiences around stigma.	Arabic speakers.	$N = 77$ mixed nationalities, (27 Arabic-speaking participants and informants), ($n = 12$ men.).	• Trauma and absence of faith responsible for mental health problems. • Stigma is a significant barrier to help-seeking.	9/10
Aarethun et al. (2021); Norway.	Focus groups and vignettes.	Investigate how refugees explain and seek help for PTSD and depression.	Syrian refugees.	$N = 31$ mixed gender ($n = 21$ men), 19–56 years old.	• War induces trauma and depression, while migration stressors (social network degradation, cultural obstacles, unemployment, loneliness, economic challenges, language barriers) contribute to mental disorders. • Younger men may favor formal sources of help. • Trust is essential to seeking help. • Self-help attitudes and behaviors include relying on yourself and engaging in sports and exercise. • Barriers to help include concerns about confidentiality and stigma.	8/10
Abdulrahim and Ajrouch (2010); United States.	Individual interviews.	Examine self-rated health.	Arab immigrants (mostly Lebanese, Iraqi, Yemeni, and Palestinian).	$N = 46$ mixed gender ($n = 39$ men), ages: 24–67 years.	• Desire to run away and not deal with mental health problems.	8/10
Mölsä et al. (2010); Finland.	Focus groups.	Examine expressions and treatment of mental distress.	Somali elders, and healers.	$N = 27$ mixed gender, ($n = 7$ men, 20 women), ages: late 20–72).	• Mental disorders caused by Jinn, God, social problems (unemployment, social isolation, adjusting to a new culture). • Religious healing and support from trusted persons are primary sources of help. • Traditional use of herbs and the Quran is considered an effective treatment. • Health services for physical ailments are highly respected, but cultural disparities hinder psychological treatment.	8/10
Silveira and Allebeck (2001); United Kingdom.	Individual interviews.	Explore views on mental health, well-being, and sources of support	Somali men.	$N = 28$ men, ages: 60 years and over.	• Causes of mental disorders include limited family support, physical disability, loneliness, restricted community access, inability to return home, lack of control, helplessness,	7/10

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Table 2 (*continued*)

Author, Year, Country	Study design	Study aims	Target population	Participant Characteristics	Key Findings	Quality Rating[a]
					and experiences of racial or religious discrimination. • Family support and religious practices are important sources of support.	
Wedel (2012); Sweden.	Individual interviews.	Examine ideas and experiences of mental health problems.	Somali men.	$N = 25$ mixed gender.	• Adjustment difficulties post migration and loneliness cause mental problems. • Seeking religious guidance and support from the local sheikh are valuable sources of support. • Psychologists wouldn't understand the client's culture and could make it worse. • Concerns about possible negative side effects of antidepressants and fears about being detained.	5/10
Amri and Bemak (2012); United States.	Case study	Examine the impact of cultural mistrust and stigmatization related to mental health.	Algerian immigrant.	$N = 2$ mixed nationalities ($n = 1$ Algerian), 62 years old.	• Discrimination and job loss may cause mental disorders. • Muslim immigrants face challenges in accessing services (cultural mistrust and stigma).	4/10
Boynton et al. (2010); United States.	Case study.	Understand the presentation of depression and posttraumatic stress disorder, in the context of culture.	Somali refugee.	$N = 1$, 55-year man.	• Consequences of war including grief and loss and the presence of Jinn (supernatural spirits). • Client was open to treatment when the psychiatrist demonstrated an understanding of the Somali conceptualization of mental health.	2/10

Critical Appraisal Skills Programme, 2018. CASP Qualitative Checklist.
Gray literature out of 6; Authority, AACODS Checklist (Tyndall, 2008).
[a] Out of 10; the Critical Appraisal Skills Programme guided evaluation of the qualitative studies' methodological quality.

shows that people who experience stress and psychiatric disorders, it is mostly people who don't believe in anything" 50-55-year-old from Somalia living in Norway (Markova and Sandal, 2016, p. 9).

Substance abuse and addiction. Three studies explored substance abuse and addiction as a causal and outcome factor (Lindert et al., 2021; Rae, 2014; Youssef and Deane, 2013). Syrian refugee men in Germany identified substance abuse as a coping mechanism for war and trauma. The perceived societal acceptance in Germany as a contributing factor: "You can try everything. No matter whether it is legal or illegal." Man from Syria living in Germany, age unknown (Lindert et al., 2021, p. 5). Similarly, a study in Australia found that 93.5% reported drug/alcohol addiction as 'very important' or 'somewhat important' causes of mental illness (Youssef and Deane, 2013).

Grief and loss. Ideas around grief and loss were present in some studies (Aarethun et al., 2021; Boynton et al., 2010; Lechner-Meichsner and Comtesse, 2022). The intensity and duration of grief following the loss of loved ones were heightened by factors such as the circumstances of death and the ability to carry out cultural rituals (Lechner-Meichsner and Comtesse, 2022). Grief was also related to loss of social networks compared to when they left their country-of-origin (Aarethun et al., 2021).

Biological and hereditary. One study reported that 93.5% of participants reported that mental health was the result of chemical imbalance and hereditary factors (Youssef and Deane, 2013).

2.6. Interpersonal factors

Interpersonal difficulties. References to interpersonal difficulties, including conflict and family breakdown, being unmarried, feelings of loneliness and a lack of connection to others, were frequently noted (Kuittinen et al., 2017; Linney et al., 2020; Markova and Sandal, 2016; Mölsä et al., 2010; Rae, 2014; Silveira and Allebeck, 2001; Youssef and Deane, 2013). One man elucidated: "They don't have the communities, they don't have anywhere to socialize, so that is for them is a mental health trigger." Man from Somalia living in UK, age unknown; (Linney et al., 2020, p. 7). This similar sentiment was expressed by another man: "Loneliness is the reason why he has such a difficult time." Man from Somalia living in Norway, age unknown (Markova and Sandal, 2016, p. 8). Others described a loss of authority or changed power dynamic within the family (Markova and Sandal, 2016; Molsa et al., 2019; Omar et al., 2017; Wedel, 2012).

Somalis described *buufis*, affecting those who dream of unattainable goals. Symptoms include loneliness, anger, and feelings of worthlessness with one describing it as an extreme version of depression (Rae, 2014): "The Somali man has lost the power of his house, family, wife, and children. In the past, nothing ever happened in his house without his knowledge. Here nobody needs men. We are useless to our families." Man from Somalia living in Finland, age unknown (Mölsä et al., 2010, p. 287). A Somali man echoed these sentiments:

> Your daughter may reject wearing hijab. She may go and walk the whole day through city without her head covered and you can't tell her to cover her head and not to go to the city … so, you feel hurt …. you will be overwhelmed with a lot of stresses and disappointment. Young man from Somalia living in Australia, age unknown (Omar et al., 2017, p. 382).

Q3. Beliefs and behaviors around sources of help

Thirty-eight studies (84%) assessed men's beliefs and behaviors around sources of help.

2.7. Intrapersonal factors

Coping style. Men reported a variety of faith-related and self-help strategies. The most salient techniques were religious and spiritual including faith in Allah, reading the Qur'an and meditation (Abuzinadah, 2019; Al-Owidha, 1996; Alqasir and Ohtsuka, 2023; Bettmann

Table 3
Characteristics and key findings of quantitative studies ranked by quality rating.

Author, Year, Country	Study design	Study aims	Target population	Participant Characteristics	Measures	Key Findings	Quality Rating[a]	Level of Evidence
Slewa-Younan et al. (2019); Australia.	Cross-sectional.	Examine help-seeking for emotional problems.	Iraqi refugees.	$N = 803$ Iraqi mixed gender, ($n = 413$ men), age ($M = 37.8$).	Professional help-seeking and frequency of help received.	• Women were 1.08 more times likely to receive formal help than men ($OR = 1.08$, 95%, CI 0.83–1.41).	Good	IV
Straiton et al. (2014); Norway.	Cross-sectional.	To determine the rate of health care services use.	Iraqi immigrants.	Iraqi $n = 15{,}053$, 59.6% men; 40.4% women. No numbers given, ($M = 34.7$).		• Iraqi men were 1.2 times more likely than Norwegian men to have had a GP psychiatric consultation, ($OR = 1.20$, 95%, CI 1.13–1.27). • Iraqi men were less likely than Norwegian men to have received a psychological diagnosis during an emergency primary care consultation ($OR = 0.68$, 95%, CI 0.55–0.85). • No difference between the number of GP psychiatric consultations among men and women. • No gender differences regarding emergency care visits.	Good	IV
Alajlan (2016). United States.	Cross-sectional.	Explore the psychological attitudes of international students toward mental health services.	Saudis.	N = 162 mixed gender (n = 55.6% men), ages: 19–45 years.	Beliefs About Psychological Services (BAPS).	• Men were more likely to feel stigmatized by counselling than females.	High	N/A
Bar et al. (2021); Germany.	Cross-sectional.	Investigate mental health self-stigma.	Syrian refugees.	$N = 133$ mixed gender, ($n = 82$ men), ($M = 33.3$).	Mental health self-stigma was assessed using the Self-Stigma of Mental Illness Scale – Short Form (SSMIS-SF) (12).	• No gender differences on self-stigma.	Fair	IV
Chimoriya et al. (2023); Australia.	Cross-sectional.	Understand mental health knowledge and stigmatizing attitudes towards mental illness.	Arab refugees and migrants.	$N = 53$ mixed gender, ($n = 18$ men), ($M = 52.3$).	A culturally valid vignette assessed recognition of PTSD and the modified Personal Stigma in Response to Mental Illness Scale.	• No gender differences on personal stigma.	Fair	IV
Khan (2006); United States.	Cross-sectional.	Describe sub-group variation in attitudes toward help-seeking.	African American, Arab, and South Asian Muslims.	$N = 459$ mixed gender, ($n = 148$ Arab men), ages: late 18–65+.	Shortened form of Attitudes Toward Seeking Professional Psychological Help scale.	• Arab men 1.96 more likely than Arab women to have negative attitudes toward help-seeking ($OR = 1.96$, 95%, CI 1.11–6.40). • No gender differences in the use of professional counselling services.	Fair	IV
Krstanoska-Blazeska et al. (2021) Australia.	Cross-sectional.	Explore mental illness stigma and various factors	Arabic-speaking religious and community leaders.	$N = 62$ mixed gender, ($n = 16$ men), age ($M = 47.1$).	Stigmatizing attitudes toward mental illness were assessed via a personal stigma scale and a social distance scale.	• Being a man was associated with an increase in personal stigma ($B = 2.06$, $SE = 0.91$, 95%, CI 3.86–0.08).	Fair	IV
Kuittinen et al. (2017); Finland.	Cross-sectional.	Analyze older Somali refugees' causal attributions of mental health problems.	Somali refugees.	$N = 128$ mixed gender, ($n = 53$ men), ages: 50–80, ($M = 57.90$).	Participants were asked to state the three most important causes of mental health problems.	• 59% of men emphasized intraindividual and 53% identified life experiences and socioreligious as causes of mental health problems.	Fair	IV

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Table 3 (*continued*)

Author, Year, Country	Study design	Study aims	Target population	Participant Characteristics	Measures	Key Findings	Quality Rating[a]	Level of Evidence
Markova and Sandal (2016); Norway.	Cross-sectional.	Investigate explanatory models of depression and preferred coping strategies.	Somali refugees.	Quan Study $N = 95$ mixed gender, ($n = 53$ men), age ($M = 28$).	The General Help-Seeking Questionnaire (GHSQ; Wilson et al., 2007) Assessed help-seeking. The Cross-Cultural Depression Coping Inventory (CCD-CI) assessed coping with depressive symptoms.	• The vignette character should deal with their depression in the following order: reconcile with God, engage in leisurely activities, reassess their life situation, pray or get someone to pray for them, reflect on their life, spend time in nature, physical exercise, rest, avoid thinking too much, find a partner, and express their emotions. • The vignette character should get support in the following order: parents, religious leaders, other relatives, intimate partners, and friends. • The depressed vignette character should feel shame ($M = 2.0$, $SD = 1.7$, CI 1.58–2.22).	Fair	IV
Mond et al. (2021); Australia.	Cross-sectional.	Examine Iraqi refugees' recognition of trauma and the association between recognition and help-seeking.	Iraqi refugees with PTSD.	$N = 66$ mixed gender, ($n = 25$ men), ages: 18–70.	Assessment of self-recognition and help-seeking was measured using a vignette.	• No gender differences on PTSD recognition.	Fair	IV
Schubert et al. (2019); Finland.	Cross-sectional.	Examine how psychosocial factors influence the use of mental and somatic healthcare services.	Somali immigrants.	$N = 351$ Somali, ($n = 155$ men), ages: 18–64.	Help-seeking of mental health services is assessed by visits to psychiatric services, use of mental health services abroad, and self-reported need for mental health services. Help-seeking of somatic health services is assessed by visits to health care centers, general practitioners (GPs), private doctors, hospital open clinics, or services elsewhere.	• Men had lower levels of mental problems ($\beta = 0.44$, $CR = 5.72$, $p < 0.0001$), even as they used mental health services more ($\beta = -0.17$, $CR = -3.68$, $p < 0.05$).	Fair	IV
Slewa-Younan et al. (2015); Australia.	Cross-sectional.	Examine levels of distress and help-seeking behavior in resettled refugees.	Iraqi refugees.	$N = 225$ mixed gender, ($n = 98$ men), age ($M = 37.9$).	Vignette.	• No association between help-seeking behavior and gender.	Fair	IV
Gerritsen and Devillé (2009); Netherlands.	Cross-sectional.	Determine gender differences in health and healthcare utilization.	Migrants from Morocco.	$N = 9{,}301$ people including 397 Moroccans, ($n = 210$ men), ($M = 37.0$).	Dutch National Survey of General Practices.	• Moroccan women were 2.92 times more likely than men to contact ambulatory mental health ($OR = 2.92$, 95%, CI 1.16–7.36) and 1.73 times more likely to contact a general practitioner ($OR = 1.73$, 95%, CI 1.12–2.67) than Moroccan men.	Poor	IV
Tippens et al. (2020); United States.	Cross-sectional.	Investigate perceived sources of support and psychological distress.	Somali men.	$N = 49$ men, age ($M = 41.2$).	Assessed by asking who/where participants sought help.	• Men turned to family/clan members more often (28.3%) than mental health professionals (11.1%).	Poor	IV

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Table 3 (*continued*)

Author, Year, Country	Study design	Study aims	Target population	Participant Characteristics	Measures	Key Findings	Quality Rating[a]	Level of Evidence
						• Men had low utilization of both informal (30.4%) and formal (24.4%) supports when sad, stressed, or worried.		
Youssef and Deane (2013); Australia.	Cross-sectional.	Explore the beliefs regarding the causes of mental illness and the use of medication for treatment.	Arabic-speaking religious leaders.	$N = 170$ men.	Adapted from the questionnaire used in the US study of Methodist pastors carried out by Lafuze et al. (1999, 2002).	• 76.5% perceive hereditary causes, 93.5% consider chemical imbalances in the brain as important factor in mental disorders. • A majority (93.5%) consider stressful life events and a significant percentage (91.2%) perceive traumatic childhood experiences as important factors in mental disorders. • A significant percentage (84.7%) perceive refusal to accept a religious leader's advice on God's will, while a substantial portion (57.1%) consider demonic possession, and a majority (66.5%) view the will of God as an important factor in mental disorders. • A majority (93.5%) consider drug/alcohol addiction as an important factor in mental disorders, according to the statistics. • Muslim clerics rated religious causes, including spiritual poverty, refusal to accept religious leaders' advice regarding God's will, failure to adhere to the tenets of God, and the Will of God, as more significant for mental illness compared to Christian clergy. • Medication is helpful ($M = 2.15$, $SD = 0.68$, $t(166) = 1.11$, $p < 0.001$) had significantly greater agreement than medication is harmful ($M = 2.32$, $SD = 0.78$, $t(163) = 2.26$, $p = 0.02$). • A majority (63.6%) believe psychiatric medication is harmful in the long term, and a significant percentage (66.2%) consider it to be addictive. • A majority (65.3%) strongly agree or agree that taking medication helps people day-to-day, and a significant percentage (72.4%)	Poor	IV

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Table 3 (*continued*)

Author, Year, Country	Study design	Study aims	Target population	Participant Characteristics	Measures	Key Findings	Quality Rating[a]	Level of Evidence
						strongly agree or agree that medication helps people control their symptoms. • No significant differences between Muslim clerics and Christian clergy.		

Gray literature out of 6; AACODS Checklist (Tyndall, 2008).
[a] Out of 14; National Heart Lung and Blood Institute (2018). NIH Study Quality Assessment Tools.

et al., 2015; Blignault et al., 2019; Bridi et al., 2023; Ellen Selman et al., 2018; Rae, 2014). These strategies helped calm their minds and manage negative emotions:

> When I read the Quran, I am fully engaged. This clears up my mind. I put off all thoughts about the past. Praying is very important and that relationship with God is what you are left with at the end of the day.
>
> Man from unidentified Arab country in US, age unknown (Bridi et al., 2023, p. 7).

Herbal remedies were considered helpful (Grupp et al., 2019; Mölsä et al., 2010; Rae, 2014), whereas traditional practices (e.g., sacrifice of an animal) were rejected (Grupp et al., 2019). Cognitive techniques to disengage from unpleasant and intrusive memories included perspective-taking (Lechner-Meichsner and Comtesse, 2022), keeping busy (Grupp et al., 2022), and exercising (Aarethun et al., 2021; Markova and Sandal, 2016): "When I think of something before going to sleep, I get nightmares. So, for example, I do physical activity to get very tired. When the night comes, I am so tired and sleep very well." Man from Syria living in Norway, age unknown (Aarethun et al., 2021, p. 5).

2.8. Interpersonal and societal factors

Negative attitudes and behaviors toward formal help-seeking. Arab men in the US showed higher negative attitudes toward help-seeking, while men and women had similar utilization of counselling services (Khan, 2006). Conversely, Moroccan women in the Netherlands had higher contact with ambulatory mental health (thrice as likely) and general practitioners (twice as likely) compared to Moroccan men (Gerritsen and Devillé, 2009). Iraqi women in Australia were 1.08 times more likely to receive formal help compared to Iraqi men (Slewa-Younan et al., 2019). In contrast, in Norway, Iraqi men had 1.2 times higher GP psychiatric consultations than Norwegian men, despite being less likely to receive a psychological diagnosis (Straiton et al., 2014). There was no difference between Iraqi men and women regarding a psychological diagnosis (Straiton et al., 2014).

Finally, countering evidence of gender differences, in a study of Iraqi refugees in Australia, no significant gender differences were found in help-seeking, with around 30% of both women and men seeking help (Mond et al., 2021). However, in Finland, Somali men utilized mental health services more than Somali women, despite women experiencing higher mental health problems (Schubert et al., 2019). Nonetheless, men's support in seeking formal help was not consistent: "Western psychology is not part of traditional Somali ways to allay mental ill health. Instead of psychology we turn to religion." Man from Somalia living in Sweden, age unknown (Johnsdotter et al., 2011, p. 745).

Preference for informal help networks. Men favored informal help from personal and social networks like family, friends, and religious practitioners, rather than formal help such as counselling or healthcare services (Aarethun et al., 2021; Abuzinadah, 2019; Alqasir and Ohtsuka, 2023; Bettmann et al., 2015; Grupp et al., 2019, 2022; Johnsdotter et al., 2011; Lechner-Meichsner and Comtesse, 2022; Linney et al., 2020; Markova and Sandal, 2016; Molsa et al., 2010; Omar et al., 2017; Rae, 2014; Silveira and Allebeck, 2001; Tippens et al., 2020; Youssef and Deane, 2006). For example, Somali men in the US reported seeking support from a family/clan member almost three times more often than from a mental health professional (Tippens et al., 2020).

Men sought solace by discussing their problems with the Sheikh at the mosque, finding understanding and relief from distressing thoughts:

> Arabic, Christian or Muslim, he approaches the religious leader because he is trying to find answers or questions to explain the puzzling

Table 4
Relationship between study findings and the socioecological model.

	Intrapersonal factors - characteristics and behaviors of individuals, such as their knowledge, attitudes, beliefs, and behaviors.	Interpersonal factors - the influence of men's partners, family, friends, and social networks.	Societal factors - social norms and culture.	Institutional factors: information from the healthcare system, healthcare workers and other organizations.
Q1 - Rates of recognition of mental health disorders	•Knowledge			
Q2 - Beliefs about the causes of mental disorders.	•Life stressors •Jinn and supernatural forces •Religion •Substance abuse and addiction •Grief and loss •Biological and hereditary	•Interpersonal difficulties		
Q3 - Beliefs and behaviors around sources of help.	•Coping style	•Negative attitudes and behaviors toward formal help-seeking. •Preference for informal help networks •Changing attitudes towards help-seeking.		
Q4 - Barriers and facilitators to seeking help for mental health disorders.	•Mistrust of medication		•Stigma and shame	•Cultural competence and distrust •Language and access difficulties •Improving awareness of services •Role of the media

condition that he is experiencing. The religious leader has a great affect in helping the person return to his previous consciousness and the ability to cope better. 59-year-old from unidentified Arab country living in Australia (Youssef and Deane, 2006, p. 58).

> Others described reading the Qur'an with the Sheikh, including instances where family members would bring religious leaders to the hospital: "One time I go to Sheikh, and he gives me this small water and he reads Quran and it's called Taleeth, and I get a help inside." 25-year-old from Somalia living in Germany (Grupp et al., 2019, p. 9).

Many Somali men attributed mental illness to supernatural factors like Jinn and relied on faith leaders:

> If the person grew up with a belief that jinn can possess you, and his community has a method to exorcise jinn, and this person meets a Swedish psychiatrist who doesn't apply this exorcist method… it will be difficult. Something else will be required. It is better if the person can be helped by exorcising the jinn. 50-year-old from Somalia living in Sweden (Johnsdotter et al., 2011, p. 749).

The role of family and friends was also central (Aarethun et al., 2021; Al-Owidha, 1996; Bettmann et al., 2015; Grupp et al., 2022; Lechner-Meichsner and Comtesse, 2022; Lindert et al., 2021; Omar et al., 2017; Silveira and Allebeck, 2001; Tippens et al., 2020). Men referred to the role of family in managing the problem, specifically for deciding whether to seek formal help (Bettmann et al., 2015). Family members were sometimes sent home to Somalia in the case of addiction (Omar et al., 2017) and prevented from leaving the home (Bettmann et al., 2015):

> I think in Syria we live in families and that makes more control, and we had less problems than we were in Syria because there are many, there is always someone to stand behind me and to give me support. Man from Syria living in Germany, age unknown (Lindert et al., 2021, p. 5).

Newly arrived young Somali men in Australia also emphasized how their fathers and grandfathers helped solve their problems and stresses (Omar et al., 2017). Similarly, Somali men in Norway reported that their parents were the most important source of support, followed by religious leader, other relatives, and intimate partners (Markova and Sandal, 2016).

> Friends from the same culture were also considered an important source of support – they understand the problems and are trusted. As explained by Syrian men in Norway and Germany: "He just needs a friend to talk to, and then the problems will be solved." (Aarethun et al., 2021, p. 5) and "Just talk, social connection especially to people who have been friends before and family, that can help. Everything that has to do with social connection." Man from Syria living in Germany, age unknown (Lechner-Meichsner and Comtesse, 2022, p. 9).

Changing attitudes towards help-seeking. Three studies suggested that younger men were more inclined to seek professional help compared to older men (Aarethun et al., 2021; Al-Owidha, 1996; Omar et al., 2017). Younger men were found to be more willing to discuss their problems. More broadly, some men recognized the importance of seeking professional help rather than solely relying on friends (Aarethun et al., 2021; Al-Owidha, 1996; Hussein, 2021). Acculturation also contributed to more accepting attitudes towards professional help: "The second generation probably has a better understanding of how to reach professional help than the first generation and its more accepted to go and reach professional help on mental help than the first generation." 55-year-old from unknown Arab country living in Australia (Krstanoska-Blazeska et al., 2023, p. 10).

Q4 - Barriers and facilitators to seeking help for mental health disorders

Twenty-one (47%) studies assessed barriers and facilitators to help-seeking, primarily emphasizing barriers.

2.9. Intrapersonal factors

Mistrust of medication. Attitudes toward medication served as both a barrier and facilitator to help-seeking. Arabic-speaking religious leaders showed concerns about long-term harm (63.6% agreed/strongly agreed), while recognizing medication's benefits in symptom control, relationships, stress management, and self-improvement (Youssef and Deane, 2013). However, fears persisted regarding negative side effects of antidepressants (Rae, 2014; Wedel, 2012): "Many people look at medication [antidepressants] as being addictive drugs, and this is a very big misinformation passed from mouth to mouth." 59-year-old from unidentified Arab country living in Australia (Youssef and Deane, 2006, p. 60).

2.10. Societal factors

Stigma and shame. Stigma was a commonly identified barrier to help-seeking (Aarethun et al., 2021; Abuzinadah, 2019; Alajlan, 2016; Alqasir and Ohtsuka, 2023; Amri and Bemak, 2012; Chimoriya et al., 2023; Habhab, 2016; Krstanoska-Blazeska et al., 2021, 2023; Lindert et al., 2021; Linney et al., 2020; Markova and Sandal, 2016; Mölsä et al., 2010; Paudyal et al., 2021; Rae, 2014; Slewa-Younan et al., 2022; Wedel, 2012; Youssef & Deane, 2006, 2013). There are conflicting results as to whether personal stigma was higher among men or women (Alajlan, 2016; Chimoriya et al., 2023; Krstanoska-Blazeska et al., 2021). Persons with mental illness were sometimes characterized as "crazy" or "violent" (Abuzinadah, 2019; Bettmann et al., 2015; Habhab, 2016; Lindert et al., 2021; Paudyal et al., 2021), with concerns about being perceived as inferior or incapacitated.

> When we talk about the community, they may not think the mentally ill person is the same as themselves and would treat them like a second-rate person … because they are not considered to be normal persons. 39-year-old from unidentified Arab country living in Australia (Youssef and Deane, 2006, p. 53).

Mental illness was seen to undermine the 'honor' and 'dignity' of the family (Youssef and Deane, 2006): "It's embarrassing for the families to admit we need help." Man from Somalia living in the UK, age unknown (Linney et al., 2020, p. 8) and "The family hide the mentally ill person away and keep it as a secret." 56-year-old from unknown Arab country living in Australia (Krstanoska-Blazeska et al., 2023, p. 6). There was shame among men having a mental illness or seeking treatment (Lindert et al., 2021; Linney et al., 2020; Markova and Sandal, 2016; Youssef and Deane, 2006): "You're ashamed to say, yeah, I need psychosocial support or treatment." Man from Syria living in Germany, age unknown (Lindert et al., 2021, p. 7).

Personal problems or the need to get treatment are not discussed:

> Mental health illness is a taboo topic or a secretive issue. No one should know about it or talk to anyone about it because we still consider mental health or psychological issues are madness.
>
> 68-year-old from unidentified Arab country living in Australia (Slewa-Younan et al., 2022, p. 8).

In contrast, three studies found some men are prepared to seek help (Aarethun et al., 2021; Al-Owidha, 1996; Paudyal et al., 2021). There was the recognition of the need to break taboos about mental health and to normalize psychiatry: "If I felt like this (having a psychological problem) in Syria; no, I would not go. But here (Norway); yes, of course." Man from Syria living in Norway, age unknown (Aarethun et al., 2021, p. 6).

2.11. Institutional factors

Institutional factors played a dual role acting as both barriers and enablers to help-seeking. Barriers included distrust of health systems and health professionals and difficulties related to accessing services. Enablers included having more from the community working in healthcare.

Cultural competence and distrust. Trust was central to whether Arab men sought help, especially formal help (Al-Owidha, 1996; Amri and Bemak, 2012; Grupp et al., 2019; Johnsdotter et al., 2011; Linney et al., 2020; Molsa et al., 2010; Paudyal et al., 2021; Rae, 2014; Wedel, 2012). Fears about the cultural competence of healthcare professionals and not being understood were common: "It would make sense if you could talk to some Somali person who could understand you rather than going to your GP." Somali man living in UK, age unknown (Linney et al., 2020, p. 8) and "No one would understand what we went through, and the situation like you would … so it's hard for me to go and explain my mental status to a doctor." 40-49-year-old from Syria living in UK, (Paudyal et al., 2021, p. 5). Conversely, there were instances where men expressed confidence in mental health services (Johnsdotter et al., 2011; Molsa et al., 2019), with more confidence expressed in secondary compared to primary health care setting (Linney et al., 2020).

Men had misconceptions about the nature and accessibility of mental health services, lacking understanding of available services and concerns about confidentiality: "They don't understand… The role of different mental-health professionals and what they can offer." 40-year-old from unidentified Arab country living in Australia (Youssef and Deane, 2006, p. 56) and "We don't know specifically what mental-health services are providing in the area." 39-year-old from unidentified Arab country living in Australia (Youssef and Deane, 2006, p. 55).

Language and access difficulties. Five studies addressed lack of English fluency as a practical barrier to help-seeking. (Linney et al., 2020; Mölsä et al., 2010). One man explained: "I think that's the biggest thing, the language, because medical terminologies you know are very difficult, especially psychological ones." 40-49-year-old from Syria living in UK (Paudyal et al., 2021, p. 5). The presence of an interpreter was not always welcome with concerns about confidentiality: "Some people are afraid that the interpreter knows about their story." Man from Syria living in Norway, age unknown (Aarethun et al., 2021, p. 6).

Facilitators to help seeking. Six studies explored facilitators; improving awareness of services (Youssef and Deane, 2006), acknowledging the benefits of medication (Youssef and Deane, 2013), access to secondary care (Linney et al., 2020) and the role of media in raising awareness (Al-Owidha, 1996). Other argued that having more Somalis working in healthcare would encourage help-seeking from the community (Hussein, 2021; Rae, 2014).

3. Discussion

This is the first systematic review of Arab men living in HIWC. This holds significance given the considerable presence of Arab men in HIWC, along with research indicating lower engagement with mental health services within this demographic. Our review incorporates both peer-reviewed and gray literature. We conducted a quality assessment, finding no significant heterogeneity in the results.

3.1. Recognition of mental health disorders

Within the intrapersonal factor of the socioecological framework, only one study addressed the recognition of mental disorders among Arab men and reported lower recognition rates for men compared to women (Mond et al., 2021). This study had a moderate risk of bias, suggesting some methodological limitations, but overall, they do not significantly affect the overall validity of the findings. This finding is consistent with most global literature on men's poorer recognition of disorders (Chong et al., 2016; Hadjimina and Furnham, 2017). However, some studies do not support this gender difference within Arab populations (Elyamani and Hammoud, 2020; Furnham et al., 2014).

3.2. Causes of mental health disorders

We found that Arab men living in HIWC reported a link between mental health disorders and life (e.g., war) and migration (e.g., trying to find work) stressors and this is well supported in the global literature (Bustamante et al., 2018; Li et al., 2016). This aligns with past research that Arab men may be more affected by financial and social hardships than women. (Alexander et al., 2021) given the expectation that men are the family breadwinner (Moghadam, 2015).

Men attributed mental illness to interpersonal difficulties, especially loneliness (Linney et al., 2020; Mölsä et al., 2010). This finding is aligned with interpersonal factors in the socioecological framework and is consistent with research documenting loneliness predicts a range of psychological disorders, including pain, depression, anxiety, and suicidality (Madsen and Harris, 2021; Powell et al., 2022). First-generation migrants often experience heightened social and emotional loneliness, linked to lower satisfaction with their relationships (ten Kate et al., 2020). Additionally, in a global study across 237 countries, men reported loneliness more frequently than women (Barreto et al., 2021).

Men also attributed religious and supernatural causes to the development of mental health disorders, aligned to intrapersonal factors in the socioecological framework. This aligns with some evidence that men from Arab states may be less likely to report belief in the 'biomedical health system' more than women (Al-Krenawi et al., 2009), even as the existence of Jinn, supernatural beings with the free will to act for good or evil, is a common belief held among Muslims (Lim et al., 2018). It was overwhelmingly men from Somalia who cited Jinn as causing mental health disorders (Boynton et al., 2010; Johnsdotter et al., 2011; Kuittinen et al., 2017; Molsa et al., 2010). Attributing mental disorders to Jinn is well supported in the broader literature on the Arab (Al Laham et al., 2020; Al-Noor et al., 2018) and Islamic world (Fawad et al., 2019; Mullick et al., 2013). While religious explanations, such as lack of faith or Allah's will, were cited by Arab men, men from Somalia were more likely to do so. In other research, Arab men often cite religious factors in the development, maintenance, and treatment of mental health disorders (Kuittinen et al., 2017; Slewa-Younan et al., 2022; Youssef & Deane, 2006, 2013). Out of 24 studies contributing to this theme, 18 were low risk, with one medium risk, and four high risk. The medium and high-risk studies do not appear to have impacted the overall validity of the findings.

3.3. Help-seeking attitudes, behaviors, and sources

Results suggest that Arab, like Western men, exhibit reluctance to seek help and prefer informal sources (Parent et al., 2018). Which align with interpersonal and societal factors of the socioecological model. Men may perceive formal help as devaluing their masculinity and capacity to support their families (Hall, 2021) and prefer guidance from religious leaders, friends, and family over professionals (Merhej, 2019; Zolezzi et al., 2018). Younger men show more openness to seeking formal help (Aarethun et al., 2021; Al-Owidha, 1996; Omar et al., 2017). With 60% under 30-years-old (OECD, 2022), changing patterns of help-seeking, including a preference for mental health professionals, may be emerging in the Arab world (Alsubaie et al., 2020; Fekih--Romdhane et al., 2022). Given the high rate of migration in the Arab world, these tentative help-seeking preferences may manifest in HIWCs. Limited focus was given to individual coping strategies, with some finding solace in exercise or religion, often through shared support. Out of the 38 studies contributing to this theme, 28 were low risk, with five medium and four high risk. The medium and high-risk studies do not appear to have impacted the overall validity of the findings.

3.4. Help-seeking barriers and facilitators

Our findings highlight stigma as the main barrier to help-seeking. Sitting within the societal factor of the socioecological model, evidence shows strong stigmatizing attitudes within Arab populations (Zolezzi et al., 2018), leading individuals to conceal symptoms to protect their family's reputation (Dardas and Simmons, 2015). Out of 21 studies contributing to this theme, 14 were low risk with 5 medium and 3 high risk. The medium and high-risk studies do not appear to have impacted the overall validity.

Moreover, these findings are consistent across diverse backgrounds of men (Covello, 2020; Seidler et al., 2016; Vogel et al., 2011). Whilst masculinity is context-dependent, evolving over time, influenced by contextual factors, and varies across cultures, hegemonic masculine ideals in many countries discourage vulnerability, weakness, or emotional expression and discourage help-seeking (Connell, 2020; Vickery, 2021). Courtenay (2000) argues that health behaviors are a way in which we uphold gender norms. In Western societies, men's conformity to masculine ideals often leads to lower rates of seeking help for mental health issues compared to women. Immigrant men face additional stress in adapting to new cultural norms, affecting health-seeking behaviors (Bell and Pustułka, 2017; Othman and Linders, 2018). Institutional factors including accessibility, cultural sensitivity, and engagement in health services for immigrants are reported to be inadequate (Gil-Salmerón et al., 2021; Norredam et al., 2009). Exacerbating the impact of entrenched masculine norms. This leads to heightened stress, feelings of inhospitality, increased distress, and intensified shame. However, traditional notions of Arab masculinity, marked by patriarchy and polygyny, are evolving, challenging these norms (Inhorn, 2012).

Considering intersectionality is crucial. Research reveals that stress is influenced by the intersection of race, gender, and economic/social stressors (Perry et al., 2013). Acculturative stress heightens depression risk in Arab Americans, and previous studies suggest that men from Arab states may be more vulnerable to acculturation stressors than women (Alexander et al., 2021). Our review suggests Arab men's lower MHL, intersecting with shame from perceived gender role failures in a new country, may explain this gender difference.

3.5. Implications and future directions

In line with the socioecological framework, the study's implications span interpersonal, intrapersonal, societal, and institutional domains. Limited research has addressed the involvement of healthcare providers, systems, and community organizations in influencing help-seeking behaviors. This is particularly evident among migrant men, who tend to engage with services at lower rates (Byrow et al., 2019). This research gap hampers our understanding of Arab men's mental health experiences and hinders the creation of a supportive environment for seeking professional help when needed. Our review underscored the importance of increasing the representation of health workers from minority communities (Hussein, 2021; Rae, 2014), Their presence could enhance culturally sensitive care, with matches in ethnicity, gender, and language between clients and counselors often leading to improved outcomes for ethnic minorities (Karlsson, 2005). There is an urgent need for health services to improve cultural safety and reduce racism (Hamed et al., 2022). Our study found that stigma was a barrier to help seeking. Therefore, developing a thorough understanding of the stigmatizing attitudes prevalent among Arab men, encompassing dimensions such as self and public stigma, is needed. Further exploration of these dimensions is vital to develop culturally appropriate and effective interventions that respond to the experiences of Arab men.

Finally, studies addressing men's recognition of mental disorders are needed. Recognition of disorders is important as it is positively associated with formal help-seeking (Angermeyer et al., 2009; Rüsch et al., 2009). More broadly, incorporating diverse demographic factors, such as age, country of birth, and level of acculturation, in future studies would allow researchers to explore both differences and commonalities within men. Additionally, employing culturally valid psychological measurements enhances the robustness of studies.

For clinical practice, the importance of cultural tailoring in clinical practice has been established in clinical guidelines (APA, 2003; APS, 2016). Healthcare professionals need to consider integrating cultural values of Arab men into therapy, while recognizing variances amongst Arab men. Findings from the current study indicate that men from different Arab countries may attribute mental illness with life stressors, migration struggles, and relationship issues, including loneliness, whereas Somali men may more frequently attribute mental illness to supernatural causes such as Jinn than other Arabs. This highlights the necessity for healthcare professionals to consider Arab men's explanatory beliefs and perspectives that may not align with current Western models of mental health.

Empirical evidence demonstrates a significant improvement in treatment outcomes when interventions are culturally tailored (Huey Jr and Tilley, 2018). Considering Arab culture, religion, and gender differences in treatment strategies may further enhance its effectiveness (Zangeneh and Al-Krenawi, 2019). In Arab societies, family members share a collective responsibility and engage in decision-making processes together (Hofstede, 2011; Padela et al., 2011). The family often serves as the primary source of informal support and sometimes replaces professional help-seeking (Al-Krenawi et al., 2009). Additionally, religious authorities play a crucial role in providing support for Arab men (Krstanoska-Blazeska et al., 2023). Men's coping strategies, such as finding solace in the Qur'an for Muslims, have been noted. Therefore, it is recommended that healthcare professionals integrate these supports into treatment plans enabling a more comprehensive and culturally sensitive approach to mental health care.

3.6. Limitations

Several limitations are worth noting. We were unable to access the original data transcripts; instead, we extracted men's statements as reported in the published studies. We did not contact authors to request additional information or clarification. These could result in missed data, incomplete synthesis, limited generalizability, and unintended biases. Many studies lacked the use of standardized scales, leading to a lack of consistency and precision in measuring different aspects of MHL. For example, across all studies, stigma and attitudes towards help-seeking and sources of help were measured overwhelmingly through open text responses. Also, only one study applied a culturally adapted measurement scale (Markova and Sandal, 2016). The review was restricted to English-language, peer-reviewed articles, although this likely had little impact on the overall findings (Dobrescu et al., 2021).

3.7. Conclusion

The application of the socioecological framework to the synthesis of findings yielded useful insights into implications for understanding and practice. Research related to intrapersonal, intrapersonal followed by societal factors, provided the most robust findings. Intrapersonal factors included attributing mental health illness to life and migration stressors, and religious reasons. Individual coping styles incorporated faith and self-help strategies. Interpersonal and societal factors included men favoring informal help-seeking sources as stigma was a barrier to formal help-seeking. Institutional factors around the perceived cultural competence of healthcare professionals and access difficulties were obstacles to seeking formal help. The rapid rise in numbers of men migrating from Arab countries highlights the need for greater engagement with these communities to ensure culturally tailored and competent care.

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Julian Madsen: Conceptualization, Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing. **Laura Jobson:** Conceptualization, Supervision, Writing – review & editing, Methodology. **Shameran Slewa-Younan:** Conceptualization, Methodology, Supervision, Writing – review & editing. **Haoxiang Li:** Data curation. **Kylie King:** Conceptualization, Supervision, Writing – review & editing, Methodology.

Declarations of competing interest

None.

Data availability

Data will be made available on request.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.socscimed.2024.116718.

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