5-2014

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**Document Type**
Capstone Project

**Degree Name**
Bachelor of Arts

**Department**
Psychology

**First Advisor**
Dawn M. Salgado

**Subject Categories**
Social and Behavioral Sciences

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*Keywords:* psychological help-seeking, men, masculinity, psychological health

# Associations between Components of Masculinity and Attitudes towards Psychological Help-seeking

The health differences between men and women are apparent in recent research on health demographics of Americans (Hoyert & Jiaquan, 2012; National Center for Health Statistics [NCHS], 2013). Reports from the U.S. government indicate that overall American life expectancy has increased over the last century, but men's life expectancy at birth has remained between five to seven years less than their female counterparts, depending on race. The death rates for men due to disease are also staggeringly higher than women. Male death rate is higher than women by almost sixty percent for heart disease, forty-three percent higher for malignant tumors, twice as high for liver disease and cirrhosis, and nearly three times as high for HIV. Men are also more likely to have high blood pressure, are more likely to be obese, and death rates from unintentional injuries are twice as high as women. Unintentional injuries are in fact the third leading cause of death in men behind heart disease and cancer. These physical health outcomes extend to psychological distress in terms of substance use, depression, and suicide (Courtenay, 2000; Hoyert & Jiaquan, 2012; Mahalik, Good, & Englar-Carlson, 2003; NCHS, 2013).

Along with physical health, mental health outcomes for men are not favorable. Suicide rates for men are nearly quadruple that of women (Hoyert & Jiaquan, 2012; NCHS, 2013). Suicide is the seventh leading cause of death for men, while suicide for women is not even in the top ten. College age males are at even higher risk. Male suicide rate between age 20 and 24 is nearly five times higher than their female counterparts (NCHS, 2013). Men are also more likely to abuse substances to offset depressive symptoms (Courtenay, 2000). Male drug abuse along with binge and heavy alcohol use is nearly double that of women (NCHS, 2013).

Some of the factors that contribute to differences in health outcomes between genders have to do with biology, economic status, and ethnicity (Eagly, 1995; Kaplan & Marks, 1995; Wamala, Ahnquist, & Mansdotter, 2009; Wood & Eagly, 2002). However, these factors do not explain longevity, whereas health and social behaviors do (Freidman, Tucker, Tomlinson-Keasey, Schwartz, Wingard, & Criqui, 1993; Osbourne, 2012). The explanatory power of genetic and biologic factors predicting mortality is also relatively small, many researchers believe that health and social behaviors have the largest impact on longevity. (Courtenay, McCreary, & Merighi, 2002).

To understand social behavior, it is important to understand gender and how it is formed through cultural upbringing as opposed to inherent. Social Construction Theory explains that behaviors of men and women are socially constructed based on the scenario or context, or that gender is performative. The theory proposes that gender is not inherent such as with biological sex, but rather learned through three basic steps that consist of observation, internalization, and expression (Messner, 2000; West & Zimmerman, 1987). The process begins by observing how others act, look, or feel depending on context and adopting those behaviors as culturally acceptable. Adopting these observed behaviors as ones own is known as internalization. Internalizing the gender is constructing a gendered self, or ones own views of their gender, or how they understand and conceptualize their gender. The final step is to portray these internalized behaviors through acting them out. Thus, the gender is attained and enacted (Messner, 2000; West & Zimmerman, 1987).

The process of gender identification and portrayal is a way of explaining why health differences occur between genders, in that men and women act in different ways because of differing concepts about masculinity and femininity that are adopted from culture. Researchers

explain that the process of socially constructing gender of men can result in three types of negative outcomes: (a) failure to fulfill long-term role expectations, with the lack of fulfillment between expectations and reality leading to low self esteem and other negative psychological processes; (b) successful fulfillment of role expectations, but only through traumatic socialization process leading to long-term negative side effects; and (c) successful fulfillment of male role expectations, but with negative consequences caused by the individual characteristics that have negative side effects in the person. These negative side effects are known as gender role conflict, or the conflict between the desire to fill the gender role while not fully agreeing with its qualities (Pleck, Sonenstein, & Ku, 1993). From this, boys and girls learn that it is normal for women to require help, and men to be independent and risk-taking. This in turn teaches men and women that it is normal for men to partake in behaviors that negatively affect health, such as smoking, drinking, and sexual promiscuity, but women should avoid these behaviors to portray femininity. This is the basis for health differences between men and women (Annandale & Hunt, 1990; Courtenay, 2000; Mahalik, Locke, Ludlow, Dietmer, Scott, Gottfried, & Freitas, 2003). As unfortunate as it may be, the effects of the masculine gender on men are much of the reasons why health outcomes are less than favorable.

**Masculinity**

Masculinity is defined as traits and ideas that make up the stereotypical or ideal man of which traditional masculinity is the stereotype. Traditional masculinity does not take on one aspect, but is a combination of many forms and constructs, known as norms. These norms encompass views and behaviors, where masculine roles are formed (Levant, Wimer, Williams, Smalley, & Noronha, 2009; Mansfield, Addis, & Mahalik, 2003). There are multiple theories of masculinity and how it is quantified, such as masculinity ideology and masculine gender role

stress. Pleck, Sonenstein, & Ku (1993) describe the differences between the two viewpoints. The process of gender role stress formation describes that cultural standards for masculinity exist, and socialization encourages men to live up to them. Brannon and David (1976) give four major male standards which are "no sissy stuff", meaning men distance themselves from femininity, are homophobic, and avoid emotions; "be a big wheel", meaning men strive for achievement and success and focus on competition; "be a sturdy oak", meaning men avoid vulnerability, stay composed and in control, and be tough; and "give-em-hell", meaning men act aggressively to become dominant.

More recent approaches to understanding masculinity and its effect on men's well-being have identified specific aspects that comprise the entirety of masculinity. These include aspects such as stoicism, emotional restriction, being a provider, sexual promiscuity, violence, etc. Levant and colleagues (1992) described these norms as restricting emotions, avoiding femininity, focusing on aggression and toughness, self-reliance, making achievement a top priority, non-relational, objectifying sex, and homophobic. These are some of the ways that masculine norms have been described in the past. More recently, Mahalik and colleagues (2003) describe a wider range of masculine norms that include winning, emotional control, primacy of work, risk-taking, violence, heterosexual self-presentation, playboy, self-reliance, and power over women.

The level of masculinity in a man depends on his level of conformity to these norms. If a man conforms closely to masculine norms then he is considered masculine. Those who endorse these norms are likely to conform to them, depending on the situation (Mahalik et al., 2003). Traditional masculinity is the embodiment of a combination of masculine norms, in which multiple norms make up traditional masculinity. A common masculine norm is being powerful, having power, or being the best. Endorsement of this idea results in beliefs such as "I need to do

anything to win" and "I feel weak if I'm not in a position of power". Individuals vary to the degree in which they adopt and conform to these ideologies, and the struggle to conform to these norms can lead to poor mental and physical health outcomes (Levant et al., 2009).

**Masculine Health and Help-seeking**

A wealth of research has shown the negative effects of conforming to masculinity. Research by Syzdek and Addis (2010) found that level of conformity to masculine norms predicted depressive symptoms for three-month periods, beyond what was associated with attributional style and negative explanatory style commonly associated with depression symptomatology. Overall conformity to masculine norms has shown to be positively correlated with hostility (Mahalik et al., 2003), social dominance (Mahalik et al., 2003), aggression (Mahailik et al., 2003), and depression (Magovcevic & Addis, 2008; Rice, Fallon, & Bambling, 2011). In summary, research has shown that these are very damaging qualities to have, and this is only overall conformity to masculinity and not the individual dimensions of masculinity.

These individual dimensions are traditional masculine norms, or rules and standards that guide and constrain ones behavior. Research has shown that conformity to specific individual norms can have poor health effects also. Men who report having been in violent situations in the last 12 months show higher conformity to the norms of winning, risk-taking, violence, power over women, and playboy (Mahalik et al., 2003). Men who report having been in trouble with the law show higher conformity to the norms of risk-taking and violence (Mahalik et al., 2003). Tobacco using men report higher conformity to the norms of risk-taking and playboy, and men who report having drinking to the point of not being able to remember what they had done during drinking show higher conformity to risk-taking, violence, and playboy norms (Mahalik et

al., 2003). This research highlights the adverse health behaviors that stem from conformity to specific dimensions of masculinity.

Increased conformity to self-reliance, dominance, and violence were consistently positively correlated with aspects of psychological distress (Mahalik et al., 2003). Self-reliance was correlated with depression, hostility, obsessive-compulsive tendencies, phobic anxiety, and interpersonal sensitivity for all except somatization (Mahalik et al., 2003). Interestingly, masculine dimensions of emotional control, winning, playboy, power over women, disdain for homosexuals, primacy of work, pursuit of status, and risk-taking were not correlated overall with symptoms of psychological distress (Mahalik et al, 2003). This is counter to what Wong, Owen, and Shea (2012) found in their study of multiracial men. They found similar results of overall positive correlation with psychological distress for the dimension of self-reliance, but also found overall positive correlation with the dimensions of winning, playboy, power over women, primacy of work, and risk-taking (Wong, Owen, & Shea, 2012); which were not found by Mahalik and colleagues (2003). This discrepancy could be attributed to the difference in sample population. More research is necessary to pinpoint where the differences occur. What this research shows is that there are associations between overall masculinity and psychological distress, but it remains unclear which specific dimensions of masculinity are most important to our understanding of men's well being and increased psychological distress. Genders are also different in their help-seeking behaviors.

**Gender, Masculinity and Help-seeking**

Men show poorer outcomes in both physical and mental health outcomes than women and when these issues come to fruition, men and women are also different in seeking help for the problems. Men are consistently shown to seek help for problems much less than women. The

idea that men do not use services enough is a relatively new phenomenon. It was previously thought that the amount that men use services is the normative standard, and women overutilized services, which shifted the focus from men to women. These views of differences in help-seeking behavior between sexes made women appear as weak and always in need and men to appear as the stronger sex, turning a blind eye to the evidence that showed men need more help than they receive (Courtenay, 2000). Research shows that men make less contact with physicians than do women and are twice as likely to go two or more years without seeing a doctor (Mansfield, Addis, & Mahalik, 2003; NCHS, 2013). Along with this, research shows that men don't participate in routine checkups and preventative care as much as necessary to adequately prevent or hinder physical health problems (Andrews, Issakidis, & Carter, 2001; Galdas, Cheater, & Marshall, 2005; Wood & Eagly, 2002).

The pattern of decreased male help-seeking is shown specifically for psychological help-seeking as well. Women have been shown to be more likely to seek therapists for psychological health issues (Andrews, Issakidis, & Carter, 2001). Research has found that men show increased negative self-stigma (viewing own actions as undesirable) towards seeking psychological help (Hammer, Vogel, and Heimerdinger-Edwards, 2013; Vogel, Heimerdinger-Edwards, Hammer, and Hubbard, 2011). This is different from public stigma, which is when the public views behavior as socially undesirable. Self-stigma is the internalization of these public beliefs and can be exceptionally damaging when someone is already in need of counseling or is under psychological stress. It is also important to note that although male suicide is four times higher than women, male reported rates of depression are about one third lower than women (NCHS, 2013). This statistic is misleading however, as research has shown that men frequently underreport symptoms of depression. This in turn causes male rates of depression to be grossly

underestimated (Berger, Addis, Reilly, Syzdek, & Green, 2012). This highlights an interesting quality of male mental health. Though male suicide rate is much higher than women, their rate of reported depression is much lower. Men frequently and repeatedly underreport psychological problems.

This is due to perceived barriers toward seeking psychological help, which stem from conformity to masculine norms. These barriers include lack of awareness that there is a psychological problem, low psychological help-seeking propensity, and stigma towards seeking mental health services (Mackenzie, Knox, Gekoski, & Macaulay, 2004). Lack of awareness means that the person does not understand that they have a problem, or fails to acknowledge that there is a problem. Low help-seeking propensity means that the person does not want to commit the time or effort to seeking help for their problem. Stigma toward mental health services means they are concerned with how others will view them if they were to seek psychological help. These barriers are due to gender roles (Mackenzie et al., 2004).

Conforming to masculine norms can be detrimental to both psychological health and views toward seeking help for psychological issues if they arise. Limited research has been done on individual components of masculinity in relation to attitudes toward help-seeking. There are nine individual components of masculinity and include: 1) Emotional control, the degree to which respondents report controlling expression of their emotions, or limiting expression. 2) Winning, the desire to win or be the best. 3) Primacy of work, the extent to which men view work as a major focus in life. 4) Risk-taking, the extent to which men view risky behavior as desirable. 5) Violence is the view that aggressive action is necessary in some situations. 6) Heterosexual self-preservation, the desire for men to be viewed as heterosexual or straight. 7) Playboy, the desire for multiple noncommitted sexual relationships and emotional distance from

sexual partners. 8) Self-reliance, the preference to rely on oneself, and to not need help from others. 9) Power over women, perceived control over women at both personal and social levels (Mahalik et al., 2003; Mahalik, Good, & Englar-Carlson, 2003). These are purely dimensions of masculinity and do not define masculinity individually, but together make up traditional masculinity.

There are a few specific dimensions of masculinity that are often linked with general help-seeking attitudes and behavior. Graef, Tokar, & Kaut (2010) showed that men who reported higher levels of emotional control and self-reliance were more likely to show more negative attitudes towards career counseling, view services as less useful, and were less willing to seek them out. Wimer and Levant (2011) also found that emotional control was inversely related to seeking academic counseling, noting that seeking status was linked with more avoidance of seeking out help and other services as well. These studies both show that the dimensions of emotional control and to an extent, self-reliance, play large roles in the influence of help seeking in general.

In terms of psychological help-seeking, the only study to look at specific components of masculinity and attitudes toward psychological help seeking was a psychometric study by Mahalik and colleagues (2003). Consistent with other studies in general help-seeking, they found that overall scores were negatively correlated along with the dimensions of emotional control and self-reliance were significantly negatively correlated with attitudes toward seeking psychotherapy. Negative trends were shown for winning, power over women, disdain for homosexuals, and violence, but were not significant. The remaining dimensions were not reported (Mahalik et al., 2003). The significance of emotional control and self-reliance is consistent with related aspects such as emotional and psychological distress, however previous

research is limited as to which components of masculinity are related to overall attitudes toward psychological help seeking and nonexistent for individual attitudes toward psychological help-seeking, such as psychological openness, help seeking propensity, and stigma toward therapy. Research is therefore nonexistent on which specific components are predictors of psychological help seeking attitudes.

The current study seeks to replicate and extend previous results by examining associations between specific dimensions of masculine norms and attitudes toward psychological help-seeking. In accordance with previous research (Hammer et al., 2013; Levant et al., 2009; Mahalik et al. 2003; McKelley & Rochlen, 2010; Vogel et al., 2013), it is expected that overall conformity to masculine norms will show an inverse relationship with overall attitudes toward mental health services. The specific masculine dimensions of emotional control and self-reliance are also expected to show an inverse relationship with overall attitudes toward mental health services as previous research has shown (Mahalik et al., 2003). The current study will also examine associations between specific dimensions of masculinity and specific attitudes toward psychological help-seeking, paying particular attention to psychological openness, help-seeking propensity, and indifference to stigma. From these results, the specific components of masculinity that best predict attitudes toward psychological help-seeking will be examined.

## Method

### Participants

A total of 385 men between the ages of 18 and 25 ($M$ = 20.80, $SD$ = 2.06) participated in the online survey through SurveyMonkey. The participants were predominantly White, Non-Hispanic ($n$ = 284, 73.80%), heterosexual ($n$ = 353, 91.90%), and currently enrolled in a four-year university ($n$ = 268, 69.60%). For complete participant characteristics, see Table 1.

## Procedure

After attaining IRB approval, male participants were recruited by student online listserves, professors forwarding the survey to their students, social networking sites such as Facebook, and word of mouth. Participants who met the criteria were encouraged to visit the link and complete truthfully without any distractions. The survey was constructed using a pre-existing survey site (surveymonkey.com). Only the researchers had access to the password-protected site. The first through fourth pages consisted of informed consent and questions that confirmed that the participant was male and between the ages of 18 and 25. Demographic information was asked first, followed by the online survey that contained the measures. The survey took between 10 to 20 minutes to complete. Once finished with the survey, participants had the option of printing out a certificate of completion to obtain credit for classes and were also given the option to enter their information into a separate, unlinked survey that entered them into a raffle for one of three $50 gift cards.

## Measures

**Demographics.** Demographics consisted of measures that assessed race, sexual orientation, age, student information, current place of residence, region of origin, family socioeconomic status, academic performance, GPA, athlete status, and semesters enrolled in school.

**Masculinity.** This was assessed using the Conformity to Masculine Norms Inventory [CMNI] (Parent & Moradi, 2009; Mahalik et al., 2003). The shortened version of the original CMNI (Mahalik et al., 2003) includes 9 of the original 11 subscales and is a 46-item measure instead of the original 96. Items are rated on a four-point Likert scale from 0 = Strongly Disagree to 3 = Strongly Agree. The measure has shown acceptable reliability coefficients and validity for

total scale and subscales (Mahalik et al., 2003, Parent & Moradi, 2009; Parent & Moradi, 2011). Total and subscale scores are calculated by averaging responses to each variable. The Winning subscale measures drive and desire to win (6-items; sample item: "In general, I will do anything to win"). The Emotional Control subscale measures respondents emotional restriction and suppression (6-items; sample item: "I tend to keep my feelings to myself"). Primacy of Work measures the extent to which the participant views work as a major focus in their life (4-items; sample item: "My work is the most important part of my life"). Risk-taking measures the extent to which participant participate in risky behavior or take risks (5-items; sample item: "I frequently put myself in risky situations"). Violence measures the extent to which the participant views violence as an appropriate response or action in some situations (6-items; sample item: "Sometimes violent action is necessary"). Heterosexual self-presentation measures the extent to which participants are against being thought of as gay or homosexual (6-items; sample item: "I would feel uncomfortable if someone thought I was gay"). Playboy measures the participants desire to have multiple or noncommittal sexual relationships and emotional distance from sexual partners (4-items; sample item: "If I could, I would frequently change sexual partners"). Self-reliance measures the participant's desire to rely on himself, or aversion to asking for assistance (5-items; sample item: "I hate asking for help"). Power over Women assesses perceived control over women at both personal and social levels (4-items; sample item: "In general, I control the women in my life").

**Attitudes toward psychological help-seeking.** This item was assessed using the Inventory of Attitudes Toward Seeking Mental Health Services [IASMHS] (Mackenzie, Knox, Gekoski, & Macaulay, 2004). This measure is a 24-item measure rated on a five-point Likert scale from 0 = Strongly Disagree to 4 = Strongly Agree. The measure examines total attitudes

and three components of seeking professional psychological help. The measure has been revised to update language, allow for better ability to standardize results, and increased reliability and validity of the measure and its subscales. Total and subscale scores are calculated by adding together responses from each variable. Items that required reverse scoring were reverse scored. The measure has shown strong internal consistency (Mackenzie et al., 2004) and consists of 3 subscales. Psychological Openness assesses the extent to which individuals believe they are willing to acknowledge they have a problem (8-items; sample item: "People should work out their own problems; getting professional help should be a last resort"). Help-seeking Propensity assesses the extent to which individuals believe they are willing to seek help for a psychological problem (8-items; sample item: "If I were to experience psychological problems, I could get professional help if I wanted to"). Indifference to Stigma assesses the extent to which individuals are concerned with how others will view them if they sought therapy (8-items; sample item: "I would feel uneasy going to a professional because of what some people would think").

## Results

To view intercorrelations within each construct, pearson correlations were used to examine the relationships of the nine masculine norms subscales to each other and the total score are shown in Table 3. Results indicate that all of the subscale scores correlated significantly and positively to the total scores and that the subscales correlated in expected directions for both measures. The strength of relationship among the individual masculine norms with each other ranged from very low and nonsignificant to a high correlation between power over women and heterosexual self-presentation, $r(383) = .48$, $p = .000$. The strength of relationship among the individual attitudes toward psychological help-seeking with each other were all positively significant with a high between indifference to stigma and psychological openness $r(383) = .50$,

$p$ = .000. Indifference to stigma and help-seeking propensity $r(383)$ = .38, $p$ = .000 were positively correlated along with help-seeking propensity and psychological openness $r(383)$ = .45, $p$ = .000. Total attitudes toward seeking psychological help were strongly correlated with psychological openness $r(383)$ = .80, $p$ = .000, help-seeking propensity $r(383)$ = .76, $p$ = .000, and indifference to stigma $r(383)$ = .82, $p$ = .000 as was expected.

To examine bivariate correlations, pearson correlations were conducted to examine total masculinity and nine masculine norms subscales in relation to attitudes toward psychological help-seeking and its subscales. As the literature consistently shows traditional masculinity to relate negatively to total attitudes toward seeking psychological help (e.g., Levant et al., 2009; Mahalik et al., 2003; McKelley & Rochlen, 2010; Hammer et al., 2013; Vogel et al., 2011), all analyses were conducted at the one-tailed level. As hypothesized, the total masculinity score was significant in relation to total attitudes score, see Table 4. A limited amount of previous research has also shown that the masculine norms of emotional control and self-reliance are negatively related to total attitudes toward seeking psychological help (Mahalik et al., 2003). As hypothesized, both emotional control and self-reliance were significant in relation to total attitudes score. The masculine norms of winning, heterosexual self-presentation, playboy, and power over women were also significantly related with negative attitudes toward seeking psychological help, see Table 4. The only previous study to examine individual masculine norms in this way did not find significance for these, but did report trends. Thus our results were fairly consistent with previous research.

Pearson correlations that have previously been unresearched were further conducted between the remaining subscales for both measures. When examining the individual attitudes toward seeking psychotherapy, unique associations are found. For example, the norm of primacy

of work was significant for psychological openness and indifference to stigma, but not for help-seeking propensity. The same was found for heterosexual self-presentation also in relation to psychological openness and indifference to stigma but not for help-seeking propensity. Another interesting relationship was found for the norms of risk-taking and violence in relation to the attitude of psychological openness. Risk-taking was significantly related to psychological openness but not the other two attitudes of help-seeking propensity and indifference to stigma. The same was also found for violence in relation to psychological openness but not the other two attitudes. Complete correlational results between masculine norms and attitudes toward seeking psychological help are shown in Table 4.

## Discussion

Consistent with previous research, our results indicated that total masculinity was significantly negatively correlated with total attitudes toward psychological help seeking (Hammer et al., 2013; Levant et a., 2009; Mahalik et al., 2003; McKelley & Rochlen, 2010; Vogel et al., 2011). This is also consistent with a previous study that measured perceived barriers toward help-seeking. The study also found an inverse relationship between conformity to masculinity and perceived barriers toward help-seeking (Boman & Walker, 2012). There has been limited research on the relationship of individual masculine norms in relation to psychological help seeking. When creating the CMNI, Mahalik and colleagues (2003) examined the individual norms in relation to attitudes toward help-seeking and found significant negative relationships for the norms of emotional control and self-reliance. The same was found for our research.

The current study extends previous research in two ways. First, the study that examined individual norms in terms of attitudes toward psychological help-seeking reported non-

significant trends for the norms of winning, power over women, heterosexual self-presentation, and violence (Mahalik et al., 2003). Our results indicated significance for all of these norms except for the norm of violence and included the norm of playboy. Thus, our results were fairly consistent with the previous study that measured masculine norms in relation to attitudes toward psychological help-seeking, however ours reported significance whereas their results only approached significance. Our results also extended previous research by examining individual masculine norms in relation to differing attitudes toward help-seeking, such as psychological openness, or how open the person is to admitting a psychological problem; help-seeking propensity, or the likelihood of the person seeking professional help for a psychological problem if one were to arise; and indifference to stigma, or how concerned with others opinions the person would be if they sought professional help for a psychological problem. Our results showed significant negative relationships between all masculine norms except playboy for the attitude of psychological openness. This means that men who conform highly to any one of the individual masculine norms, except playboy, were more likely to be opposed to admitting a psychological problem of any kind. This attitude had more significant relationships with the individual masculine norms than any other attitude, and may be attributed to the pattern of admitting a problem being the first and possibly toughest step of making the problem right (Addis & Mahalik, 2003; Mansfield, Addis, & Mahilik, 2003). Another interesting finding is the significant negative results for the norms of primacy of work and heterosexual self-presentation for the attitudes of psychological openness and indifference to stigma, but not for help-seeking propensity. It is unclear what these findings represent, as no previous studies have focused on these individual norms in this aspect.

Our research may have been limited in that we conducted correlations. Correlational research does not necessarily imply causation, but merely examines similar score patterns between variables. Another possible limitation of the study was the lack of a social desirability measure. A social desirability measure assesses if respondents answer questions completely truthfully, or if they answer in a way that would be viewed more favorably by others. As one was not included in our survey, we assume that all answers are truthful, though answers may be underreported.

Further research should examine the differences between different subgroups of men such as race/ethnicity, old and young, sexual orientation, etc. Research has examined overall masculinity for community size, education, income, race, and sexual orientation in relation to attitudes toward help-seeking and found negative significance for all variables except gay and Asian-American men (Hammer et al., 2013; Vogel et al., 2011). These results should further be assessed in relation to the individual masculine norms, instead of just focusing on total masculinity. It is also necessary to examine which masculine norms are most predictive of attitudes toward help-seeking. Using this research as reference, regressions could examine which masculine norms most closely predict attitudes toward seeking professional psychological help. This would provide crucial information that correlations cannot provide, such as which norms should be most targeted when creating programs aimed at men.

This research also has strong implications for the clinical field. Addis and Mahalik (2003) examine the different contexts that may or may not facilitate help-seeking for men. They suggest that the contexts include perceptions of normativeness of problems, perceived ego-centrality of problems, characteristics of potential helpers, characteristics of the social groups of which men belong, and perceived loss of control. Normativeness of problems refers to the perceived sharing

the experience with others. Normativeness is communicated through masculine norms that are shown in typical male society. Norms such as emotional control and self-reliance suggest that men should not have problems, and when they do they are not normal. The authors state that when these problems become more normalized, the likelihood that other men with the same problems will understand them as normal will also increased (Addis & Mahalik, 2003). This shows that it is important for clinicians to target the problems themselves or the masculine norms that hold strict ideas of normativity (such as emotional control and self-reliance), in doing so changing recruitment strategy so that men with potential problems become more accepting of them and thus potentially becoming more likely to admit their own problems. Ego-centrality is something that reflects a central part of them. This is related to group association, such as being intelligent, hard-working, or a father (Addis & Mahalik, 2003). Masculine norms that may be representative of the quality of ego-centrism are heterosexual self-presentation, primacy of work, playboy, etc. It is critical to target these norms so that they don't detract from the person's sense of self or self-esteem, thus increasing their chances of admitting or receiving help for a psychological problem independent of their sense of self. Others perceptions and perceived loss of control are other factors that contribute to negative attitudes toward help-seeking, as suggested by Addis & Mahalik (2003). It can be argued that all masculine norms suggest a desire for control and power over oneself and their surroundings, which are compromised if a problem is admitted. The person is perceived by others as losing power or control over oneself, which in turn promotes risk-taking behavior and reduced help-seeking to restore the lost power and opinions of others (Addis & Mahalik, 2003). Thus clinicians should aim to change the most closely related masculine norms with attitudes toward seeking professional psychological help, such as the ones provided in this research, so that men will be more likely to admit problems,

thus increasing the willingness to admit a problem, likelihood of seeking help, and decreasing rate of attrition.

In conclusion, clinicians can use these results to change advertising or recruitment strategies based on the specific masculine norms that men adhere to, thus increasing the likelihood that men would want to go to the therapy. The therapy itself can be adjusted to better fit the differing masculine norms. This would help men stay in therapy for longer amounts of time, thus lowering the rate of attrition. Also this information could be used to change the stigma that surrounds psychotherapy by targeting the men that are most influenced by it.

Table 1.

Participant Characteristics

| Variables | *N* | % |
|---|---|---|
| Race/Ethnicity | | |
| White, Non-Hispanic | 284 | 73.80 |
| African-American/Black | 3 | 0.80 |
| Native American/Alaska Native | 13 | 3.40 |
| Asian | 35 | 9.10 |
| Native Hawaiian/Other Pacific Islander | 2 | 0.50 |
| Hispanic/Latino | 24 | 6.20 |
| Two or more races | 24 | 6.20 |
| Sexual Orientation | | |
| Heterosexual | 353 | 91.90 |
| Gay | 11 | 2.90 |
| Bisexual | 20 | 5.20 |
| College Education Status | | |
| Enrolled in a 4-year university/college | 268 | 69.60 |
| Enrolled in a 2-year university/college | 18 | 4.70 |
| Enrolled in Graduate level studies at university | 36 | 9.40 |
| Not enrolled and no completed degree | 28 | 7.30 |
| Not enrolled but have completed degree | 35 | 9.10 |
| First person in family to attend university/college | | |
| Yes | 61 | 15.80 |
| No | 296 | 76.90 |

Table 2.

Descriptives for Components of Masculinity and Attitudes Toward Seeking Psychotherapy

| | Items | α |
|---|---|---|
| Masculinity Total | 46 | .86 |
| Emotional Control | 6 | .91 |
| Winning | 6 | .87 |
| Primacy of Work | 4 | .78 |
| Risk-taking | 5 | .85 |
| Violence | 6 | .83 |
| Heterosexual Self-presentation | 6 | .89 |
| Playboy | 4 | .81 |
| Self-reliance | 5 | .86 |
| Power over Women | 4 | .84 |
| Attitudes Toward Psychotherapy Total | 24 | .86 |
| Psychological Openness | 8 | .67 |
| Help-seeking Propensity | 8 | .79 |
| Indifference to Stigma | 8 | .83 |

*Note.* Sample sizes range from 382-384 participants.

Table 3.

Intercorrelations of Masculine Norms

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Masculinity Total | - | | | | | | | | | |
| 2 | Emotional Control | .48 * | - | | | | | | | | |
| 3 | Winning | .63 * | .07 | - | | | | | | | |
| 4 | Primacy of Work | .26 * | .08 | .07 | - | | | | | | |
| 5 | Risk-taking | .28 * | -.16 * | .15 * | .01 | - | | | | | |
| 6 | Violence | .56 * | .10 * | .39 * | .01 | .09 * | - | | | | |
| 7 | Heterosexual Self-presentation | .60 * | .20 * | .32 * | .11 * | .02 | .21 * | - | | | |
| 8 | Playboy | .36 * | .04 | .17 * | -.03 | .20 * | .19 * | -.08 | - | | |
| 9 | Self-reliance | .40 * | .36 * | .16 * | -.05 | -.09 * | .09 * | .05 | .03 | - | |
| 10 | Power over Women | .66 * | .20 * | .29 * | .18 * | .15 * | .23 * | .48 * | .21 * | .19 * | - |

*Note.* * $p < .05$.

Table 4

Associations between Masculinity and Attitudes toward Seeking Psychotherapy

| | Attitudes Toward Psychotherapy Total | Psychological Openness | Help-seeking Propensity | Indifference to Stigma |
|---|---|---|---|---|
| Masculinity Total | -.41 ** | -.44 ** | -.21 ** | -.33 ** |
| Emotional Control | -.38 ** | -.35 ** | -.24 ** | -.31 ** |
| Winning | -.21 ** | -.20 ** | -.14 ** | -.16 ** |
| Primacy of Work | -.07 | -.13 ** | .04 | -.09 * |
| Risk-taking | -.02 | -.09 * | -.02 | .05 |
| Violence | -.08 | -.15 ** | -.07 | .00 |
| Heterosexual Self-presentation | -.27 ** | -.32 ** | -.07 | -.24 ** |
| Playboy | -.09 * | .08 | -.03 | -.09 * |
| Self-reliance | -.25 ** | -.19 ** | -.17 ** | -.23 ** |
| Power over women | -.33 ** | -.34 ** | -.15 ** | -.31 ** |

*Note. * p < .05. ** p <.01.*

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