

**Barriers to Help-Seeking in Men for Mental Health Issues: The Impact of Gender  
Role Socialization and Masculinity Ideologies**

Leanne J. Frederick

Master of Counselling, City University of Canada

Dr. Heather Macdonald

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### **Abstract**

According to the World Health Organization (2017), depression is a significant contributor to suicides globally and that men lead in the number of suicides. However, there is a discrepancy between the extent of men diagnosed with depression and their rates of suicide. Diagnosis of depression is higher in females than males; however, men die by suicide by twice the rate as women. Men are also less likely to seek professional or social help for mental health issues, and the literature has shown that adherence to traditional masculine ideologies and social norms are a barrier to help-seeking in men for mental health issues. This research project examines the current literature on the impact that socialized masculine norms and masculinity have as a barrier to help-seeking in men. The findings indicate that adherence to masculine social norms does impose barriers to help-seeking in men for mental health issues. The main barriers are masculine gender ideologies, gender role conflict, stigma, mental health literacy, maladaptive coping strategies, and men's lack of confidence in the health system. Conclusions made from the literature are that these barriers are diverse and multi-faceted within each individual. It is too simplistic to assume that they produce all resistant help-seeking behaviours and mental health issues equally for all men. More research on the impact of gender socialization and help-seeking using men from different races, ethnicity, sexual orientation, age, social status, and levels of education will provide a greater understanding of how to navigate the barriers.

*Keywords:* masculine gender norms, masculine ideology, help-seeking, barriers, depression, suicide

## **Barriers to Help-Seeking in Men for Mental Health Issues: The Impact of Gender Role Socialization and Masculinity Ideologies**

Literature has consistently acknowledged that, compared to women, men are less likely to seek help for health-related issues in many countries; this is especially prevalent for mental health issues (Addis & Mahalik, 2003; Courtenay, 2000; Good & Wood, 1995; Mansfield et al., 2008; Robertson & Fitzgerald, 1992; Salgado et al., 2019; Seidler et al., 2016; Thompson et al., 2016; Yousaf et al., 2015). There is a connection between adherence to traditional male gender roles and low rates of help-seeking in men, as well as with men's mental health problems including anxiety, depression, stress, and suicide (Ellis, 2018; Heath et al., 2017; Good, et al., 1989; Kaya et al., 2018; O'Neil, 2008; Seidler et al., 2018; Wong et al., 2017; Yousef et al., 2015). Men's endorsement of dominant masculine ideologies is a barrier influencing their help-seeking behaviour (Addis & Hoffman, 2017; Good, et al., 1989; Ellis, 2018; Kaya et al., 2018; O'Neil, 2008; Wong et al., 2017; Yousef et al., 2015). Help-seeking is an integral step toward preventing severe illness and poor health among the male population (Call & Shafer, 2018; Shafer & Wendt, 2015).

The World Health Organization (WHO) (2017) estimates the global number of people with diagnosed depression is about 300 million and that depression is a significant contributor to close to 800 000 suicide deaths per year; globally, the statistics of male suicides dominate. There is a discrepancy between men diagnosed with depression and their rates of suicide. Diagnosis of depression in females is at a higher rate (5.1%) than males (3.6%); however, statistics show that men are twice as likely to die by suicide as women (Creighton et al., 2017; Ritchie et al., 2015; WHO, 2017).

Men are taught at a young age that to seek help is not masculine and that depression is a feminine problem (Ellis, 2018; Shafer & Wendt, 2015; Cole & Davidson, 2019). Not taking into consideration the unique issues and presentation in men's mental health issues, especially depression, may contribute to the under-diagnosis of problems and the underutilization of health care providers by men (Cole & Ingram, 2019; Shafer & Wendt, 2015; Wahto & Swift, 2016). There is a lack of research to explain why adherence to masculine norms has had such an adverse effect on men's help-seeking attitudes (O'Neil, 2016; Mckenzie et al., 2018; Thompson et al., 2016; Wong et al., 2016).

This research project illustrates the current literature concerning masculine ideologies and gender role socialization among men and how it impacts help-seeking attitudes concerning mental health issues. It will show how adherence to masculine social norms imposes barriers to help-seeking behaviour in men experiencing depression, which contributes to men underutilizing professional or social support for mental health issues. The focus will be on understanding why men continue to adhere to societal masculine gender roles, which have negative consequences on their mental health and well being. Further to that, how to address the implicit barriers to help-seeking in order for men to be less reluctant in seeking professional help for mental health issues.

Research focusing on men and masculinity only originated after the women's liberation and gay liberation movements in the 1970s when there was "social critique of masculinities" (Connell, 2014, p. 7). The early 1980s was when researchers began to recognize that men also suffered from restrictive gender role socialization and sexism in their life (O'Neil, 1981). Early studies relied on a sex-difference approach that uses a framework of men vs. women, which not only normalizes men's socialized behaviour, but it also supports stereotypes (Rivers, 2018; Wenger, 2011). This binary approach uses an essentialist understanding of gender, which posits

that men and women are fundamentally different for reasons they cannot change (Addis & Mahalik, 2003; Connell, 1995; Connell, 2014). The problem with this approach is that it ignores the significant impact that gender role socialization has on men's help-seeking behaviour (Addis & Mahalik, 2003; Addis et al., 2016; Connell, 1995).

Unfortunately, most literature on masculine social norms and help-seeking in men stems from patriarchal models of male socialization in the Western world. Much of the documented empirical research has utilized male participants who are white, heterosexual, from Western industrialized countries; predominantly North American, and live in urban environments (Cole & Davidson, 2019; Cole & Ingram, 2019; Guvensel et al., 2018; Kaya et al., 2018; Pederson & Vogel, 2007; Salgado et al., 2019; Wahto & Swift, 2016; Wong et al., 2017). With the increased interest in men and masculinity studies, there will hopefully be newer studies with more diverse populations participating.

This paper will begin with a self-positioning statement on what led me to this research project, as well as any potential biases that I may bring to the project and how I will bracket these biases. A literature review will describe the basis of gender role socialization and masculinity, followed by outlining the research findings on prevalent help-seeking barriers that impede men from utilizing professional or social support for mental health issues. These barriers include masculine gender ideology and gender role conflict, stigma, literacy, maladaptive coping strategies, and men's lack of confidence in the health system.

Following the literature review, this paper will proceed with the implications the research findings have for counselling psychology. Next, an evaluation of what was missing in the research will be in the fundamental next steps section, and then recommendations for practice

based on the research will be identified. Concluding the paper will be a reflexive statement on how the findings in the research have influenced me, followed by an encompassing conclusion.

### **Self-Positioning Statement**

The personal journey that led me to do this research project originated from my brother's suicide. I wanted to gain knowledge from existing research regarding men's societal norms and expectations, and build an understanding of how they negatively affect their health, well being, and, as in my brother's life, are a barrier to seeking help leading to tragic consequences.

My brother's suicide blindsided me, "why" was all I kept repeating. The week proceeding my brother's death, I learned through the letter he left that my sibling had suffered from depression and anxiety since adolescence - he was 54 years old when he died. He never felt he could live up to the expectations of his parents as a son, as a brother to his three sisters, as a husband to his wife, or a father to his children. He was frustrated, angry, and anxious, but also embarrassed, lonely, and sad.

I had no idea that my brother suffered so much all his life. He was six years older and wiser than me, and I never questioned: why he was quiet and stayed in his bedroom while his sisters, and all the neighbourhood kids, were outside playing; why he was so quick to get angry; why he did not have many friends; or why he could not keep a job. As a young child, my siblings and I learned not to challenge our family's status quo. The implicit rule was that we do not have problems, and we do not quarrel; everyone must get along. We learned not to question anything or anyone.

It is heartbreaking that my brother felt alone in his anger, frustration, loneliness, anxiousness, embarrassment, and the feeling of letting people down. If only I could have shared that, I too felt all of that. If only he had asked me, or if only I had asked him. We were, however,

raised in a family that did not show emotion - especially my dad or brother. The men were to behave like "men": stoic, strong, in control, and unemotional just as the men before them were, and those before them. This generational influence of what a man is supposed to be, maintained through the expectations laid down by paternal and maternal farmers and ranchers, was formidable. The consequences of these restrictive male social norms, which became the expected familial norms, were tragic for my family. After gaining knowledge from the literature on this subject, I understand that we are not alone (Hackler et al., 2016; Mackenzie et al., 2019; Oliffe et al., 2016).

As a young girl and into adulthood, I grew up blindly following the socialized female gender roles expected of me; my siblings were no different in their gender socialization. It took this personal tragedy to realize how I was passively accepting these socially imposed gender stereotypes and was living in a bubble of ignorance and self-absorption.

My heritage includes a long line of male farmers and ranchers who lived the strong, stoic, self-reliant, emotionless, and masculine role expected. My brother's death generated many conversations within my extended family. Previously unspoken and silenced stories regarding generations of men in the family and their mental health struggles with masculinity and societal expectations were abundant. Suffering in silence was commonplace. Not only was there stigma within the family unit but also community-wide. Living in a very rural farm in Saskatchewan, there were very few people (if any) to discuss these problems, and there were even fewer health care services accessible.

### **Bias**

Going into this project, I am predisposed to bringing in my biases; if I were not passionate about the subject, I would not be putting my authentic self into the project. Through

my lived experience, I have seen firsthand what some of the literature posits regarding men and how gender socialization can harm men's mental health and wellbeing. Their inability or reluctance and lack of permission to seek help for mental health issues can cause harm. I have seen, through generations of men in my life, the physical and mental harm that adhering to male stereotypes can cause.

By gaining knowledge through this research, I will be able to transfer my new knowledge into both my personal and professional domains. Understanding the barriers that men have toward seeking help will allow me to provide counselling that will challenge the norm to best suit their unique issues. I would ideally want for society as a whole to change in a way that enables men to show weakness and vulnerability without the fear of stigma and questioning their masculinity.

As stated in this self-positioning section, I have a personal interest in the subject matter of this project. I will, however, be able to bracket myself so that the content will focus on the literature that is presented and not on my personal experiences. I intend to set aside any perceived thoughts or bias I have, to the best of my ability, so as not to influence what and how I present the research.

### **Review of Literature**

Literature has consistently acknowledged that, compared to women, men are less likely to seek help for health-related issues in many countries and this is especially prevalent for mental health issues (Addis & Mahalik, 2003; Courtenay, 2000; Good & Wood, 1995; Mansfield et al. 2008; Robertson & Fitzgerald, 1992; Salgado et al., 2019; Thompson et al., 2016; Yousaf et al., 2015). Further to that, men who live in rural settings are even less likely to access mental health providers than their urban male counterparts (Creighton et al., 2017; Roy et al., 2019). There is,

however, a gap in the research to explain how to support them in seeking help (O'Neil, 2016; Shafer & Wendt, 2015; Thompson et al., 2016; Wong et al., 2016).

Adherence to socialized male gender roles can be associated with men's mental health problems including anxiety, depression, stress, and suicide and why they are hesitant to seek help (Good, et al., 1989; Ellis, 2018; Kaya et al., 2018; O'Neil, 2008; Wong et al., 2017; Yousef et al., 2015). Globally the WHO (2017) estimates that the number of people with diagnosed depression is about 300 million, and the diagnosis of depression in females is 1.5% higher than males. Depression occurs at any age but is most prevalent, 7.5% in females and males, 5.5%, aged 55-74 years (WHO, 2017). The WHO further states that depression is a significant contributor to the 800 000 suicide deaths per year. There is a disconnect, however, in that statistics show men are twice as likely to die by suicide as women even though the diagnosis of depression in men is at a lower rate (Creighton et al., 2017; Ritchie et al., 2015; WHO, 2017). In some Eastern European countries, male suicide rates could be as high as six or seven times that of females (Ritchie et al., 2015).

### **Basis of Gender Role Socialization and Masculinity**

Gender is socially constructed based on social relations and culture, as opposed to sex, which is a biological concept. Gender refers to the socially prescribed beliefs, perceptions, behaviours, interests, and expectations of what one's society accepts as typical of either men or women (Courtenay, 2000; Evans et al., 2011; Franklin, 1984). Socially dominant groups shape these gender norms, and society encourages individuals, from a young age, to conform to these stereotypical gender roles; this gender role socialization enforces the dominant gender norms of femininity and masculinity (Courtenay, 2000; Guvensel et al., 2018; O'Neil, 1981). In Western cultures, the male gender norms that are endorsed are being assertive, competent, dominant,

strong, and rational (Levant & Richmond, 2016; Valkonen & Hanninen, 2012; Wellman & McCoy, 2014).

Masculinity is a social structure based on cultural and specific historical time frames, which means that its subjective meanings are continually changing depending on the time and place which can also create different paradigms of masculinity (Connell, 1995; Connell & Messerschmidt, 2005; Evans et al., 2011). Masculinity is a social construction of the various expressions of men's gender roles, and these expressions influence how individuals think, feel, and behave and are associated with being male and masculine (Salgado et al., 2019; Scott-Samuel et al., 2015; Thompson Jr. & Bennett, 2015). In Western cultures, expected masculine attributes include avoidance of engaging in any socially constructed feminine behaviour or emotions, being self-reliant, stoic, heterosexual, competitive, dominant, aggressive, and strong (Browning et al., 2019; Levant & Richmond, 2016).

Masculinity is an individual's displayed social behaviours in different societal contexts, not their character traits, for example (Patrick & Robertson, 2016). An individual, depending on the social circumstances, will behave in ways that will minimize marginalization (Cleary, 2012; Vogel & Heath, 2016). Not all men adhere firmly to these masculine social norms; however, most men have been influenced by them and have had to navigate them since childhood (Silver et al., 2018; Wirback et al., 2018).

Connell (1995), in her studies on masculinities, used the term hegemonic masculinity to describe men, gender, and social hierarchy. Connell describes hegemonic masculinity ideology as the currently accepted cultural and gendered practice that ensures male dominance, which includes the subordination and marginalization of women, and other groups of men from different races and cultures, socioeconomic status, and sexual orientation. Put another way,

hegemonic masculinity is the most widely believed ideal of what being a man is, and it maintains the dominant patriarchal ideology (Connell, 1995; Connell & Messerschmidt, 2005).

A moment in time, place, culture, social group, or subgroup determines these masculinities, and they are subject to change and replaced by newer forms (Connell, 1995; Connell & Messerschmidt, 2005; Silver et al., 2018; Thompson & Bennett, 2015). In Western nations, the revered hegemonic masculinity states that men be self-reliant, problem-free, strong, brave, and emotionless (Call & Shafer, 2018; Shafer & Wendt, 2015). Most men, however, do not succeed at reaching a notable level of hegemonic masculinity; they take an active role in trying to emulate some aspects but fall short of the idolized stereotype (Hiebert et al., 2018; Patrick & Robertson, 2016).

Similar to hegemonic masculinity, the basis of traditional masculinity ideology is the patriarchal society present at the beginning of the twentieth century. It is the dominant view of Western culture (predominantly North American), Caucasian, heterosexual masculine ideologies of gender-based power and is expressed by male gender norms such as: being stoic; not showing weakness; not being vulnerable; suppressing certain feelings and emotions; and, not being feminine, weak, soft, or sensitive (Addis & Mahalik, 2003; Franklin, 1984; Levant et al., 2015; Vogel & Heath, 2016). Proper, expected gender behaviours include remaining strong, acting rationally, being logical, maintaining control, and acting responsibly (Addis & Mahalik, 2003; Patrick & Robertson, 2016; Vogel & Heath, 2016).

As mentioned, most research done on men and masculinities include individuals who live in urban environments. There is a form of rural masculinity referred to as monologic masculinity, a model developed by Peter et al. (2000). This ideology encompasses traditional men living in rural settings in agriculture: farming and ranching and resource-based communities: forestry, oil

and gas, and mining (Coen et al., 2013; Coldwell, 2007; Creighton et al., 2017; Hiebert et al., 2018; Roy et al., 2019). Monologic masculinity has its basis on traditional and hegemonic masculinity, and maintains specific confines of what a man should be encompassing ideals of being: tough, rugged, proud, resilient, self-reliant, stoic, competitive, successful, and appeal to risk (Caldwell, 2017; Creighton et al., 2017; Roy et al., 2019)).

Similar to other gender socialized masculine ideologies, men in rural communities who are primarily influenced by the occupations mentioned above and adhere firmly to monologic norms, perceive mental health issues and seeking help as being weak or feminine (Creighton et al., 2017; Roy et al., 2019).

### **Barriers to Help-Seeking**

For the intentions of this project, help-seeking refers to disclosing a health problem to a general practitioner, or health worker, and seeking treatment, or reaching out to familial or social supports. The gender-role socialization approach for understanding men's help-seeking originates with the belief that men learn gendered norms about what it means to be a man from cultural beliefs and ideologies (Addis & Mahalik, 2003; Addis & Hoffman, 2017). As stated previously, men are taught from a young age the importance of self-reliance, not showing weakness or vulnerability, avoiding femininity, and having emotional control. However, seeking help from a health professional conflicts with these expectations which can create a barrier making it challenging for men to seek help when they are suffering (Addis & Hoffman, 2017; Good et al., 1989; Kaya et al., 2019; Salgado et al., 2019; Wong et al., 2017). Society may label, judge, and reject men who do not adhere to the social norms required of them (Latalova et al., 2014; Rasmussen et al., 2018)

### *Masculine Gender Ideology*

Gender role socialization and the adherence men have to masculine ideologies is a chronic barrier to men seeking help for their mental health problems (Connell and Messerschmidt, 2005; Courtenay, 2000; Ellis, 2018; Heath et al., 2017; Good, et al., 1989; Kaya et al., 2019; O'Neil, 2008; Seidler et al., 2016; Wahto & Swift, 2016; Wong et al., 2017; Yousef et al., 2015). Research has found that conforming to masculine ideologies impact men with depression through the type and expression of symptoms and their attitudes and behaviours toward help-seeking (Addis, 2008; Call & Shafer, 2018; Genuchi & Mitsunaga, 2015; Genuchi & Valdez, 2015; McCreary et al., 2019; Rochlen et al., 2010; Seidler et al., 2016; Shafer & Wendt, 2015). Men who grew up with firmly imposed traditional masculine ideologies and strict gender role socialization might have experienced traumatic consequences (Guvensel et al., 2018). These consequences would include bullying, rejection from significant male figures, and physical injury if they did not live up to the standards impacting their mental health (Cleary, 2012; Guvensel et al., 2018; Rasmussen et al., 2018).

Rochlen et al. (2010) found that men who adopt traditional and restrictive masculinity norms perceive the experience of depression differently than men who do not adhere firmly to masculine ideologies. Men may feel that depression is a normative male trait, as they perceive happiness is a feminine feeling, and do not need to address the symptoms (Shafer & Wendt, 2015). Men are taught from a young age to avoid taking part in anything that is feminine behaviour or emotions and, in turn, behave accordingly (Browning et al., 2019; Levant & Richmond, 2016). A study by Hudson et al. (2018) on depression and help-seeking in African American black men also found that awareness of depressive symptoms inhibited seeking help.

In turn, their depression goes undiagnosed. Seehuus et al. (2019) found that men significantly do not seek help concerning their higher levels of symptomology.

Research by McCreary et al. (2019) involving Canadian men, support this in that 20% of the men in the study met the criteria to be diagnosed with depression; however, Statistics Canada (2015) reported a diagnosis of depression in only 6.0% of men. Globally, the proportion of the population with depression is 4.4%; females account for 5.1%, and men account for 3.6% (WHO, 2015). Further to this, across age ranges of 15 – 80+ years of age, females consistently have higher depression percentages than men. In contrast, the suicide rate in men, across most countries in the world, is 2 to 4 times higher (Ritchie et al., 2015).

Studies have shown that men who conform to traditional masculine gender norms may present with atypical symptoms of depression, and their distress can go undetected (Call & Shafer, 2018; Creighton et al., 2017; Genuchi & Mitsunaga, 2015; Seidler et al., 2016). Creighton et al. (2017) go further to say that the lower recorded diagnosis of men with depression may be due to the general use of diagnostic criteria that are not sensitive to how depression presents in men. The *Diagnostic and Statistical Manual of Mental Disorders 5<sup>th</sup> Edition* (DSM-5) (2013), uses more internal symptoms for a diagnosis of major depressive disorder: feeling sad, empty, hopeless; diminished interest or pleasure in activities; significant weight loss or gain; insomnia; fatigue; agitation; loss of concentration; and suicidal ideation. For a diagnosis to be made the presence of five or more of these symptoms during a consecutive two-week period and must include “depressed mood or anhedonia, cause significant distress, and not be caused by substance use or another medical condition” (Nussbaum, 2013, p. 42)

The typical male symptoms for depression are more externalizing symptoms: irritability, anger; antisocial behaviour; social withdrawal; drinking; and somatic symptoms (Addis &

Hoffman, 2017; Genuchi & Mitsunaga, 2015; Shafer & Wendt, 2015). Genuchi and Valdez (2015) found that men who follow traditional norms and present with externalizing symptoms are also at an increased risk for depression, Call and Shafer (2018) go further to say that they are also among the least likely to seek help for depression.

As indicated previously, depression is a significant contributor to suicide, but there is a discrepancy in that women are diagnosed with depression more often than men; however, men die by suicide at twice the rate of women (WHO, 2017; Ritchie et al., 2015). In their research examining this disconnect, Genuchi and Mitsunaga (2015) found that both men and women supported similar levels of internalizing symptoms, but men exhibited more external symptoms than women. Further to their research, when they included external symptoms, along with the standard assessment for depression, the sex differences of diagnosis disappeared. In other words, there was no longer a discrepancy between men and women in meeting the diagnostic criteria for depressive disorder. Lee et al. (2017) supported the presentation of these external symptoms for depression in gay men, as well.

In contrast to the correlation of depression to suicide, research by Rasmussen et al. (2018) on barriers to help-seeking among young men in Norway before suicide, found there was no causal link to depression or other mental illnesses and suicide. These findings support Shneidman's (1996) central theory on suicidal behaviours, which posits that even if depression is present in an individual, it is not inherently the cause of suicide. Depression is an influential predictor of suicide behaviours and suicide, but there is not a direct cause and effect relationship (Creighton et al., 2017; Gunnell, 2015). Gunnell (2015) states that "suicide is a fatal outcome of a behaviour," which is influenced by the susceptibility of an individual's risk factors, including mental illness, social pressures, and their ability to seek help (p. 155).

Suicidal behaviour occurs in vulnerable individuals in the context of a range of different mental illnesses and social stresses, which are influenced by help-seeking behaviours and cultural attitudes (Creighton et al., 2017; Gunnell, 2015; Rasmussen et al., 2018). The principal barrier in the study by Rasmussen et al. (2018) was the perceived failure of being unable to live up to the standards and expectations of prominent male figures in their life, and there was a "lack of room for weakness" (p.101). Cleary's (2012) research on Irish young men who attempted suicide found that adherence to hegemonic masculine norms inhibited their ability to reveal their pain as it was considered feminine and, therefore, harmful. These studies reinforce the importance of acknowledging the unique barriers that hinder men from seeking help and their overall wellbeing (Cleary, 2012; Cole & Ingram, 2019; Genuchi and Mitsunaga, 2015; Lee et al., 2017; Rasmussen et al., 2018; River, 2018; Shafer & Wendt, 2015).

Another barrier to help-seeking in men is Gender Role Conflict (GRC). GRC is when men internalize masculine ideological beliefs and socialized traditional gender roles that need them to be strong, stoic, self-reliant, and emotionally in control (O'Neil, 1981). GRC limits an individual to express behaviours and be themselves freely or makes them feel negatively judged if they do (Cole & Ingram, 2019; O'Neil, 1981). Research has shown that the more an individual adheres to traditional masculine ideologies, the higher their experience of GRC, which in turn, results in more negative help-seeking attitudes (Cole & Ingram, 2019; Coleman, 2015; Good et al., 1989; Wahto & Swift, 2016).

The basis of O'Neil's (1981) model of GRC is the conflict men have in fear of appearing feminine. There are four patterns of conflict O'Neil's (1981) GRC model: success, power, and competition; restrictive emotionality; restrictive affectionate behaviour between men; and conflict between work and family relations. Men can experience both subordination and

marginalization if they deviate from these expected societal norms, which can become a barrier for seeking help (Anderson, 2018; Cole & Ingram, 2019; Evans et al., 2011). In a study by Coen et al. (2013) on rural men living with depression in Northwestern Canada, they found that if men did not comply with the traditional masculine gender constructs of concealing their depression, they would be marginalized and considered subordinate.

Research has found that in young adult men, traditional attitudes toward masculine norms and GRC influence their health behaviours, wellbeing, and are a significant barrier to psychological help-seeking (Cole & Ingram, 2019; Good et al., 1989; Good & Wood, 1995; Guvensel et al., 2019; Kaya et al., 2018; Robbins et al., 2016; Wahto & Swift, 2016; Wong et al., 2017). Restrictive emotionality was found in the literature to be a common limiting factor in not seeking help and negatively affecting men's wellbeing (Cleary, 2012; Kaya et al., 2018; Good et al., 1989). Adhering to hegemonic and traditional masculine concepts pressure men to suppress their emotions, which, in turn, causes mental distress when they cannot live up to these social standards (Cleary, 2012). Cleary goes on to say that this inhibited expression of emotion can have tragic effects; that suicide may "represent the externalized cost to society of the repression of normal emotions" (p. 504).

Restricted expression of emotion may also contribute to Normative Male Alexithymia (NMA), which is when men find it difficult to identify, describe, or show how they are feeling (Silver et al., 2018). Through socialization, men learn from childhood to suppress any emotional responses that may be considered feminine. This suppression deprives them of learning how to communicate their feelings in adulthood effectively, and it also inhibits their ability to interpret and respond appropriately to the emotions of others (Levant et al., 2015; Silver et al., 2018). NMA restricts men from reaching out for social supports, increases self-stigma, and damages

friendships with other men (Cole & Ingram, 2019; Guvensel et al., 2019; Levant et al., 2015; Sullivan et al., 2015).

Similar to the previously stated literature on the atypical symptoms that men present regarding depression, masculinity may involve doing alternative forms of emotionality (de Boise & Hearn, 2017; Holmes, 2015). de Boise and Hearn (2017) explore how men express emotions in ways that are societally not accepted displays of emotion and, therefore, not recognized. They describe that emotions society deems to be acceptable are responses centred on feminine gender roles based on hegemonic masculine frameworks. Men may present a masculine based "rational" form of emotion in certain situations, such as anger because to show any other emotion would be irrational to them (p. 781). Holmes (2015) found that men who conform to hegemonic masculine ideologies show their emotions in more concrete and physical forms.

The literature on the role GRC plays in older men that are typically past the university and college age is not as prevalent as that of younger men between the ages of 18-15-years. Thompson and Barnes-Langendoerfer (2016) looked at the masculinity expectations in older men, and the results showed that older men still adhere to the traditional, hegemonic ideologies that they lived when they were young men. Their physical and social circumstances have changed significantly; however, the effects of GRC, such as restrictive emotionality, not showing weakness, and being strong and independent still influences older men's behaviours (Robbins et al., 2016; Thompson & Barnes Langendoerfer, 2016).

Masculinity ideologies vary within all ethnic groups and cultures, and each one will have its traditional gender norms. Conforming to the dominant Western masculinity norms will affect minority populations coming from diverse racial and ethnic backgrounds differently depending on their ethnic origins (Sun et al., 2016; Vogel et al., 2011; Wong et al., 2017). Although there

may be similar traditional gender roles and norms on how a man should behave, they may have differing levels of cultural importance depending on their traditional masculinity ideology and privilege (Wong et al., 2017)

The literature supports that men from diverse cultural backgrounds (African American, Asian, and Hispanic) still have a GRC that is a barrier to help-seeking in men (Davis & Liang, 2015; Hudson et al., 2018; Sun et al., 2016; Vogel et al., 2011; Wong et al. 2017). Mincey et al. (2015) reported more mental health distress in African American men who exhibit higher GRC. Restrictive emotionality is a much more significant barrier to seeking help in Asian cultures over African Americans or Hispanics (Lindinger-Sternart, 2015; Sun et al., 2016).

In the literature regarding gay men and conforming to gender roles, individuals often admit difficulties adhering to hegemonic and traditional masculinity ideologies compared to heterosexual men (Parent & Bradstreet, 2017; Sanchez et al., 2013). Research has also found that gay men have more favourable attitudes toward seeking help with mental health problems (Sanchez et al., 2013; Seehuus et al., 2019). This supports the findings that gay men may not experience GRC regarding restrictive emotionality and are more emotionally expressive (Herdman et al., 2012; Sanchez et al., 2013; Wester et al., 2005).

In contrast to the prevalence of literature indicating the negative consequences of adhering to masculine socialized ideologies in men's well being, some research has found that conforming to masculine norms may facilitate protective and positive health behaviours in men (Gough, 2013; Salgado et al., 2019; Shafer & Wendt, 2015). Salgado et al. (2019) found that men who adhered to the GRC pattern of success, power, and competition were more engaged in the use of health care resources. Shafer and Wendt (2015) suggest that masculine norms, such as being goal-oriented and self-reliant, are often useful in therapeutic settings.

### *Stigma*

Stigma is a negative stereotype, and there are three forms of stigma included in this project: public, self, and social stigma. Public stigma refers to perceived negative attitudes, beliefs, and behaviours that society expresses toward individuals; self-stigma is the internalization of the negative perception of society by an individual; and social stigma is the perceived expectation that family and friends place on an individual (Mackenzie et al., 2019; Pederson & Vogel, 2007; Sun et al., 2016).

Public, self, and social stigma have a negative influence on help-seeking attitudes in men. They are reluctant towards seeking help for depression because they view asking for help as a violation of normative male behaviour (GRC) which threatens their status as men (Clement et al., 2015; Latalova et al., 2014; Mahalik & Dagirmanjian, 2019; Oliffe et al., 2016; Seidler et al., 2016; Vogel et al., 2011; Wahto & Swift, 2016). Men who live in rural settings, their self-stigma concerning masculinity norms are twice as high as those in urban settings (Coen et al., 2017; Latalova et al. 2014).

The research of Oliffe et al. (2016) on English-speaking adult Canadian men, indicated that men would feel public stigma in the form of embarrassment, which would make them hesitant to seek help. They also found that self-stigma was equally significant in both men and women who have experienced depression; Latalova et al. (2014) also found this result in African American men and women. Mackenzie et al. (2019) found that self-stigma was higher in younger men aged 18-50-years than older men 50+-years regarding seeking help for depression.

Research has also suggested that potential risk factors of male suicide include stigma and stoicism as barriers to help-seeking in a traditionally masculine environment (Cleary, 2012; Mackenzie et al., 2019; Milner et al., 2017; Oliffe et al., 2016). Rasmussen et al. (2018),

however, found that any self-stigma of having a mental illness to be irrelevant to those individuals where there was no room for weakness in their relationship with significant male figures in their life. In other words, having a mental health diagnosis was an insignificant factor; they could not get beyond their perceived failures.

Self-stigma was a facilitating factor in the majority of the literature regarding negative help-seeking attitudes for depression, and other mental health issues, in diverse populations (Brenner et al., 2018; Clement et al., 2015; Heath et al., 2016; Liu & Iwamoto 2006; Lynch et al., 2018; Seehuus et al., 2019; Sun et al., 2016; Vogel, 2011). Self-stigma was at a higher level in Arab and Asian cultures (Clement et al., 2015; Heath et al., 2016; Liu & Iwamoto, 2006; Oliffe et al., 2016; Seehuus et al., 2019; Sun et al., 2016). Within younger males from Asian cultures, social stigma was also present as there was shame brought on the family (Seehuus et al., 2019). Latalova et al. (2014) found that there was a weaker relationship between self-stigma and traditional masculinity than their European American counterparts.

Brenner et al. (2018) and Lynch et al. (2018) found that religious commitment, combined with the expectations of traditional masculine norms, amplifies the effect of self-stigma on men's attitudes toward help-seeking. In the research by Lynch et al. (2018) among young college men in Ireland, individuals described the Catholic Church's traditional help-seeking methods of prayer and confession as enforcing stoicism. They went on to say that it not only had an adverse effect on attitudes toward seeking help; it was also a barrier for families to be able to communicate or deal with mental health issues.

Similar to the findings regarding gay men's lower adherence to masculine ideologies and help-seeking, Latalova et al. (2014) found that the gay men in their study showed a weaker association between masculine norms and self-stigma. However, Vogel et al. (2011) and Lynch

et al. (2018) found that for gay men, self stigmatizing views attribute to negative help-seeking attitudes. Lynch et al. also found that the negative social stigma of disclosing both sexuality and mental health issues intensified gay young men's stigma.

### ***Literacy***

Lack of mental health literacy, which make it challenging to acknowledge personal distresses as harmful, is a barrier in help-seeking for mental health issues for men (Addis & Hoffman, 2017; Cole & Davidson, 2019; Latalova et al., 2014; Lynch et al., 2018; Milner et al., 2019; Ogrodniczuk et al., 2017). Literature suggests that men would seek help should they need it, the disconnect is their lack of knowledge and understanding of what depression symptoms are and also what health services are available (Cole & Davidson, 2019; Lynch et al., 2018; Ogrodniczuk et al., 2017).

In research conducted by Lynch et al. (2018), young men expressed that when they try to understand their emotions, they do not have the capacity or framework to make sense of what they are feeling on their own. They go on to say that the only accessible information in their community is either inaccurate or judgemental toward mental health problems leading to increased self-stigma. Milner et al. (2019) found that men's health literacy was lower in those who conformed to traditional masculine norms and in those who had higher levels of depressive symptoms. Latalova et al. (2014) found that, regardless of gender, those who had reliable information about depression had a lower self-stigma.

### ***Maladaptive Coping Strategies***

To avoid the threat of possible stigma or marginalization, men used avoidance or distraction strategies such as alcohol, drugs, isolation, working more, or going to the gym more (Cleary, 2012; Mckenzie et al., 2016; Rasmussen et al., 2018). Men often try to manage their

symptoms of depression on their own; however, some of these strategies can cause more distress or even tragic consequences; these maladaptive coping strategies can increase the risk of suicide (Cleary, 2012; Heath et al., 2017; Lynch et al., 2018; McKenzie et al., 2016; Rasmussen et al., 2018). Rasmussen et al., 2018 suggested that for the individuals in their study, not choosing to seek help was their maladaptive "coping strategy for normalization" (p. 101).

Strict autonomy and self-reliance are significant factors in coping with mental health issues instead of seeking help in men who adhere to masculine ideologies (Cleary, 2012; Coen et al., 2013; Lynch et al., 2018; McKenzie et al., 2016; Roy et al., 2019). These masculine norms suggest that men should cope on their own and self-manage their problems and mental health issues (Coen et al., 2013; Creighton et al., 2017). Roy et al. (2019) found that rural farmers, who maintain a monologic ideology, are more likely to deny mental health issues until it reaches a crisis state of high levels of distress, suicidal ideation, and possible death by suicide when compared to men in rural and urban non-farming men.

### ***Lack of Confidence in the Health System***

Literature suggests that the health services available may not be conducive to the unique mental health care needs of men who adhere to traditional masculine ideologies (Lynch et al., 2018; Milner et al., 2019; Seidler et al., 2018). A significant barrier for men to seek help, when they are experiencing mental health distress, is their lack of confidence that the systems available in their community are not going to be beneficial or may even make the problem worse (Lynch et al., 2018; Milner et al., 2019; Seidler et al., 2018). These attitudes may have resulted in previous negative encounters with health care professionals (Lynch et al., 2017).

Available health services may not be conducive to the unique mental health care needs of men who adhere to traditional masculine ideologies mentioned previously. Literature provided

by Seidler et al. (2018) goes further to question whether health professionals, directly or indirectly, support masculine norms, such as stoicism, and men should not show weakness, which undermines men's help-seeking. Milner et al. (2019) found that their male participants reported that health care providers did not understand their concerns, and in turn, were unable to engage and continue to seek help.

Gay men in River's (2018) study found the health services available for their suicidal distress was a barrier to seeking help as it marginalized them more; health care providers considered their suicidal distress as symptoms of mental illness. As Rivers goes on to explain, this approach medicalizes their experience of social stigma and discrimination, which is based on a hegemonic framework and takes away trust that these services will be helpful.

### **Implications for Counselling Psychology**

Previous literature has shown that men who adhere to strict masculine norms have negative attitudes toward seeking help for mental health issues (Good, et al., 1989; Ellis, 2018; Kaya et al., 2018; O'Neil, 2008; Wong et al., 2017; Yousef et al., 2015). When counsellors begin to engage in a therapeutic alliance with a male client they should be cautious in not presuming that masculinity is a relevant factor or that it has been a barrier for seeking help for mental health issues; not all men follow hegemonic or traditional masculine ideologies (Gough, 2013; Silver et al., 2018). In adherence to the Canadian Code of Ethics for Psychologists (Canadian Psychological Association, 2017), clinicians must avoid any bias or unfair discrimination. They need to listen to their client's narrative of their health and wellbeing; their story should not be prematurely categorized (Richards & Bedi, 2015; River, 2018). The clinician needs to be aware of their client's prevailing views so as not to be condescending but be respectful of their values

and culture and go on to competently apply those views to effective interventions (Shafer & Wendt, 2105).

Through this dialogue, the health care provider can get an understanding of their client's adherence to masculine ideologies, concerns, coping strategies, and potential barriers to receiving help which will influence the overall effectiveness and engagement of treatment (Milner et al., 2019; Silver et al., 2018). The clinician will begin to understand the agency of significant individuals and societal influences that have shaped their client's beliefs of masculinity (Creighton et al., 2017; Mahalik & Dagirmanjian, 2019). This assessment will also give valuable information regarding the client's influential male role models, support from family and friends as well as their access to social support (Good et al., 2018; Hiebert et al., 2018).

The social contexts that men find themselves in and the types of relationships they have are determining factors in men's help-seeking behaviours (McKenzie et al., 2018). Clinicians need to understand the impact that the variables of gender socialization, stigma, and negative attitudes toward health providers has on their client to determine how to proceed with a treatment plan that will be accepted and sustained (Cole et al., 2018; Lindinger-Sternart, 2015; Proudfoot et al., 2105). With the knowledge of a client's individual differences in gender role socialization, coping with stigma or shame, and their attitude toward help-seeking, clinicians, can get an understanding of specific therapy preferences for their client also (Cole et al., 2018; Levant et al., 2015).

By understanding the complexities of a client's presenting issues emphasizes the importance of adapting treatment to meet their client's needs (Cole et al., 2018; Silver et al., 2018). It is also essential to appreciate the individual differences in each of those variables in all clients in tailoring a treatment plan that respects their gender identity (Cole & Ingram, 2019;

Cole et al., 2018). Silver et al. (2018) add that it is also important for clinicians not to view their client's traditional positions as "burdens to overcome" and instead be aware of their unique beliefs and modify treatment plans appropriately (p. 101). A significant component in examining a client's masculine identity and making them feel validated and accepted, rather than blamed and criticized, is to allow room to show their vulnerability (Jewkes et al., 2015).

Men who adhere to masculine ideologies and seek help will likely be more engaged and maintain treatment when it is received in a way that supports and does not threaten, their sense of masculinity (Cole & Ingram, 2019; de Boise & Hearn, 2017; Sullivan et al. 2015). Reframing conventional help-seeking interventions need to be consistent with masculinity and observed as being successful and courageous, not feminine or weak (Gough, 2013; Oliffe et al., 2016; Richards & Bedi, 2015; Salgado et al., 2019). These reframing techniques help to destigmatize, normalize and degender help-seeking, which in turn, reduces the barriers to mental health-seeking (Cole & Ingram, 2019; Lynch et al., 2018; Oliffe et al., 2016). Hammer et al. (2012) found that destigmatizing seeking health interventions were more effective in improving men's attitudes toward seeking help for mental health issues than just focussing on changing their adherence to masculine norms.

Literature indicates interventions that are strength-based and utilize resources that the client already possesses can improve attitudes toward help-seeking and maintaining treatment (Hammer et al., 2013; Lindinger-Sternart, 2015; Proudfoot et al., 2015; Seidler et al., 2016). Supporting men to help them realize their existing strengths may increase their willingness to seek help (Lindinger-Sternart, 2015; Proudfoot et al., 2015). Emotion directed approaches are not a favoured form of therapy for men; drawing on their strengths, men will be more engaged in effective, societal, and goal-oriented therapies (Proudfoot et al., 2015; Sullivan et al., 2015).

If conversations open up, which normalize mental illness and help-seeking, then there can be a shift in perceived social norms and lessens the fear of negative judgement of not meeting masculine ideals of being strong and stoic (Boysen, 2017; Hackler et al., 2016; Mahalik & Dagirmanjian, 2019). In the studies done on men in rural communities, the researchers found that some men, within their home environment, adopted a dialogic form of masculinity as a strategy to manage their depression. Dialogic masculinity, as opposed to the rigid hegemonic form of monologic masculinity, allows for men to be more flexible in their gender roles, the ability to show emotions, and talk about mistakes (Coen et al., 2013; Creighton et al., 2017; Hiebert et al., 2018). Coen et al. (2013) found that family involvement in the therapeutic process within the home positively supports the dialogic strategies, which improves men's well-being and help-seeking behaviour.

Men may be less resistant to mental health care if it is normalized by validating their conflict to adhere to idealistic expectations and making them aware of other men who have experienced mental health problems and seek help for it (Kaya et al., 2019; Mahalik & Dagirmanjian, 2019; Wahto & Swift, 2016). If a mental health issue appears as a common problem for men, it will lessen the threat to their masculine identity and self-esteem and increase the probability that they will seek professional help (Hiebert et al. 2018). Just hearing that men can actively participate in their prevention of poor mental health, and thrive, could be a powerful and positive message (Proudfoot et al., 2015).

Schafer and Wendt (2015) found it useful to reframe mental health issues into the context of a medical condition as a way to reduce men's reluctance to treatment. The example they used was that if you break your leg, you need to see a health professional. Clinicians also need to be aware not to use unnecessary labels and utilize less stigmatizing language, as it is perceived as

more respectful (Richards and Bedi, 2015). In line with this positive framework, one needs to be cognizant to not put negative labels, such as a workaholic, on an individual who is using their adherence to work positively as a source of their value; clinicians should appreciate the dual role that works can have in their client's life (Wong et al., 2017).

Men can also be made aware that in specific settings, adherence to masculine norms may contribute to positive mental health and well being, like winning (Kaya et al., 2019; Mahalik & Dagirmanjian, 2019). Addressing the positive components of masculine norms and reworking how asking for help can be a sign of self-reliance and strength, in that it is action-oriented, problem-solving, and goal focussed, may increase men's attitudes toward seeking help (Salgado et al., 2019; Schafer and Wendt, 2015; Oliffe et al., 2016; Wahto & Swift, 2016). Also, men who do access help respond positively to an environment where they can provide some choice and control in interventions and can authentically perform their masculinity while maintaining their wellbeing (Gerdes & Levant, 2018; Lynch et al., 2018).

In the study done by Roy et al. (2017) study on monologic masculinities in rural communities, suggests reframing the exhibiting individual masculine strengths to positive coping strategies. Proudfoot et al. (2015) supported that men are not only able to use positive coping strategies; they incorporate the use of them regularly in their everyday lives. The researchers highlight the importance of matching a client's use of strategies to their specific mental health issues as one strategy may not be helpful in every situation.

Clinicians need to be aware that men acknowledge that depression is a serious health concern and are open to receiving help; however, there is a gap in mental health literacy among men about depression regarding symptoms, triggers, and available support for them to act on the intent (Addis & Hoffman, 2017; Cole & Davidson, 2019; Latalova et al., 2014; Lynch et al.,

2018; Milner et al., 2019; Ogrodniczuk et al., 2017). Clinicians should get an understanding of their client's knowledge of depression and inquire about their feelings about depression as a practical approach to adjusting their help-seeking attitude (Cole & Davidson, 2019; Latalova et al., 2014). They also should keep in mind that men who adhere to traditionally masculine norms often neglect to report or minimize their symptoms because they may appear too feminine (Cole & Davidson, 2019; Latalova et al., 2014; Ogrodniczuk et al., 2017).

When assessing a client's symptoms, clinicians use the *Diagnostic and Statistical Manual 5<sup>th</sup> edition* (DSM-5) (2013). This medical standard of diagnosing and treatment planning does not account for an individual's gender role socialization or social contextual factors such as age, coping strategies, ethnicity, gender, personality, race, religion, sexual orientation, social class, or supports (Jacob, 2015; Rasmussen et al., 2018; River, 2018; Vogel & Heath, 2016). As stated earlier, the DSM-5 addresses symptoms for depression that are more internal: depressed mood, anhedonia, significant weight loss or weight gain, insomnia or hypersomnia. In contrast, Magovcevic and Addis' (2008) Masculine Depression Scale (MDS), posits that men who adhere to traditional ideologies display more external symptoms such as anger, irritability, agitation, increased activity level, substance/alcohol abuse, interpersonal withdraw, and increased sexual behaviours. The MDS allows clinicians to take these discrepancies into account when assessing their male client for depression (Ogrodniczuk et al., 2017; Cole & Davidson, 2019; Call & Shafer, 2018).

Health care providers not only need to be assessing their client's level of adherence to masculine norms, but they should also use construct-specific measures that take into consideration male gender norms. This assessment is not specific to only male clients. Clinicians

should also consider that women may also endorse masculine norms and, therefore, may present with atypical depression symptoms (Genuchi & Mitsunaga, 2015; Price et al., 2018).

Studies by Rasmussen et al. (2018) and River (2018) indicate how using a diagnostic only approach is not suitable for clients with suicidal behaviour. Only treating the underlying mental illness will overlook their client's lived experience of psychological pain, emotions, and the lack of coping strategies; this will lead to the individual losing trust in any potential help-seeking for their mental health issues (Creighton et al., 2017; Rasmussen et al., 2018; River, 2018). Clinicians need to be mindful when working with gay suicidal clients. Gay men are subjected to subordination and marginalization by not living up to hegemonic masculinity expectation; this medical approach has the potential of marginalizing them even more (Connell & Messerschmidt, 2005; Rasmussen et al., 2018; River, 2018). If clinicians only focus on the psychiatric symptoms for depression, then the significance of the patient's story is ignored.

Masculine ideologies socialize men to deny their emotions, and they may have difficulties expressing or articulating their emotions (alexithymia). They may also be having issues with fear of intimacy; this emotional restrictiveness can cause Normative Male Alexithymia (NMA) (Cleary, 2012; de Boise & Hearn, 2017; Guvensel et al., 2018; Silver et al., 2018). Studies have associated NMA in men who have experienced strict enforcement of masculine ideologies; clinicians should consider any trauma that may have impacted their client which in turn affects their mental health and unhealthy coping strategies (Guvensel et al., 2018; Lynch et al., 2018; Rasmussen et al., 2018).

Acknowledging the unique ways in which men communicate is a practical and critical aspect of helping men have a more positive attitude toward seeking help for mental health issues (Shafer & Wendt, 2015). Clinicians need to be sensitive to the likelihood that when these

individuals do seek help, they may not be comfortable in expressing their feelings in traditional interventions. They may not see their behaviours as a problem, which can inadvertently produce barriers to men (Kingerlee et al., 2014; Sullivan et al., 2015; Jewkes et al., 2015).

Engagement in any treatment approach may be the most challenging obstacle if the client is unaware of the impact their actions have on those around them (Jewkes et al., 2015). By opening up a conversation implicitly, either by discussing what is seen as a problem for the affected group or by focussing on the impact that therapy will have on the client's well being and all individuals in their social system, will begin the therapeutic process (Jewkes et al., 2015; Silver et al., 2018). This approach may not only improve the client's health, but it will also increase the quality of life for his family and other vulnerable individuals that have been affected (Silver et al., 2018).

Similar to how men present with male-typical symptoms for depression, the same is true for emotions. It is essential to be mindful not only to the different roles of emotions but also to establishing what represents an emotion that may not present in traditional feminine behaviours; lack of culturally appropriate emotions does not mean their client is unemotional (de Boise & Hearn, 2017). Further to this, the health provider cannot assume that talking about emotions will lead to action; clinicians need to observe men's non-verbal cues as well as their use of language through a lens that aligns a male-specific experience (Patrick & Robertson, 2016; Sullivan et al., 2015).

It is imperative that mental health professionals be culturally sensitive to the barriers affecting minority populations and of the unique multicultural masculine gender norms and expectations, traditions, and values their clients have toward mental health and help-seeking (Levant et al., 2015; Lindinger-Sternart, 2015; Silver et al., 2018). Understanding ethnic minority

men and the degree that their norms interrelate with masculinity ideologies at the societal level can help inform clinicians on best practices (Levant et al., 2015). Research has shown that modifying traditional interventions into culturally tailored approaches to be more successful in getting men from diverse cultures and sexual orientations to seek help (Ellis, 2018; Hammer et al., 2013; Lindinger-Sternart, 2015; River, 2018).

Men's help-seeking behaviour is subject to the individual's social and situational factors as well as the context of masculinity within their race, ethnicity, sexual orientation, and age (Addis & Mahalik, 2003; Vogel & Heath, 2016). The gendered social expectations within each of these contextual factors have significant impacts on men's mental health and wellbeing (McKenzie et al., 2018; Pirkis et al., 2017).

The importance of gender relations must be incorporated when planning treatment interventions for men. Treatment approaches should introduce processes where men become aware of alternatives to societal norms, and they can change their practices regarding social relationships with men and women; this will emphasize the multiplicity of masculinities (Guvensel et al., 2018; Jewkes et al., 2015; McKenzie et al., 2018; Milner et al., 2019).

The gender of the clinician is not a barrier to men seeking help, nor does matching client and clinician gender been found to increase men's commitment to continuing with therapy (Bhati, 2014; Liddon et al., 2017). Further to that, most men do not have a preference for their therapist's gender. However, Isacco et al. (2016) found that men who may prefer a male clinician may do so when the issue is related to male gender roles as the clinician might be able to provide a positive model of masculinity.

### **Fundamental Next Steps for Research**

Men's negative attitudes toward seeking help for mental health issues is a well documented and critical issue for the well being of men globally and one that can be assisted by research on behaviour from within a social context (Erentzen et al., 2018). McKenzie et al. (2016) found that when looking at all the research done on barriers to help-seeking in men, most of the studies only added to existing results of why men are resistant to seek help for their mental health issues. Research needs to establish how to motivate and assist men in seeking help, how to produce greater adherence to treatment and lasting change, and also try and determine why some men ask for help for mental health issues but others do not (Addis & Mahalik, 2003; Shafer & Wendt, 2015; Sullivan et al., 2015; Vogel & Heath, 2016).

A predominant gap found in the literature is the lack of diversity in the population of research participants; they are predominantly white, young heterosexual males from Western Culture (Clement et al., 2015; Cole & Davidson, 2019; Cole & Ingram, 2019; Guvensel et al., 2018; Kaya et al., 2018; Pederson & Vogel, 2007; Salgado et al., 2019; Sullivan et al., 2015; Wahto & Swift, 2016; Wong et al., 2016). Salgado et al. (2019) found it is difficult to find a diverse population of men to participate in health-related intervention studies and indicates that there needs to be more research on how to recruit more men.

Research using more diverse populations will provide valuable insight into whether mental health symptoms and help-seeking attitudes differ among men of different races, ethnicity, sexual diversity, age, social status, level of education or cross-generational comparisons (Shafer & Wendt, 2015). This diversity would allow the research to encompass different cultural variations in masculinity and norms; which would expand the literature on men's help-seeking behaviours and would strengthen the current generalized results found in

existing research (Cole & Ingram, 2019; Salgado et al., 2019; Sullivan et al., 2015). Clement et al. (2015) also indicate the importance of having more studies done on men's help-seeking attitudes in low and middle-income countries as most of the existing research consists of upper-middle-class populations. A gap also remains in the research regarding the role that masculinity and gender roles play in men who are in the later stages in their lives (Robbins et al., 2016).

Research addressing the multiplicities in masculine attitudes or the intersection between male attitudes toward help-seeking and mental health issues in men would be beneficial (Shafer & Wendt, 2015; Vogel & Heath, 2016). Gerdes and Levant (2018) suggest that there should be research done to compare the nature of specific masculine norms on protective behaviours in men's health behaviours and health risks. Further to this, research should also explore within-group differences in each masculine norm construct (Genuchi & Valdez, 2014; Seidler et al., 2016).

There is a gap in research on masculinity, gender relation, and how they intersect with men's emotions (de Boise & Hearn, 2017). Studies need to explore the relationship of masculine emotional expression through a gender relational lens (de Boise & Hearn, 2017; Sullivan et al., 2015). Further to this, more research can show the correlation between men having difficulty articulating and showing emotions (alexithymia) and fear of intimacy, both of which are consequences of male gender socialization.

There needs to be more research focussed on the mental health perspectives of role models or significant influences in men's lives (Lynch, 2018; Mahalik & Dagirmanjian, 2019). Attention to this micro-level would look at beliefs and attitudes of adult males who had considerable influence in a man's life growing up; at the macro level would be workplace environment and its level of endorsement of masculine norms (Lynch, 2018; Mahalik &

Dagirmanjian, 2019; Munsch et al., 2018). Studies on rural dialogic forms of masculinity have shown success in the micro context of the home, but need to be done so that this success can permeate this to the broader rural norms of the community to lessen the stigma of depression (Coen et al., 2013, Creighton et al., 2017)

There is a lack of research on male gender roles in men of colour, gay, bisexual, and transgender men as they may experience intensified stigma while trying to balance gender roles of their culture of origin and the dominant culture (Cole & Davidson, 2019; Levant et al., 2015; Lynch et al., 2018). Studies looking at the relationship between acculturation and cultural identity and how societal norms influence men's experience will provide additional information on men's mental health issues and attitudes regarding seeking help (Cole & Davidson, 2019; Levant et al., 2015; Lynch et al., 2018). More examination into the intersection of ethnicity, culture, masculinity, and health in men of colour is an important area that needs to be addressed more in masculinities research (Daniel-Ulloa et al., 2017).

Specific research is also needed to obtain more awareness of the experiences of gay, bisexual, and transgender individuals have concerning traditional masculine norms and seeking help for mental health issues (Lynch et al., 2018; Silver et al., 2018). Lynch et al. (2018) go further to indicate how vital new research is for young men in this marginalized population as they are the highest at-risk group for suicidal ideation.

The constructs of masculine norm adherence cannot predict all negative attitudes and behaviours toward help-seeking in men; there needs to be an effort made to understand how specific norms within the constructs, such as restrictive emotionality, self-reliance, affects behaviours (Cole & Ingram, 2019; Guvensel et al., 2018; Heath et al., 2017; Salgado et al., 2019;

Wahto & Swift, 2016). Heath et al. (2017) indicate that future research needs to examine the multiple components that makeup masculinity and help-seeking barriers.

For any of the findings from research regarding men seeking help for mental health issues to be effective, those individuals who do access help need to be engaged in the process and interventions, adhere to the treatment, and also obtain effective coping strategies for lasting change (Seidler et al., 2016). There is a gap in the literature in understanding what methods of accessing help provide positive outcomes for men seeking help: formal health providers, informal social support, or self-help behaviours (Cole & Ingram, 2019).

More studies on the effectiveness of the existing psychoeducation programs on seeking and adhering to treatment need to be done, and also what contributes to disengagement or termination where an individual feels that the health provider or interventions are ineffective and unable to help them (Latalova et al., 2014; Shafer & Wendt, 2105). Lynch et al. (2018) suggest that studies done on the improvement of treatment outcomes should include the perspectives of individuals and have them create more accessible solutions to mental health issues. This future research may give more insight into why some men ask for help and are successful, and other men do not ask for help at all.

### **Recommendations for Practice**

As stated in the implications for counselling section, a significant first step in counselling men is to assess their level of adherence to masculine ideologies. Through conversation with their male client, the therapist can get an understanding of their client's traditional lives, cultural diversity, coping strategies, strengths, and their attitudes toward seeking help (Cole et al., 2018; Silver et al., 2018). Cole and Ingram (2019) suggest that making sessions more "man-friendly" by empowering their client through reframing the masculine norm of courage and risk into the strength of seeking help will engage him more with therapy (p. 9).

Through the use of appropriate assessment tools and instruments, clinicians will get comprehensive information regarding the degree of adherence to hegemonic and traditional masculine ideologies, attitudes toward help-seeking, and self-stigma levels. Suggested assessment tools are Gender Role Conflict Scale (GRCS) (O'Neil et al., 1986), Conformity to Masculine Norms Inventory (CMNI) (Mahalik et al., 2003), Attitudes Toward Seeking Professional Psychological Help Scale – short form (ATSPPHS) (Fischer & Farina, 1995), Self-Stigma of Help-Seeking Scale (SSOSH) (Vogel et al., 2006). Another helpful assessment tool is the Preferences for Psychotherapy Approaches Scale-Revised (PPAS-R) (Cole et al., 2018), which will guide the therapist to the client's preferred therapy orientation.

Men may present with male-typical symptoms of depression, or they may not be aware of what depression symptoms are, the clinician will want to learn more about their client's knowledge of depression and if their symptoms have impacted their masculinity (Cole & Davidson, 2018). The clinician may also want to assess their client for depression, some assessment tools are Beck's Depression Inventory Scale (BDI) (Beck et al., 1996) along with the more male symptom-specific Male Depression Scale (MDS) (Magovcevic & Addis, 2008), and

the Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977). Further to this, an assessment of the levels of Normative Male Alexithymia (NMA) through the NMA-Scale (Levant et al., 2006), or fear of intimacy levels may also be wanted, Fear of Intimacy Scale (FIS) (Descutner & Thelen, 2006).

Through these assessments, the clinician, and their client, will be able to utilize the client's strengths, differences, and gender identity to effectively tailor their treatment plan, which will increase their engagement and adherence. By building upon these strengths, clinicians can focus on the positive aspects of masculinity, which will help normalize men's mental health-seeking, implement positive coping strategies, and, in turn possibly minimize hegemonic and traditional masculinity (Cole et al., 2018; Oliffe et al., 2016; Proudfoot et al., 2015).

As stated, traditional men respond best to goal-oriented, problem focussed treatment interventions and not to those that are emotionally focussed (Sullivan et al., 2015). These interventions allow for the client to develop positive coping strategies to reduce self-stigma and barriers to seeking help. Cognitive Behaviour Therapy (CBT) is have been used successfully as a therapeutic intervention for male clients. CBT uses men's strengths and offers problem-solving tools to reduce mental health symptoms, encourage help-seeking behaviours, and maintain well being long term (Coleman, 2015; Seidler et al., 2016; Silver et al., 2018; Sullivan et al., 2015).

Motivational Interviewing (MI) increases client engagement in treatment regarding self-reliance and autonomy (Lindinger-Sternart, 2015; Patrick & Robertson, 2016; Sullivan et al., 2015). Silver et al. (2018) indicate that MI is especially beneficial for men who adhere to masculine ideologies and are not aware of the negative consequences of his behaviour. They go on to explain that addressing this pre-contemplation stage using MI begins the process of change. Patrick and Robertson (2016) go further to say that Gender-Based Motivational Interviewing

(GBMI) helps reduce mental health stress and is less stigmatizing. The use of common male language in GBMI helps to normalize and enhance continued and positive engagement in therapy (Patrick & Robertson, 2016). Conversations about the negative impact of self-reliance on mental health and well being can also promote awareness (Pirkis et al., 2017)

For clients who score higher on the alexithymia scale, clinicians can use the psychoeducational group treatment approach of Alexithymia Reduction Treatment (ART) for their client's emotional restrictiveness (Guvensel et al., 2018; Silver et al., 2018). This treatment plan concentrates on the recognition and understanding of emotions, which reduces NMA and also the adherence of traditional masculine norms (Guvensel et al., 2018; Silver et al., 2018). Guvensel et al. (2018) suggest that this psychoeducation could allow male clients to gain insight into common incorrect stereotypes of men, such as they are unemotional or that they are unable to express emotions.

Person-centred interventions are the most preferred and helpful approach for suicidal men, and medical-centred services to be a significant barrier to seeking help (Creighton et al., 2017; Rasmussen et al., 2018; River, 2018). Suicidal individuals require a dialogue that can potentially help their specific problem, not the underlying mental illness; their overwhelming mental pain will not go away (Rasmussen et al., 2018; River, 2018). Shneidman (1996) purposes that the most critical question to a potentially suicidal person is, "Where do you hurt, and how can I help you?" (p.6).

It is crucial for clinicians to destigmatizing mental health and improve help-seeking attitudes through increasing public awareness and promoting public services and policy primarily to address male depression and their higher rates of suicide (Erentzen et al., 2018; Mackenzie et al., 2019; Lomas et al., 2016; Oliffe et al., 2016; Vogel & Heath, 2016). Through the

implementation of mental health education at the elementary level, community outreach programs, and increasing mental health literacy through psychoeducation clinicians will be able to normalize mental health problems, help-seeking and improve men's understanding of depression symptoms (Cole & Ingram, 2019; Lynch et al., 2018; Ogrodniczuk et al., 2017).

Informing families and communities about the potentially harmful impact of restrictive emotionality and gender roles on men can be done through parenting classes and family counselling (Guvensel et al., 2018). Men who attend support groups, for men with mental health issues, could help normalize help-seeking for clients, possibly due to the significance of sharing information (Guvensel et al., 2018; Liddle et al., 2016). Parenting skill courses could inform fathers about the impact they have on their children's lives and provide them positive coping strategies (Guvensel et al., 2018; Mahalik & Dagirmanjian, 2019; Proudfoot et al., 2015). Further to this, workplace settings could also address mental health factors and reframe seeking help from a positive masculinity perspective (Guvensel et al., 2018; Mahalik & Dagirmanjian, 2019).

The importance of including gender relations in interventions has been stated previously as the concepts of masculine ideologies can be integrated into interventions to enable change (Jewkes et al., 2015; McKenzie et al., 2018). Interventions for individual clients will allow for behaviour and attitude changes in seeking help, and also on the impact, these shifts will have on those in their life. A more societal gender relations approach, through groups, programs, and policy, will change stereotypes shared at the societal level, which will lessen stigma and break down barriers (Jewkes et al., 2015; Pirkis et al., 2017).

### **Reflexive Self-Statement**

I went into this project with the opinion that societal masculine stereotypes harm men regarding seeking help for mental health issues. I intended to bring awareness to how men's

societal norms and expectations negatively affect their health, well being, are a barrier to seeking help which can have tragic consequences.

In support of my original position, the literature on gender socialization consistently indicates that adherence to masculine norms such as being stoic, self-reliant, and not show emotion are a barrier to men in seeking help for mental health issues. As correct as this statement is, it is not very helpful in understanding how these norms affect all men, why they adhere to them, or how to change their attitudes toward help-seeking. It is too simplistic to assume that these factors produce all resistant help-seeking behaviours and mental health issues equally for all men; it is the proverbial "tip of the iceberg."

As the literature reflects, male masculinity is not a singular entity, nor is there a direct cause and effect as not all men are governed by social norms equally (Mckenzie et al., 2018; Silver et al., 2018). An individual's race, ethnicity, sexual orientation, and age are integral to their masculine socialization and their subsequent behaviours (Addis & Mahalik, 2003; Vogel & Heath, 2016). There is no possible way for any two men to have the same life experiences regarding their gender role socialization and resulting masculinity, let alone a whole society of men conforming to one masculinity.

The existing literature on the negative impact of self-reliance, autonomy, and not allowing certain emotions have provided information on understanding why men do not seek help because of the stigma that is attached. What is missing is how we, as a society and health care providers, can break down the stigma, and get men to seek help and maintain treatment. Within the literature, the approach I see that may be most effective, for any longstanding changes, is a shift to a gender-relations approach, which will generate more gender equality (Jewkes et al., 2015; Pirkis et al., 2017; Silver et al., 2018). A gender relations approach will

deconstruct the masculine norms in the existing ideologies and allow for men to behave in ways that are more authentic to themselves, which in turn will be beneficial for their mental health and wellbeing (Mckenzie et al., 2018; Pirkis et al., 2017).

### **Conclusion**

This research project posited that adherence to traditional masculine norms harms the way men seek help for mental health issues, which was supported by the literature. It is challenging for men who adhere strongly to masculine ideologies and who have mental health problems, to seek and accept professional help and treatment (Coleman, 2015).

Unfortunately, many of the points made in this project that suggest how to get men to engage in seeking help will go unresolved if men remain resistant to mental health care.

As has been previously stated, that more research is needed using more diverse populations. A majority of the research uses participants who are from dominant models of male socialization in the Western World. Much of the documented empirical research has utilized participants that are white, heterosexual males from Western Culture. Research on the impact of gender socialization and help-seeking using men from different races, ethnicity, sexual orientation, age, social status, and level of education will provide a greater understanding of how to engage all men in professional help.

The prevalent consequence for men maintaining the societal expectations of masculinity and not appearing feminine is maladaptive coping strategies. Without adequate coping strategies, men self-manage their problems, and their men's mental health issues do not get addressed (Coen et al., 2013; Creighton et al., 2017). As has been noted, some coping strategies can do more harm than good and can have tragic outcomes.

Some traditional men are not aware of what the symptoms of depression are, behaviours that are associated with it, or what supports are available to them. Improving men's literacy on depression will help them to understand and identify their behaviours and seek the necessary help. Clinicians using appropriate male depression symptoms assessment tools will be able to get comprehensive information that will help guide their treatment approach. Other assessment tools, which will help with determining interventions, can also be used to find their client's degree of adherence to masculine norms, attitudes toward help-seeking, levels of stigma, or levels of alexithymia.

Destigmatizing and normalizing mental health problems, and seeking help for them, are crucial to getting men to begin to engage in treatment. Reframing conventional interventions to empower men using strength-based, goal-oriented and problem focussed approaches allows for them to maintain some control and provide some input into their treatment, which leads to better engagement and maintenance. Making treatment approaches person-centred, tailored to the individual male client and less medicalized will make help-seeking more desirable for men (Creighton et al., 2017; Rasmussen et al., 2018; River, 2018).

Providing tailored treatment approaches for men's unique needs may decrease their stigma and shame and breakdown the barriers to help-seeking and increase the continuation of treatment (Jewkes et al., 2015; Seidler et al., 2019). The importance of destigmatizing and normalizing mental health issues for men is critical; the global suicide rates for men demonstrate the tragic consequences of men not seeking help for mental health issues.

Taking a more gender-relations approach to interventions for men presenting with mental health issues may be a more appropriate and effective way of providing professional help (Seidler et al., 2018). This framework considers the connection between gender and other social

circumstances as well as the multiplicities of masculine norms that impact men's mental health, coping strategies, and help-seeking behaviours (Guvensel et al., 2018; Jewkes et al., 2015; McKenzie et al., 2018; Milner et al., 2019; Seidler et al., 2019). Shafer and Wendt (2015) highlighted the importance of helping men as their wellbeing is fundamental to the wellbeing of women, children, and society in on the whole.

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