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Original Research Article

Men's Formal Help-Seeking for Eating and/or Body Image Psychopathology: A Systematic Review of Barriers and Facilitators

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Abstract

This systematic review synthesized findings from 15 articles that report barriers and/or facilitators to/of adult men's formal health-related help-seeking for eating and/or body image psychopathology (EBIP). A convergent integrated approach was used to summarize studies into eight synthesized findings (SF; six barriers, two facilitators). Barrier SFs are located at individual (e.g., viewing EBIP as a "women's illness"), cultural (e.g., lacking knowledge of men's EBIP), and organizational (e.g., lack of male-inclusive healthcare systems) levels. Facilitator SFs were found mostly at individual (e.g., recognition of the issue following critical life events) and cultural/social (e.g., family/peer interventions) levels. This review highlights concerns within EBIP and men's help-seeking literature, and suggests issues with the available support for men experiencing EBIP.

Keywords

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Introduction

Men's eating and/or body image psychopathology (EBIP) is a growing concern in Western societies. Prevalence rates of eating disorders (ED; Sweeting et al., 2015), body dysmorphic disorder (BDD; Veale et al., 2016), muscle dysmorphia (Applewhite et al., 2022; Mitchison et al., 2022), and sub-clinical EBIP behaviors (Ganson et al., 2022a, 2022b; Hafstad et al., 2023; Pila et al., 2017), for example, suggest significant populations of men are experiencing these preoccupations. Despite the recent rise in research on men's EBIP (see, Brown & Keel, 2023), in comparison to research focused on women's experiences, men remain under-represented within much of the ED (Brown & Keel., 2023), BDD, and body image literature (Prnjak et al., 2022). As such, the majority of "evidence-based" resources (Downs & Mycock., 2022), treatment options (Kinnaird et al., 2018, 2019), and psychometric tools (Byrne et al., 2024; Halbeisen et al., 2024) are designed from research focused on women. This female-centric focus may shape men's experiences of seeking and accessing EBIP formal health care. Research, for example, estimates that while men account for 25% of community ED cases, men make up just 10% of clinical ED samples (NHS Digital, 2020; Sweeting et al., 2015). This discrepancy may indicate that men's EBIP experiences could be disproportionately minimized and/or unidentified within clinical care pathways for EBIP. Indeed, men accessing care for EBIP often report that their eating-related symptoms are missed or misunderstood by staff in healthcare organizations (Richardson & Paslakis, 2021). Given the growing significance of EBIP for men in Western societies, the current review aims to collate and synthesize the EBIP literature that has explored men's formal help-seeking.

Men may find it difficult to identify EBIP symptoms as the behaviors may typically be associated with health (e.g., exercising and nutritional monitoring), however, these behaviors exist along a continuum which may become excessive and/or unhealthy (e.g., exercise and eating preoccupation), potentially leading to adverse consequences (e.g., social isolation and functional impairment; Edwards et al., 2014; Lavender et al., 2017). Many experiences of disordered eating and body dysmorphia concerns also share similar symptomatology, antecedents, and foundational relationships with body image (see Prnjak et al., 2022). In the current review, we use the term EBIP to encompass both diagnosed and non-diagnosed experiences of concerns related to eating and body image. EBIP does not replace a specific preoccupation, concern, or disorder (e.g., ED, BDD) but encompasses those with a diagnosis, those with eating and/or body image concerns that may not fit with current diagnostic criteria (e.g., muscularity-oriented disordered eating), and those experiencing such concerns who do not (yet) have a clinical diagnosis. All of these preoccupations/concerns may lead an individual to engage in help-seeking. Additionally, few studies have explored men's EBIP-related help-seeking. Synthesizing these related concerns together may reveal overarching barriers and/or facilitators, and identify gaps in men's help-seeking research for particular forms of psychopathology.

Many cultural, individual, and organizational factors may contribute to the discrepancy between men experiencing EBIP and those seeking/accessing support. These factors (or levels) do not exist independently, as each can influence, reinforce, or recreate the other. Some scholars argue that help-seeking research views men through a

myopic lens that focuses on individual level decisions, giving little thought to cultural and organizational responsibility in the help-seeking process (Hoy, 2012; Lee & Owens, 2002). Indeed, it is common for men's help-seeking research to focus on individual reluctance to seek help for health-related concerns. However, this is often considered in relation to cultural pressures of masculinity and negative experiences or perceptions of healthcare organizations (Gough & Novikova, 2020; Seidler et al., 2016; Yousaf et al., 2015). Reviews of men's mental health help-seeking often feature limited studies on EBIP-related help-seeking, with many articles instead concentrating on "deaths of despair" (i.e., drugs and alcohol abuse, and suicide; Joint Economic Committee, 2019, pp. 2–3; Gough & Novikova, 2020). The present review aims to uncover the barriers and facilitators to/of men's EBIP-related help-seeking, reported within relevant literature, that apply across cultural, individual, and/or organizational levels.

Previous reviews of men's health-related help-seeking for EBIP have highlighted similar individual level reluctance-based barriers (as seen in general men's help-seeking literature; Bomben et al., 2022; Thapliyal & Hay, 2014) but have also revealed a number of articles reporting cultural and organizational factors preventing men from seeking/ accessing support (e.g., EDs viewed as a "woman's illness"). These reviews, however, were limited to only eating psychopathology which may limit insight of help-seeking across men's EBIP experiences. A review which uses the term EBIP may extend this knowledge by exploring barriers which span wider concerns, whilst highlighting gaps in men's EBIP help-seeking literature. Additionally, neither review reported facilitators to men's help-seeking as both noted a lack of relevant available findings at the time of publication (Bomben et al., 2022; Thapliyal & Hay, 2014). Barriers and facilitators may not exist independently, and the recent growth in EBIP-related articles on men may uncover recently published examples of facilitators (Brown & Keel, 2023). Help-seeking facilitators have been identified elsewhere (e.g., the general men's mental health literature; Gough & Novikova, 2020), and a review that explores both barriers and facilitators to men's EBIP help-seeking may contribute to knowledge and support the development of interventions to improve men's EBIP care access.

To explore both barriers and facilitators, the reviewers searched for papers within the span of EBIP and extracted data on both barriers and facilitators to/of adult men's formal health-related help-seeking for EBIP. Consequently, this review provides a synthesis of articles that allows for recognition of men whose symptoms are often missed by diagnostic descriptions (e.g., muscularity-oriented concerns; Bohrer & Donahue, 2021; Murray et al., 2016), and identifies areas of EBIP where additional research is required. Collating and synthesizing the relevant EBIP literature will also assist in highlighting shared help-seeking influences across EBIP experiences that may support development of interventions to improve men's access to EBIP healthcare.

The term "formal health-related help-seeking" is defined as help-seeking from professionals who require specified qualifications to deliver health-based care (e.g., psychologists, psychiatrists, nurses). This term is adapted from Rickwood and Thomas's (2012) definition of formal help-seeking to specify healthcare professionals only. Formal

health-related help-seeking includes psychological help-seeking, in the context of EBIP (e.g., Shepherd & Rickard, 2012) and specific help-seeking from relevant healthcare services (e.g., eating and body image-related services; Thapliyal et al., 2020) but excludes other forms of care seeking such as social support (e.g., Akey et al., 2013).

Methods

This review follows the PRIMSA statement guidance (Moher et al., 2009) to improve reporting across systematic review publications. The research question and search process were designed using a SPIDER statement (Cooke et al., 2012; see Table 1). To help avoid duplication and reporting bias, this systematic review was pre-registered with PROSPERO (ID: CRD42024491371).

Search Strategy

The search terms used in this review can be found in Table 2. The reviewers searched for literature by using the Boolean operator "OR" to create three blocks of search terms for help-seeking, EBIP, and men/male participants, which were combined using "AND". Appropriate truncation and word combinations were adapted for each database search with input from a librarian and were selected to include clinical and sub-clinical variants of EBIP. The search took place across seven databases (PsychInfo, Academic Search Complete, CINAHL Complete, MEDLINE, SPORTDiscus, APA PsycArticles, Web of Science) in July 2023, and was filtered to ensure only peer-reviewed journal articles written in English were included. This search was re-run in January 2025, where two additional articles were located and included (i.e., Billman Miller et al., 2024; Lehe et al., 2024). No publication cutoff date was specified during the search. Manual searching of included articles and correspondence with three external researchers within the ED, BDD, and body image academic fields identified 14 additional articles. (Table 3)

Table 1. SPIDER Statement Used to Inform Research Question and Search Process.

SPIDER statement	
Sample:	Men aged 16 or over, or healthcare staff working with men aged 16 or over.
Phenomenon of interest:	Formal health-related help-seeking barriers and/or facilitators for eating and body image pathology.
Design:	Non-review peer-reviewed papers
Evaluation:	Subjective and objective data regarding barriers and facilitators to help-seeking, including help-seeking views, experiences, attitudes, intentions, predictors, or factors.
Research type:	Qualitative, quantitative, or mixed methods.

Table 2. Search Terms and Boolean Operators Used.

Search terms:

("help seek*" OR "seek* help" OR "treatment seek*" OR "seek* treatment" OR "care seek*"
    OR "seek* care" OR "service utili*") AND ("eating disorde*" OR "eating distress" OR
    "disordered eating" OR "restrict* eating" OR "eating concern" OR "eating difficult*" OR
    "Muscle dysmorphi*" OR "drive for musc*" OR "drive for thinness" OR "drive for leanness"
    OR "bigorexia" OR "reverse anorexia" OR "Muscularity oriented disordered eating" OR
    "body dysmorphi*") AND ("men" OR "male*" OR "boy*" OR "gender")

Selection Process

Articles were initially imported into reference management software, Zotero, to remove duplicates, before being uploaded to the systematic review software Rayyan (Ouzzani et al., 2016). The process began with George Mycock (GMy; the first author) and Una Foye (UF; the second author) separately screening titles and abstracts which resulted in ten accounts of disagreement of in/exclusion. All disagreements were taken to the wider research team to resolve through critical discussion and finalize in/exclusion of the articles. This process was repeated with the full text review, and three articles were discussed via a critical friend meeting. The screening process utilized the criteria shown in Table 1.

To assist with the review process, the research team adopted the following definitions of barrier and facilitator from Zaman et al. (2022, p. 2): *barrier*: "a circumstance or obstacle that keeps people from accessing mental health services"; *facilitator*: "a circumstance or process that makes it easier for people to access mental health services."

Quality Appraisal

The Mixed Method Appraisal Tool (MMAT; Hong et al., 2018) was used to assess the methodological quality of the studies. Quality assessment was undertaken separately by GMy and UF and disagreements were discussed and resolved. The MMAT supplies five questions based on the methodology of each paper, which are scored from 5 (excellent quality) to 1 (poor quality). Within this review papers are referred to as high quality (meaning a score of 4 or 5) or below expected quality (meaning a score of 3 or lower; see supplemental materials for the full scores). Given the small number of studies on the phenomenon of interest, methodological quality was not used to exclude studies.

Data Extraction and Transformation

A data extraction sheet was created in Microsoft Excel and data extraction was conducted by GMy following guidance from Lockwood et al. (2015). GMy identified

Table 3. Included Study Information.

Citation	Aims	Sample	Setting	Design
Freedman et al. (2021)	To characterize how male athletes experience eating and exercise concerns and identify the onset and maintenance factors that may be unique to this demographic.	8 male athletes with diagnosed or self-identified past or current ED and/or disordered eating	USA	Cross-sectional questionnaire followed by semi-structured interviews
Malova and Dunleavy (2022)	To confirm and explore factors to may affect disordered eating behaviours in men, and to explore barriers that prevent men with ED from seeking help.	25 videos of men talking about lived experience of a diagnosed ED	Online videos (YouTube)	Thematic analysis of online videos
McArdle and More (2013)	To examine the moderating effect of gender on the relationship between sport type, indices of mental health literacy (i.e., perceived barriers to help-seeking, perceived stigma), and attitudes toward help-seeking'	133 (37% male; n = 49) university athletes	UK	Cross-sectional questionnaire
Griffiths et al. (2015)	To examine sex differences in the association between self-stigma of seeking psychological help and the likelihood of having an undiagnosed ED	485 (7.4% male; n = 36) participants - 360 with diagnosed ED (16 men) and 125 with undiagnosed ED (20 men)	Australia, UK, USA	Cross-sectional questionnaire
Romano & Lipson (2021)	To examine gender differences in restraint symptoms, and differences in associations between stigma, negative affect and perceived need of ED treatment in restraint type groups	3201 university students (69.2% women; percentage of men not identified)	USA university	Cross-sectional questionnaire

Table 3. (continued)

Citation	Measures	Data analysis
Freedman et al. (2021)	- the Questionnaire for ED Diagnosis (Mintz et al., 1997)	Thematic analysis
Malova and Dunleavy (2022)		Thematic analysis
McArdle and More (2013)	- a mental health literacy questionnaire about disordered eating modelled from other research - The 10 items of the Attitudes Toward Seeking Professional Psychological Help—Short Form Scale (ATTSPPH-SF; Fischer & Farina, 1995) - a perceived stigma scale and perceived barriers scale similar to Britt et al., (2008)	Correlational and moderated hierarchical regression analysis
Griffiths et al. (2015)	- The 10-item Self-Stigma of Seeking Help scale (SSOSH; Vogel et al., 2006) - the Perceived Discrimination and Devaluation Scale (PDD; Link, 1987) - the Eating Disorder Examination (EDE-Q; Fairburn & Beglin, 1994)	Binary logistic regression
Romano & Lipson (2021)	- Restraint items from The Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994) - ED stigma questions made for the study - Four items comprising the Patient Health Questionnaire-4 (PHQ-4; Löwe et al., 2010) - Single item for level of agreement with a statement regarding treatment need.	Structural equation mixture modelling

Citation	Aims	Participants	Setting	Design
Thapliyal et al., 2020	Investigate the treatment experiences of men who had sought help, were diagnosed with an ED and received ED-specific treatment'	Eight men who have accessed treatment for ED/DE	Australia and USA	Semi-structured interviews
Dearden & Mulgrew, 2013	To understand the various perspectives of service provision for men with ED's	15 organisation representatives, 10 practitioners, and 5 men with 'eating issues'	Australia	Prospective observational design

(continued)

Table 3. (continued)

Citation	Aims	Participants	Setting	Design
Shepherd & Rickard, 2012	To investigate the relationships between drive for muscularity, gender role conflict and help seeking related variables	176 male university students	USA university	Cross-sectional questionnaire
Raisanen & Hunt, 2014	Investigate men's experiences of DE and perceived barriers to help seeking for DE.	10 males - 8 diagnosed with ED's and 2 undiagnosed.	UK	Phenomenological interviews
Pettersen et al., 2016	Investigate what males experience as helpful in their recovery process from ED	15 men who had completed ED focused treatment for a DSM-5 recognised ED	Norway and Sweden	Phenomenological interviews

Citation	Measures	Data analysis
Thapliyal et al., 2020		five-stage inductive framework approach to thematic analysis
Dearden & Mulgrew, 2013	separate survey for each group, each comprised of open and closed questions - no scales specified	Thematic analysis
Shepherd & Rickard, 2012	GRC was measured using the GRCS (O'Neil et al., 1986) - Body image attitudes and related body change behaviours were measured using the Drive for Muscularity Scale (DMS) (McCreary & Sasse, 2000) - the shortened version of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Farina, 1995) - the Self-Stigma of Seeking Help Scale (SSOSHS; Vogel et al., 2006) - the Perceptions of Problems in Living Questionnaire (PPLQ; Magovcevic & Addis, 2005) - the Concrete Barriers and Distrust of Caregivers subscale (CBDC) of the Barriers to Help Seeking Scale (Mansfield et al., 2005) - the Intentions to Seek Professional Psychological Help Scale (ISPPHS; Deane et al., 1999)	Mediation analysis

Table 3. (continued)

Citation	Measures	Data analysis
Raisanen & Hunt, 2014		Secondary analysis - qualitative interpretative approach
Pettersen et al., 2016		Content analysis

Citation	Aims	Participants	Setting	Design
Lyons et al., 2019	Explore the lived experiences of men who have, or have had, an ED	7 men with a self-reported diagnosis of anorexia nervosa	UK	Narrative interviews
Robinson et al., 2012	To answer three questions: 1. What is it like for men to live with an ED? 2. What is it like for men to seek treatment for an ED? 3. What is it like for men to receive treatment for an ED?	8 men with diagnosed ED's	UK London ED services	Phenomenological interviews
Hackler et al., 2010	Investigate the relationships between self-stigma, anticipated risks and benefits associated with seeking counselling, and attitudes towards seeking counselling	145 (14.5% male; n=21) psychology students who met criteria for DE as measured by EAT-26	USA	Cross-sectional questionnaire
Billman Miller et al., 2024	To examine the differences in the level of ED pathology and self-stigma of help-seeking between groups based on race and gender in a sample of sexual minority adults, and to explore the strength of associations between self-stigma of help-seeking and self-reported ED pathology at the intersection of race and gender.	354 sexual minority participants (47% cismen; n = 167)	USA	Cross-sectional questionnaire

Table 3. (continued)

Citation	Aims	Participants	Setting	Design
Lehe et al., 2024	To investigate the effect of stigma-related perceptions of EDs in men on men's help-seeking intentions for disordered eating symptoms	132 adult men	Germany	Cross-sectional questionnaire

Citation	Measures			Data analysis
Lyons et al., 2019				Thematic analysis
Robinson et al., 2012				Interpretative phenomenological analysis
Hackler et al., 2010	- The EAT-26 (Garner et al., 1982) - the Self-Stigma of Seeking Help Scale (SSOSH; Vogel et al., 2006). - the Attitudes Toward Seeking Professional Psychological Help–Short Form (ATSPPH-SF; Fischer & Farina, 1995). - the Disclosure Expectations Scale (DES; Vogel et al., 2005)			Hierarchical regression analysis
Billman Miller et al., 2024	- Eating Pathology Symptom Inventory (EPSI; Forbush et al., 2013) - Self-Stigma of seeking Help Scale (SSOSH; Vogel et al., 2006)			Correlational analysis
Lehe et al., 2024	- The Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994; Hilbert & TuschenCaffier, 2016) - The Muscle Dysmorphic Disorder Inventory, German version (MDDI; Zeek et al., 2018) - The Duesseldorf Orthorexia Scale (DOS; Barthels et al., 2015) - The Eating Disorders in Youth-Questionnaire (EDY-Q; Hilbert & van Dyck, 2016) - German version of the Stages of Change Questionnaire for Eating Disorders (SOCQ-ED; Von Brachel et al., 2012) - Help seeking questionnaire made for the study.			Moderator analysis

qualitative and quantitative findings in line with the definitions of "barrier" and "facilitator" set for the review. For articles with mixed male and female samples (e.g., Griffiths et al., 2015), only articles reporting men's data separately were included in the current review.

Qualitative Findings. For papers reporting qualitative data, a "finding" was defined as "a verbatim extract of the author's [referring to the author of the included article] analytical interpretation of the results or data" (Lockwood et al., 2015, p. 183). GMy did not include themes as findings, instead focusing on verbatim statements of the authors' analysis within themes for a deeper understanding of the interpretations which construct the themes. Each qualitative finding was paired with the best fit example of an illustration (a participant quote) from the paper/supplemental material, that supported the finding. The finding and illustration pairings were then categorized into the following three groups, as suggested by Lockwood et al. (see p. 183). This process was completed by GMy and critically discussed with UF to finalize pairings and categories: (1) Unequivocal (findings accompanied by an illustration that is beyond reasonable doubt and; therefore not open to challenge); (2) Equivocal (findings accompanied by an illustration lacking clear association with it and therefore open to challenge); (3) Unsupported (findings are not supported by the data).

Unsupported findings were removed from the synthesis. The remaining equivocal and unequivocal findings are presented in the review synthesis (see Supplemental Material).

Quantitative Findings. Consistent with previous reviews (e.g., Bennett et al., 2023; Gray et al., 2021; Jackson et al., 2023), the JBI protocol was followed for quantitative findings by undergoing data transformation via qualitizing the quantitative data into textual data (e.g., themes, categories, or narratives; Stern et al., 2020). The qualitized findings were then pooled with the verbatim findings directly extracted from qualitative and mixed method studies. The qualitizing process was completed by GMy and the qualitized findings were brought to Christian Edwards (the fourth author) to critically discuss and finalize (see supplemental materials to review qualitized findings).

Data Analysis and Synthesis

A meta-aggregation was used to synthesize findings. Meta-aggregation aims to create synthesized findings (SF) that can directly inform practice, policy, and protocol, whilst attempting to remove researcher bias to create statements that speak to the essence of the data (Lockwood et al., 2015). An example of an SF is Bennett and colleagues' (2023) SF: "young people need to feel comfortable when using a digital sexual health intervention" (p. 5), which speaks to data encompassing comfort, credibility, access, and environment. Despite the suggestion of meta-aggregation removing researcher bias, the research team found that the process of qualitizing during data transformation inherently creates an axiological position within this review that must acknowledge the

role of the researchers' interpretation (Nzabonimpa, 2018). Therefore, the research team utilized reflexive measures (i.e., critical discussions) throughout the analysis and have included information on the authors' positionalities (see below).

The process of meta-aggregation (Lockwood et al., 2015; see supplemental materials) involved the repeated examination of the articles' findings and grouping those into categories based on similarity of meaning. The categories are brief descriptions of the key concepts from the two or more findings located within the category. The categories are then repeatedly examined and grouped again, where possible, into SFs. When categories could not be grouped, due to being unique, they are still presented as an SF with the singular category reported. Findings that were too distinct to be grouped into categories are presented as non-synthesized findings. The SFs are expressed as indicatory statements which can be suggestive, symbolic and/or representative of the collated findings, allowing for subjectivity from the researcher as to what constitutes "indicatory" (Lockwood et al., 2015, p. 184). For example, in SF3 (Table 4) the phrase "seem to marginalize men's experiences" is used to "indicate" the collective reports of concern with resources, staff, and systemic practices that fail to recognize men. Despite critiques of meta-aggregation (Bergdahl, 2019) the researchers chose this form of synthesis due to the pragmatic focus that creates results applicable to policy, protocol, and intervention developments.

Positionality Statement

Understanding the lead researcher's positionality can add further clarity to this review. GMy is an English born, white, cisgender man, with lived experience of EBIP and help-seeking for EBIP. GMy is also the founder of a mental health organization called MyoMinds which engages in campaigns, research, and delivering training around EBIP. These experiences may have influenced what GMy recognizes as a barrier and facilitator to/of help-seeking within the collated papers and what were considered as similar findings during synthesis. To monitor GMy's lived experience throughout the research process, GMy took part in regular critical discussions with the research team. All authors also have direct and/or indirect experiences with EBIP (e.g., excessive exercise, muscularity-oriented preoccupations, and/or disordered eating), and each brought these experiences to support GMy in shaping the review and interpreting the findings.

Results

Study Characteristics

Initial searches found 1590 articles. Once duplicates ($n = 865$) were removed, GMy and UF separately screened the titles and abstracts of the remaining 725 (46%) articles for relevance to the study, leading to the removal of an additional 685 articles. GMy and UF retrieved and separately screened the full text of the remaining 40 articles (6% of title

Table 4. Synthesized Findings Following Meta-Aggregation.

Synthesized findings	No. of papers and findings
Barriers	
SF1 – Being men: Men see EBIP as a 'woman's illness' and feel reluctant to seek help due to masculine norms.	Seven papers (five qualitative, one quantitative, and one mixed method) 14 findings (ten from high quality papers)
SF2 – Insufficient knowledge: Men, and men's social circles, were unable to recognize EBIP in themselves/others as they were unaware of what disordered eating and exercise practices may look like in men.	Six papers (five qualitative and one mixed method) Ten findings (nine from high quality papers)
SF3 – Unwelcoming healthcare: Men and healthcare professionals report that EBIP healthcare services, and their resources, seem to marginalize men's experiences.	Seven papers (five qualitative, one quantitative, and one mixed method) Ten findings (nine from high quality papers)
SF4 – Shame and stigma: Men report experiencing self-stigma and being afraid to talk about their EBIP due to expected negative reactions from their social circles.	Seven papers (five quantitative and two qualitative) Eleven findings (seven from a high quality papers)
SF5 – The benefits of EBIP: Men believe that their EBIP behaviors serve a purpose in their lives and create a sought-after identity.	Three papers (all qualitative) Five findings (all from high quality papers)
SF6 – Misunderstood and Misdiagnosed[a]: Men report that clinicians minimize and misdiagnose their EBIP symptoms, making it harder to receive appropriate help.	Two papers (both qualitative) Two findings (both from high quality papers)
Facilitators	
SF7 – Symptom recognition: Men report a sudden realisation that their eating and body image psychopathology was a problem, usually after feeling out of control or experiencing a health scare.	Seven papers (four qualitative, two quantitative, and one mixed method) 15 findings (12 from high quality papers)
SF8 – Interpersonal Persuasion[a]: Friends, family, and romantic partners sometimes initiate help-seeking for eating and body image psychopathology by urging men to engage in help seeking.	Three papers (two qualitative and one mixed methods) Four findings (two from high quality papers)

[a]Only one category included within the SF.

and abstract screened articles) for eligibility, concluding 13 articles (33% of the full text screened articles) were eligible for inclusion in the synthesis. This process was repeated during rerun of the systematic review, locating an additional two articles for synthesis, meaning that 15 articles met the inclusion criteria (see Figure 1). A total of 4737 participants (including the 15 organization representatives and 10 practitioners

included as participants in one study; Dearden & Mulgrew, 2013) are included in this review. Within the 15 articles, 1653 (35%) of participants were reported as men/male. Of the 1653 men, 90 (5%) reportedly had a diagnosis of an ED, and 27 (1%) reported some form of eating psychopathology. 13 articles focused on eating psychopathology, one article investigated body image (Shepherd & Rickard, 2012), and one article explored help-seeking for EBIP (including measures for eating psychopathology and a measure for muscle dysmorphia; Lehe et al., 2024). Of all 15 included articles, only two included muscularity-oriented experiences (Lehe et al., 2024; Shepherd & Rickard, 2012). Four of the 14 articles that investigated eating psychopathology report samples of only men with ED diagnoses (Malova & Dunleavy, 2022; Pettersen et al., 2016; Robinson et al., 2012; Thapliyal et al., 2020) and four report a mix of diagnosed EDs and those with undiagnosed eating psychopathology (Freedman et al., 2021; Griffiths
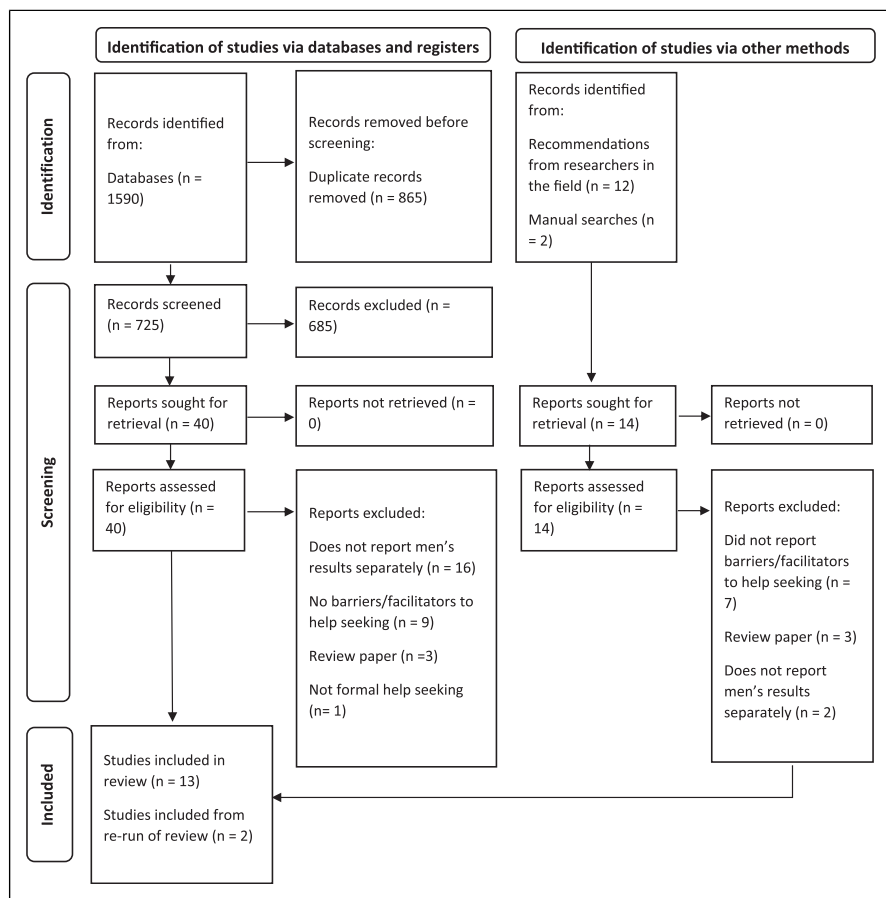

Figure 1. PRIMSA flow chart.

et al., 2015; Lyons et al., 2019; Räisänen & Hunt, 2014). Of the eight articles containing some or only ED diagnosed men as participants, five report the specific diagnoses of those diagnosed. Together the five articles outline 26 participants with Anorexia Nervosa or the Eating Disorder Not Otherwise Specified (EDNOS) variant of Anorexia (all seven of Lyons et al.'s [2019] participants are included, as they do not state how many were undiagnosed), 12 participants with Bulimia Nervosa or the EDNOS variant of Bulimia, two participants diagnosed with an unspecified form of EDNOS, and one participant diagnosed with Anorexia and Bulimia. It is noted that EDNOS is no longer a diagnosis, as this was replaced with Other Specified Feeding or Eating Disorder (OSFED).

Six (40%) of the included articles used qualitative methods, seven (47%) used quantitative methods, and two (13%) used mixed methods. Most of the papers were based in the United States ($n = 5$, 33%) and the United Kingdom ($n = 4$, 27%), or were multinational ($n = 3$, 20%). One study was located in Australia (7%), one in Germany (7%), and one did not specify the geographic location of participants (7%). The publication dates of the papers span from 2010 to 2024. 10 of the 15 articles were assessed as high quality (66%; six qualitative papers, three quantitative and one mixed method), with the remaining five scoring below expected quality (36%; four quantitative papers and one mixed method). Below expected quality scores were mostly because of non-representative samples, which often lacked descriptive information, and a lack of acknowledgement of potential non-response bias.

Findings Characteristics

81 findings were extracted from all articles, 17 (21%) of these findings are from the qualitizing process. The remaining 64 (79%) findings are from the qualitative and mixed method papers. After the removal of unsupported findings ($n = 7$), the remaining 57 qualitative findings contained 37 unequivocal and 20 equivocal findings. The unequivocal and equivocal groups were not used to provide weighting towards particular findings during meta-aggregation, as both unequivocal and equivocal findings were supported by data. The results of unequivocal and equivocal categorizing are instead presented to provide a unique critical perspective of the results from the included qualitative papers (see supplemental materials). With the unsupported findings removed, a total of 74 findings remained for synthesis.

Synthesized Findings

The 74 findings were condensed into 13 categories which were synthesized into eight SFs, via meta-aggregation (see Table 4). Four of the papers included in this review contained only men who had a diagnosed ED (Malova & Dunleavy, 2022; Pettersen et al., 2016; Robinson et al., 2012; Thapliyal et al., 2020). Two of the categories (4b, 5b) contain findings from these papers only and, as such, refer to ED rather than EBIP. Specifying ED where ED diagnosis is confirmed allows for recognition of ED specific

results, which still fall under the EBIP umbrella term. Additionally, four non-synthesized findings are presented as narratives. A full breakdown of the findings, categories, and SFs is included in the supplemental materials.

Below we present the eight SFs, and the categories encompassed within them, alongside illustrative quotes from the findings included within each of the categories. The SFs are then discussed. The 8 SFs have each been given a short title followed by the summarizing statement/s (Lockwood et al., 2015). The title is included to assist organizations wishing to refer to individual SFs within this review (i.e., referring to "Being Men" rather than "SF1"). The SFs are split into two sections: barriers and facilitators. The barriers SFs are titled (1) Being Men, (2) Insufficient Knowledge, (3) Unwelcoming Healthcare, (4) Shame and Stigma, (5) The Benefits of EBIP, and (6) Misunderstood and Misdiagnosed. The facilitator SFs are titled (7) Symptom Recognition and (8) Interpersonal Persuasion.

Barriers to Help-Seeking

Synthesized Finding 1 – Being Men: Men See EBIP as a "Woman's Illness" and Feel Reluctant to Seek Help due to Masculine Norms

In SF1 the findings suggest that men felt that societies attach a feminine label to EBIP, and that this label, alongside pressures of masculinity, meant they were less likely to recognize and accept their concerns and, if recognized, more likely to hide them. This SF contained two categories:

Category 1a: Men Believe that Society Views EBIP as Feminine, which Leads to Experiences of Stigma And/or an Inability to Recognize Their EBIP. Many of the findings ($n = 6$) within this category reference the perspectives of men who believe that society sees EBIP as a girl's/woman's/female issue. For example: "Individuals from all 25 videos mentioned a 'girl's disease' label attached to ED" (Malova & Dunleavy, 2022, p. 442). Authors report that this feminization contributes to men's inability to recognize their EBIP and/or deters men from acknowledging their EBIP, often due to feelings of contradiction for being a man with EBIP (Robinson et al., 2012).

Category 1b: Men Feel that They Are Expected to Hide Emotions. This Led to a Reluctance to Seek Help. Men reported they experience pressures due to their gender which can cause anticipation of stigma and reluctance to seek help as they feel pressured by societal expectations to hide their emotions. For example, Räisänen and Hunt (2014) noted that men's beliefs around emotional expression played a part in reducing help-seeking: "Men also referred to generalized beliefs about gender-appropriate expressions of emotion and help-seeking when explaining their reluctance, as men, to seek help" (Räisänen & Hunt, 2014, p. 4).

Synthesized Finding 2 – Insufficient Knowledge: Men, and Men's Social Circles, Were Unable to Recognize EBIP in Themselves/Others as They Were Unaware of what Disordered Eating and Exercise Practices May Look Like in Men

SF2 encompasses findings from papers that highlight a lack of awareness and understanding about disordered eating and exercise (from the men themselves and those around them) which limited recognition that there was a problem. This SF contains two categories:

Category 2a: A Lack of Knowledge About EBIP (From the Men Themselves and Those Around Them) Meant It Was Harder to Recognize the Problem. The findings within these papers revealed gaps in knowledge about EBIP in men, by men and people (of any gender) in men's social circles: "all the men described having no or very little awareness of EDs in men" (Räisänen & Hunt, 2014, p. 3). The papers highlight how this lack of awareness acted as a barrier whilst additionally contributing to a reduced likelihood of recognition of the issue and a reduced likelihood of knowing where to go when/if trying to seek help for EBIP (Dearden & Mulgrew, 2013).

Category 2b: Men Did Not Know the Dangers Associated with Their EBIP-Related Behaviors and Were Unaware of "Healthy" or "Safe" Alternatives. This Limited the Likelihood of Men Recognizing the Concerns They Were Experiencing. The findings highlight how a lack of understanding of surrounding "unhealthy" eating and exercise behaviors seemed to encourage a minimization of the potential danger of their behaviors. For example, "[men] did not feel their condition was serious enough, and they were seemingly unaware of the risks" (Freedman et al., 2021, p. 12). Men also reported that they were not aware of what "safe" and "healthy" behaviors would be, potentially contributing to the normalization of their behaviors (Malova & Dunleavy, 2022).

Synthesized Finding 3 – Unwelcoming Healthcare: Men and Healthcare Professionals Report that EBIP Healthcare Services, and Their Resources, Seem to Marginalize Men's Experiences

Findings within SF3 report that men, and some healthcare professionals, believe that healthcare systems for EDs fail to appropriately cater to men's experience and are therefore unwelcoming to men. SF3 contains two categories:

Category 3a: Men and Healthcare Professionals Believe There Is Stigma Located Within the EBIP Healthcare System, which Can Make Men Feel Unwelcome. The findings highlight that men often report their experiences of EBIP healthcare systems as feeling ignorant of their presence. For instance, Lyons and colleagues (2019) report that "Participants believed it [an ED charity] lacked a male ED presence, the Web site design was female orientated (which has now changed) and its fund-raising activities inappropriate"

(p. 562). Findings also state that men report feeling stigmatized by, or burdensome to, the system and feel that doctors are unable to help "due to stigma around the health issue" (Malova & Dunleavy, 2022, p. 443). Additionally, Dearden and Mulgrew (2013) reported that "Both the [healthcare] practitioners and men specifically noted problems with the recognition of men's eating issues within the health care system" (p. 599).

Category 3b: Men Perceive the Care and Resources Available for EBIP as Ignorant to Men and Their Experience of EBIP. These findings report that men's attempts to learn more about EBIP are often thwarted by finding little information that pertains to men's experiences. Men reported that this felt as if the information available confirmed societal labels of EBIP as a women's issue (SF1). For example, "Men expressed a strong desire for balanced, gender-tailored information. They felt that gender-blind information reflected wider societal constructions of EDs as predominantly or only affecting women" (Räisänen & Hunt, 2014, p. 6). Authors report that this can make men feel like "outsiders of a health system that inadvertently was unable to acknowledge or provide space for them" (Thapliyal et al., 2020, p. 540).

Synthesized Finding 4 – Shame and Stigma: Men Report Experiencing Self-Stigma and Being Afraid to Talk About Their EBIP due to Expected Negative Reactions from Their Social Circles

In SF4 the findings collated represent reports from men who state that they find it difficult to talk about their EBIP with others. Men explain that talking about their experience can be difficult due to feelings of shame about experiencing EBIP, self-stigmatization about seeking help, and fear of how others will react. Two categories are contained in SF4:

Category 4a: Men Found It Difficult to Talk About Their Experiences of EBIP, Often Feeling Shame and Self-Stigmatization About Seeking Help And/or Having These Concerns. The findings highlight the difficulties men felt in acknowledging their EBIP and speaking about it to others. Robinson et al. (2012), for example, state that "Participants found it difficult to admit to themselves and to others that they had an ED" (p. 179). Further findings report feelings of shame and self-stigma from the men. Men mention holding back from talking because they do not want "pity" (Lyons et al., 2019, p. 562) from others. Quantitative data suggests that self-stigma around seeking help is a common barrier to both seeking and receiving care for men experiencing EBIP (Billman Miller et al., 2024; Griffiths et al., 2015; Hackler et al., 2010; Lehe et al., 2024; Shepherd & Rickard, 2012).

Category 4b: Men Report Specific Worries About How Others Around Them Will React if They Tell Them About Their ED-Related Thoughts and Behaviors. The findings highlight how men report refraining from sharing their concerns with others due to fears of how they may react. For example, "Participants had hidden (and were still hiding) the ED from

people for fear of what people would think about them and how they would react…" ([Robinson et al., 2012](), p. 180). Some participants stated the specific reactions they feared, such as laughter or shunning and that "loved ones would blame themselves" ([Robinson et al., 2012](), p. 181).

Synthesized Finding 5 – the Benefits of EBIP: Men Believe that Their EBIP Behaviors Serve a Purpose in Their Lives and Create a Sought-After Identity

SF5 collates findings from papers that suggest that men can perceive their EBIP behaviors as positive, helpful, and identity defining, and do not want to give that up. SF5 contains two categories:

Category 5a: Men Saw Their EBIP Behaviors as Serving a Purpose and Providing Them with Benefits They Perceived as Needed. These findings speak to the way that behaviors integrate into men's lives over time and can provide seemingly needed benefits that the men now rely on, making it harder to seek help. For example, "As men often recognized their problem late in their illness trajectory … they had become reluctant to relinquish behaviours which they felt had a purpose and function in their lives" ([Räisänen & Hunt, 2014](), p. 4). One paper outlined how men's ED's can be "initially a solution" ([Robinson et al., 2012](), p. 181) before becoming a problem, making it difficult to let go of behaviors, despite concerns, due to worries that the benefits may also be lost.

Category 5b: Men Felt that Their ED Behaviors Helped Create a Sought-After Identity. These findings point to a drive for feelings of worth and agency, and the role of the behaviors in constructing masculine identities: "These men's actions were an effort to re-instate a sense of worthiness (e.g., "being enough"), personal agency (e.g., "not in the hands of someone else's actions") and in the construction of their identities as men" ([Thapliyal et al., 2020](), p. 537). The findings also touch on how EBIP behaviors helped men construct ideas of themselves as "'good' enough as a person" ([Thapliyal et al., 2020](), p. 537), meaning a loss of these behaviors could threaten the loss of this identity.

Synthesized Finding 6: Misunderstood and Misdiagnosed: Men Report that Clinicians Minimize and Misdiagnose Their EBIP Symptoms, Making It Harder to Receive Appropriate Help

SF6 findings point to men reporting that their EBIP symptoms were minimized (perceived or explained as something less impactful) and misdiagnosed by clinicians, resulting in a reduced ability to seek EBIP care. SF6 only contains one category:

Category 6a: Men Reported that Their EBIP Symptoms Were Minimized, and Behaviors Misdiagnosed when First Reporting to Healthcare Services, Limiting Their Ability to Access Help for an EBIP. These two findings spoke to issues surrounding diagnosis from clinicians (e.g., being incorrectly diagnosed with bipolar disorder or depression;

Räisänen & Hunt, 2014; Thapliyal et al., 2020), where men felt their experiences were misunderstood. For example, "These men's diverse experiences of treatment settings indicate the negative impacts of misdiagnosis, minimization of symptoms and the lack of understanding of men's experiences and treatment needs for an ED" (Thapliyal et al., 2020, p. 539). This minimization and unrecognition of men's symptoms meant men had to repeatedly engage in help-seeking to access relevant care, an additional barrier to traverse (Räisänen & Hunt, 2014).

Facilitators of Help-Seeking

Synthesized Finding 7 – Symptom Recognition: Men Report a Sudden Realization that Their Eating and Body Image Psychopathology Was a Problem, Usually after Feeling out of Control or Experiencing a Health Scare

SF7 encompasses findings reporting men's recognition of their EBIP when experiencing symptoms causing serious health risks, a feeling of loss of control, or a realization that the negative effects outweigh the perceived benefits. Two categories are collated with SF7:

Category 7a: Men's Recognition of the Issue Came from Increased Symptom Prevalence, Loss of Control, or Psychoeducation. The findings highlight how the increasing intensity of negative symptoms (e.g., loss of adaptive control; Freedman et al., 2021), or the realization of the negative impact of behaviors due to an event or improved education of the risks (e.g., emergency referral to hospital; Räisänen & Hunt, 2014), led to men acknowledging their need for help. Freedman et al. (2021) provide this example: "The tipping point that prompted four [male] athletes to get help was when they recognized that they were no longer controlling their behaviours, but instead, their behaviours were controlling them" (p. 12). This recognition of EBIP was not always directly linked to help-seeking by the authors. However, recognizing one's symptoms is a facilitator of help-seeking within the concept of mental health literacy (Jorm, 2012). Mental health literacy suggests that recognizing mental illness symptoms in oneself or in others likely improves the chance of engagement in help-seeking behavior (Jorm, 2012) and the potential for this was noted in some of the papers included in this review (e.g., Pettersen et al., 2016).

Category 7b: According to Healthcare Practitioners, and Men Themselves, Men Often Seek Help due to a Physical Issue Caused by Their EBIP, which May Raise Their Awareness and Initiate Seeking Help for Those Symptoms. These findings highlight that practitioners working in ED services, and men experiencing EBIP, both report physical symptoms of the EBIP being the reason for seeking help, rather than a recognition of the psychosocial effects. For example, Räisänen and Hunt (2014) note that "...initial awareness of their ED was precipitated by a crisis point that led to a hospital admission

or emergency referral. These crises were often linked to marked deterioration in physical health" (p. 4).

Synthesized Finding 8 – Interpersonal Persuasion: Friends, Family, and Romantic Partners Sometimes Initiate Help-Seeking for Eating and Body Image Psychopathology by Urging Men to Engage in Help-Seeking

SF8 contains four findings which report the role of family members, peers, and romantic partners in instigating help-seeking behavior for eating and body image psychopathology in men. SF8 contains only one category:

Category 8a: Men Reported that Pressures From, and Problems Within, Their Relationships Were Catalysts to Seeking Help. These findings highlight the involvement of men's social circles in the initiation of their help-seeking, be it family, friends, or romantic partners. This initiation took different forms, sometimes through relationships breaking down (e.g., partner threatening to end their relationship if they did not do something; Dearden & Mulgrew, 2013) and other times through encouragement and/or enforcement of help-seeking. One example is seen in Pettersen et al.'s (2016) paper who state that most men report being *"pushed"* or *"forced"* (p. 3) into seeking help by family members or friends.

Non-Synthesized Findings

Four findings did not fit into the dominant categories of SF. Three of the papers (Dearden & Mulgrew, 2013; Romano & Lipson, 2021; Shepherd & Rickard, 2012) were assessed as below expected quality, and one as high quality (Robinson et al., 2012).

Dearden and Mulgrew (2013) stated that "Problems with motivation to seek help were cited by two men" (p. 599). This finding suggests that there may be other individual barriers within men experiencing EBIP that may not relate to gendered ideals, stigma, or fear of losing perceived benefits.

Secondly, Robinson and colleagues (2012) highlighted long waiting times for ED services as a barrier (i.e., "Having asked for help, they found the long waiting list wait difficult" p. 180), which is a concern that likely spans gender due to severely underfunded ED services (Viljoen et al., 2023).

Third, Shepherd and Rickard's (2012) qualitized data reports that "more positive attitudes towards seeking help predict greater intentions toward help-seeking in university men" (see supplemental material). This suggests that interventions aimed at improving men's attitudes toward help-seeking may lead to an increased intention to seek help.

The final non-synthesized finding is a qualitized finding from Romano and Lipson (2021) which reads "For university men in the moderate/high and low restraint level groups, having higher levels of perceived ED stigma was associated with being more

likely to perceive a need of treatment for their EBIP behaviours" (see supplemental material). This finding draws attention to the complex role of stigma, as here stigma is associated with increased awareness of treatment need. It may also be that the stigma highlighted serves as a proxy for, or is a result of, negative affect associated with awareness of one's own EBIP behaviors.

Discussion

This study reviewed the barriers and facilitators to/of adult men's formal health-related help-seeking for EBIP. The use of the inclusive term EBIP resulted in a synthesis of findings from 15 papers which formed six barrier SFs and two facilitator SFs spanning cultural, individual, and organizational levels.

Barriers to EBIP Help-Seeking

SFs 1 and 2 both encompass cultural barriers which view EBIP experiences as feminine and limit the understanding of EBIP in men due to these gendered assumptions. Additionally, cultural pressures of gender-appropriateness and masculinity were reported as barriers as they may compel men to hide their concerns. This aligns with academic understanding of traditional masculine pressures, such as the concept of self-reliance (which suggests that men should handle distress by themselves; Addis & Hoffman., 2017) and antifemininity (the expectation to avoid feminine roles, values and practices; Thompson & Bennett, 2015), which may explain the reason behind men hiding their EBIP concerns when these concerns are perceived as feminine. The limited recognition of men's EBIP behaviors were seemingly linked to gendered assumptions which framed men's EBIP behaviors as "personal choices" (Räisänen & Hunt, 2014, p. 4) or meant that the symptoms were missed entirely. It may be that limited recognition of EBIP in men has led to the perception of EBIP behaviors as "healthy" choices, which may parallel reports in athlete populations (Fatt et al., 2024). Organizations may reframe societal perspectives of EBIP, and men's perspectives of seeking help for EBIP, through masculine-informed training for staff, and the inclusion of language within healthcare resources that reflects the realities of men experiencing EBIP (Farrimond, 2011; Seidler et al., 2018a, 2018b).

Barriers at the Individual level, such as men holding limited knowledge of potential EBIP symptoms, and men's reluctance to seek help due to fear of shame and stigma, were central to SFs 1, 2, 4, and 5. Men also believed that the behaviors associated with their EBIP were providing solutions and sought-after identities that may be replaced with shame and stigma, if they were to discuss their concerns. This environment of anticipated stigma may be an example of a stigmatizing context as proposed by social-self-preservation theory (Dickerson et al., 2004). The theory suggests that certain social contexts may threaten how an individual would like to be perceived by others due to a trait viewed as undesirable. Stigmatization was found across SF1 and SF4 with the key difference being that SF1 refers to stigma due to gender incongruity and SF4 refers to

self-stigma directly related to EBIP behaviors, a distinction that may be explored further in future studies. As mentioned previously, these individual factors do not exist separately to the cultural and organizational influences. The fear of stigmatization seems to be somewhat linked to the self-reliance and antifemininity themes mentioned above. Previous qualitative research has suggested some men are re-conceptualizing help-seeking behavior as a more masculine act (i.e., as "taking action" to address health concerns; Farrimond, 2011, p. 221) to work around these issues. A re-conceptualization of EBIP help-seeking, through public campaigns and healthcare initiatives, may prove helpful to address men's fear of losing social capital, by offering an alternative. However, this must be cautious to not restrict messaging to only traditional hegemonic masculinities (Seidler, Rice, River et al., 2018).

At the organizational level, SFs 3 and 6 highlight men's concerns with the lack of male-inclusive EBIP healthcare resources, healthcare staff's lack of knowledge of men's EBIP, and the unique difficulties men face when trying to access EBIP care. These systemic concerns point to an underrepresentation of men's perspectives within EBIP healthcare policy, protocol, and staff training which may be explored in the future. The reviewers found that many of the barrier-related findings were focused on individual level concerns (e.g., men's lack of knowledge), and concerns regarding individual and cultural interactions (i.e., masculine discourse leading to individual beliefs about men's emotional expression) with less focus on organizational concerns. However, those that did uncover organizational level barriers reported similar perceptions across various samples of men, which suggests a poignant, yet under explored, issue. These concerns were echoed by staff (Dearden & Mulgrew, 2013), a perspective also seen in studies outside of this review (Foye et al., 2024). The reduced number of organizational findings may reflect less impact of mental health organization barriers, but it may also speak to a form of the "myopic lens" of men's help-seeking, turning focus away from organizations (Hoy, 2012). Future research may look to further understand why men report feeling excluded by resources, staff, and the healthcare system (Dearden & Mulgrew, 2013; Lyons et al., 2019; Malova & Dunleavy, 2022; Räisänen & Hunt, 2014; Robinson et al., 2012; Thapliyal et al., 2020) and may look at developments to improve men's experiences.

Facilitators of EBIP Help-Seeking

In addition to the collated barriers, a novel contribution of this review is the inclusion and synthesis of facilitating factors of men's EBIP-related formal health help-seeking. Reported facilitators manifest across individual (men's self-recognition of their EBIP) and cultural (the influences from men's social circles) levels. Within categories 7a, 7b, and 8a, organizational influences to facilitating men's help-seeking for EBIP were limited to two reports: clinicians referring patients seeking crisis care to relevant services (Räisänen & Hunt, 2014) and healthcare provided psychoeducation, leading to recognition of the concern (Robinson et al., 2012). As such, further investigations into

organizational influences (as suggested above) may also uncover further examples of successful facilitation that can be developed further.

The facilitator findings found in this review suggest that men either experience intensified symptoms, leading to the realization of the concern, or they are encouraged/forced to seek help earlier by those around them, sometimes doing so whilst still unaware of the issue (Pettersen et al., 2016). These findings point to: (1) a need for accelerated awareness of EBIP in men, to help men recognize their EBIP and understand the dangers associated with it, prior to the experience of intensified symptoms (SF7), and (2) the importance of those who make up men's interpersonal relationships, who may benefit from mental health first aid (Kitchener & Jorm, 2002) guidance, as the methods reported in studies (e.g., forcing or providing ultimatums; Dearden & Mulgrew, 2013) do not align with expert consensus (Jorm, 2012).

Limitations

Limitations of the Review. This review only included peer-reviewed articles that were written in English. The researchers acknowledge that these restrictions may limit the review to mostly include perspectives of white and/or Western men from industrialized, rich, and democratic societies (Henrich et al., 2010), missing the perspective of other men, and may miss relevant information from book chapters and grey literature.

Limitations of the Field. This review was limited due to a number of issues with the included articles. Firstly, few papers report barriers and/or facilitators to/of formal health help-seeking for EBIP in men ($n = 15$). Almost all of the articles ($n = 13$) exclusively explored help-seeking for eating psychopathology, meaning the use of the inclusive term EBIP led to data from two, non-eating psychopathology related, articles being included (both of which explored muscularity-oriented body image psychopathology; Lehe et al., 2024; Shepherd & Rickard, 2012). Additionally, articles disproportionately report barrier findings ($n = 54$) compared to facilitator findings ($n = 21$; 28% of findings were facilitators) and many articles ($n = 18$) were excluded from the current review as they presented the combined results of mixed male and female samples, which restricted their inclusion in this review (e.g., Fitzsimmons-Craft et al., 2020). These findings highlight a need for help-seeking research, specific to men, that explores beyond "deaths of despair" (Joint Economic Committee, 2019, pp. 2–3) to encompass barriers and facilitators to/of men's help-seeking for a wider range of concerns, including those typically perceived as feminine concerns (e.g., EBIP). The sparsity of muscularity-oriented EBIP articles found reflect limited knowledge about men's help-seeking for body image psychopathology and muscularity-oriented EBIP. Given the growing prevalence of men's concerns with muscularity (Ganson et al., 2022a, 2022b; Pila et al., 2017), future research is needed to explore men's help-seeking for these concerns. Doing so may lead to insights specific to muscularity-oriented concerns and nuanced findings that may extend knowledge of men's help-seeking for adverse behaviors/symptoms associated with pursuing the dominant western male

physical ideal. The quality assessment process identified concerns with the quality of most quantitative papers in the review. Future quantitative studies should aim to collect samples that represent the aims of the study (e.g., those with identified EBIP and relevant diagnoses, if the aim specifies a diagnosis) and improve reporting of methods and participant demographics.

Practice Implications

The SFs reported in Table 4 summarize the findings across the 15 papers. The SFs may be utilized as foundational statements to justify changes to organizational policy and protocol where possible. The SFs combined highlight the role of gendered expectations and deficient knowledge of men's EBIP symptoms in EBIP organizations, wider society, and men themselves. EBIP Healthcare organizations can assess the SFs in line with the messaging and information they share, with the aim to reduce barriers located in this review (e.g., do resources share information relevant to men). Research investigating the content of documentation used by EBIP healthcare organizations (e.g., resources and policy) may highlight areas for development to reduce gendered assumptions of EBIP and promote knowledge around men's experiences within healthcare organizations.

Conclusion

This systematic review adds novel findings to men's help-seeking and EBIP academic fields by collating peer-reviewed research surrounding barriers and facilitators to/of formal health-related help-seeking for EBIP in adult men. A meta-aggregation produced six barrier SFs and two facilitator SFs. The SFs point to several areas where relevant healthcare organizations can develop policies and protocols to improve men's help-seeking for EBIP. The overall number of papers included is small and many papers focus solely on eating psychopathology and barriers to help-seeking. Research is needed to further understand men's help-seeking for EBIP, especially surrounding body image/BDD, muscularity-oriented concerns, cultural/organizational influences, and facilitating factors. Researchers should investigate specific areas within healthcare organizations that may be contributing to help-seeking barriers in men, to inform future policy and/or practice developments that aim to facilitate men's help-seeking/access to care.

Contributorship

George Mycock: Conceptualization, Methodology, Investigation, Formal analysis, Writing - Original Draft, Writing - Review & Editing, Project administration. Una Foye:

Conceptualization, Supervision, Methodology, Investigation, Formal analysis, Writing - Review & Editing. Christian Edwards: Conceptualization, Supervision, Methodology, Writing - Review & Editing. Győző Molnár: Conceptualization, Supervision, Writing - Review & Editing.

Declaration of Conflicting Interests

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Supplemental Material

Supplemental material for this article is available online.

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