Man, You Should See a Therapist: A Quasi-Experimental Research Proposal to Increase Men's
Engagement with Mental Health Help-Seeking Behavior using Masculine-Oriented Brochures

by
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A Capstone Research Project submitted in partial fulfillment
of the requirements for the degree of

Master of Counselling (MC)

City University of Seattle
Vancouver BC, Canada site

June 19, 2019

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Abstract

This paper seeks to understand reasons for men's underutilization of counseling through the theoretical lens of Connell's (1995) hegemonic masculinity. My hypothesis is that due to the adherence to Western society's dominant masculine traits, men avoid seeking psychotherapeutic help for fear of threatening their masculinity. Following an exploration of key definitions associated with masculinity and a review of existing literature on the relationship between masculinity and mental health help-seeking attitudes/behaviour, I will present a research proposal for a quasi-experimental study using brochures that appeal to men that could be a possible strategy to increase men's participation in therapy. Suggestions for further study will follow.

Keywords: masculinity, men in counselling, mental health, help-seeking attitudes, help-seeking behavior.

Introduction

Studies have shown that men outnumber women in certain mental illnesses, unhealthy behaviors, and stigmatized groups. Men are more likely to be diagnosed with substance use and antisocial disorders, while more women are diagnosed with anxiety and depression (Eaton et al., 2011), and the prevalence of substance disorders nearly doubles that of mood disorders in Canada (Pearson, Janz, & Ali, 2013). Men accounted for 74% of fentanyl-detected overdose deaths in British Columbia in the last 6 years (British Columbia Ministry of Public Safety and Solicitor General, 2018). The suicide rate for males was three times higher than the rate for females in Canada (17.9% versus 5.3% per 100,000), which is a long-standing pattern since the 1950s (Navaneelan, 2012). There is a growing awareness about the debilitating effects and need for support services for post-traumatic stress disorder (PTSD) in male-dominant occupations such as police officers (Green, 2003) and military veterans (Boscarino, 2005). Often overshadowed by concerns about the misrepresentation of women's bodies in the media, rates of eating disorders and body dysmorphic disorder (BDD) are also increasingly concerning among men. "Bigorexia" is a form of BDD where a man becomes insatiably obsessed with gaining weight and musculature, leading to overexercising, abusing steroids, and undergoing potentially harmful cosmetic surgeries (American Addiction Centers, 2018). Most individuals in the criminal justice system report having experienced substantial adverse events in childhood such as family violence, physical, sexual, or emotional abuse, or being involved in the welfare system - almost 90% of which are men (Kouyoumdjian, Schuler, Matheson, & Hwang, 2016), and disproportionately men of colour (Owusu-Bempah & Wortley, 2014). Men also make up the majority of victims of physical assault, homicide, sexual assault within institutional settings such as a university or church, and are more likely to be victimized by a stranger (Vaillancourt, 2008).

What does the field of psychotherapy have to offer men? In conjunction with psychopharmacological treatment, cognitive-behavioral therapy (CBT) has been empirically proven to treat substance use disorders (Dutra et al., 2008; Magill & Ray, 2009), eating disorders (Fairburn, Cooper, & Shafran, 2002; Hilbert et al., 2017; Murphy, Straebler, Cooper, Fairburn, 2010), depression (Cuijpers et al., 2012; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; Weisz, McCarty, & Valeri, 2006;), and anxiety disorder (Hofmann & Smits, 2008; Stewart & Chambless, 2009). Eye movement desensitization therapy (EMDR) and exposure therapy have been successful for individuals with PTSD (Seidler & Wagner, 2006; Taylor, 2003). Psychotherapy has been beneficial for reducing distress among HIV-infected gay men (Mulder et al., 1994) and lowering levels of psychological and physical abuse among partner violent men (Taft et al., 2003).

However, in North America, men are less likely to seek help for emotional issues (Moller-Leimkuhler, 2002) and less likely to have positive attitudes towards counseling than their female counterparts (Nam et al., 2010). Men exhibit higher levels of public stigma and self-stigma around counseling (Vogel, Wade, Hackler, 2007). Almost double the amount of women compared to men reported having seen or talked to a health professional about their emotional or mental health in 2015 (Statistics Canada, 2015). As psychotherapists, it is critical that we not only service those who are brave enough to ask for help and walk through our doors, but recognize the gender barriers that potentially inhibit essentially half the population from participating in therapy.

Defining Masculinity

Masculinity is a set of traits, behaviors, and roles associated with boys or men. Distinct from biological sex, it is a social construct that is performed to various degrees by individuals of any given sex or gender. What is considered "masculine" is dependent on historical and cultural contexts; an ever-evolving identity paradigm. Although many aspects of masculinity appear to be the opposite of femininity, masculinity and femininity actually exist on separate spectrums of gender expression, in which an individual can exhibit equal or differing levels of both constructs simultaneously.

Men and masculinity studies started in the 1970's alongside the rise of feminism. First, theorists identified personality traits and characteristics of what is considered masculine. According to the *Brannon Masculinity Scale* developed in 1984, there are four dimensions that make up American masculine ideology: avoid appearing feminine ("No Sissy Stuff"), gain status and respect ("The Big Wheel"), appear invulnerable ("The Sturdy Oak"), and seek violence and adventure ("Give 'Em Hell") (Brannon & Juni, 1984). Some more commonly used scales today are the Personal Attributes Questionnaire (PAQ) (Spence & Helmreich, 1986), and Male Role Norms Scale (MRNS; Levant et al., 1998). The PAQ consists of self-reported levels of particular traits and statements that represent one's self, such as degrees of aggressiveness, helpful to others, and ease of making decisions. Each item is either on the scale of masculinity, femininity, or both. Examples of extreme responses on the masculinity scale include "never cries", "very competitive", "very independent", and "never gives up easily". The MRNS has seven theoretically derived norms of traditional masculinity ideology: Avoidance of Femininity, Fear and Hatred of Homosexuals, Self-Reliance, Aggression, Achievement/Status, Non-Relational Attitudes Toward Sex, and Restrictive Emotionality.

There is criticism around a lack of ethnic diversity and sexual orientation coding in the samples from which most masculinity scales are developed from. Samples are also often drawn from college-aged men only, which does not represent the age-related diversity of manhood across the lifespan (Whorley & Addis, 2006). Some measurement scales of masculinity show reduced validity among gay men (Alt, Lewis, Liu, Vilain, & Sanchez, 2014) and most scales focus on Western values of masculinity (Shek, 2007). Doss and Hopkins (1998) created the Multicultural Masculinity Ideology Scale, though their sample consisted of only three ethnic groups - Chilean, Anglo-American, and African-American men.

A few recent studies have addressed the intersectional understandings of masculinity across race and sexual orientation. European American men tend to endorse less traditional masculinity ideology than African-American men or Hispanic-American men or Hispanic men from the Caribbean (Levant et al., 2003). Higher levels of "machismo", the Spanish term for masculine pride, aggression, and responsibility to provide and protect one's family, among Mexican-American men has been linked to higher levels of depression and stress (Fragoso & Kashubeck, 2000). Higher levels of gender role conflict are linked to negative feelings about being gay (Sanchez, Westefeld, Liu, & Vilain, 2010) and higher rates of depression among men of sexual minority (Szymanski & Ikizler, 2013). In Haak's (2014) study based on interviews with transgender men (individuals assigned as female at birth and identify with the male gender) and cisgender men (individuals assigned as male at birth and identify with the male gender), transgender men have a higher awareness of what constitutes as masculine or feminine than cisgender men in order to adequately perform masculinity in their daily lives, such as wearing men's clothes and a short hairstyle, suppressing emotional expression, and exerting physical strength. Many participants acknowledged their own hypocrisy when speaking against

stereotypical traits of masculinity but also performing those same traits and behaviors in order to pass as masculine. Transgender men also reported learning what was considered masculine not from their peers or parents, but from LGBT community centres, gender and sexuality classes, or television/films (Haak, 2014).

Hegemonic Masculinity

The seminal sociological work of Connell (1995)'s *Masculinities* defined masculinity and femininity as "gender projects" that configure the social world. These configurations are applied to one's individual life, culture or ideology, and institutions. At any given time, one form of masculinity is culturally accepted over others, while other forms are subordinated. Connell coined the term *hegemonic masculinity* - "the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women" (p. 77). Hegemonic masculinity is marked by successful societal claim to authority. It is based on hierarchical relationships of power and oppression of other identities, namely femininity. Thus, gender relations of dominance and subordination exist between groups of men. For example, in Western society, gay men are on the lowest rung of the gender hierarchy among men; their stereotyped preferences and behaviors are likened to those of femininity, and are thus devalued. This subordination results in political, cultural, and legal oppressions and discriminatory attacks of LGBT members. Other features of hegemonic masculinity include endorsement of violence, self-reliance, toughness, and stoicism. Connell posits that hegemonic masculinity is not a personality type or male character per se. A small number of men fully embody the traits of hegemonic masculinity, however men's collective aspiration to and complicity with its definition affords men the patriarchal privilege through the overall subordination of women.

While Connell's theory of multiple, hierarchical masculinities has expanded discourses on gender oppression and power, Seidler (2006) argues that Connell's hegemonic masculinity is incomplete without considering the lived experiences of men themselves. Seidler contends that Connell's framing of masculinity solely through power dynamics over women silences men's opportunities to reconcile with what it is to be a man and their own pain. As discourses about women's oppression made their way into academia and now mainstream culture, men who are aware of gendered oppression may feel that their own experiences of abuse, neglect, trauma, and other struggles are relatively unimportant in the gender conversation. It sends a message that men are not allowed to feel pain or ask for help because they are the privileged group and perpetrators of the oppression, on top of the existing societal expectation of being strong and emotionally bulletproof. When masculinities are homogenized into mere oppressive definitions, cultural differences in men's lived experiences are rendered invisible. Hegemonic masculinity fails to offer an adequate method to understand how men position themselves as gendered beings and the sociopsychological reproduction of male identities (Wetherell & Edley, 1999). Therefore, the theorization of hegemonic masculinity needs to recognize its effects on men as well as women.

Though I myself do not identify as male in sex or gender, I can attest to the influence of hegemonic masculinity in my personal life as a cisgender woman and observe it in everyday society. My grandfather told me from a very young age how he always wanted a grandson, and between me and my older sister, I was his favored grandchild because I possessed more masculine traits like ambition, confidence, and high achievement. Education was the highest held value in my immigrant Chinese family, so my parents did most of the household chores so I could spend my energy and focus on school as opposed to the traditional domestic skills like

cooking and sewing that my female ancestors before me were trained to do. I got along with boys

when I was a teenager because I had a dark sense of humor and played poker like "one of the

guys". I make judgments about people who care too much about their appearance and what other

people think about them, or are dependent upon others. I have been in conversations with people

who have teased or gossiped about gay and transgender men. I have made comments before

about certain men not being "man enough" because they were not confident, money or career-

oriented, and/or demonstrated leadership skills. Hegemonic masculinity is not only something

that permeates through the value systems that I have been brought up to internalize, but be

complicit in the prioritization of traditional Western masculine behaviours and traits and

devaluation of feminine ones.

I strongly support the noted criticisms of Connell's originally theorized hegemonic

masculinity as incomplete and rendering the lived experiences of men invisible. To focus solely

on the victimhood of women under men's privilege and power, we silence men's experiences of

pain and trauma. It is worth noting that Connell later came out as a transgender woman, thus her

theories about masculinity and patriarchy as decisively antagonistic towards women may have

been reflective of her own rejection of societal expectations needed to define her gender identity.

Men are not only being told that they need to fit into very rigid definitions of masculinity

in order to be validated and accepted in society, but that they have no right to complain, shed a

tear, or even admit there is a problem - whether it be a stressful life event or not being able to

conform to the unrealistic standards of manhood. It also stifles conversation around how

different men experience hegemonic masculinity differently, and the intersectional experiences

of marginalized men and non-dominant gender and sexual identities (we will touch upon this

later). The inability to process pain and overcome the stigma around seeking help could

exacerbate the problem and lead to harmful manifestations of unhealthy but masculine-affirming coping mechanisms like anger, violence, and substance abuse. When I ask the men in my life how they would feel about going to counseling during trying times, all of them either expressed avoidance or hesitation at the very idea. By increasing men's receptivity to professional help, counseling services would at least be an option for men so they do not have to struggle alone.

Male Gender Role Conflict

Gender role conflict (GRC) arises when restrictive, rigid gender roles result in negative consequences in multiple areas of life. Male GRC is a psychological state where socialization to the traditional male gender role causes the restriction of men and boys' ability to actualize their human potential or the restriction of someone else's potential (O'Neil et al., 1986). GRC is hypothesized to occur cognitively, behaviourally, and unconsciously.

O'Neil's (1986) conceptual model of male GRC is based on male gender socialization and the fear of femininity. Men avoid showing affection, passivity, vulnerability, and tending to one's pain because they are seen as weak and feminine. The six domains of GRC patterns include (a) *restrictive emotionality*, having difficulty expressing feelings openly, giving up emotional control, and being vulnerable to self and others; (b) *control*, having others or situations under one's command; *power*, obtaining authority or influence over others; and *competition*, striving against others to gain something or the comparison of self with others to establish one's superiority; (c) *homophobia*, supporting a belief system that perpetuates negative myths and stereotypes about non-heteronormative people; (d) *restrictive sexual and affectionate behavior*, having limited ways of expressing one's sexuality and affection toward others; (e) *obsession with achievement and success,* having persistent and disturbing preoccupation with work,

accomplishment, and eminence to maintain one's masculinity and personal value; and (f) *health care problems*, ignoring symptoms that lead to acute illness or chronic health problems such as poor sleep hygiene, extensive alcohol consumption, nutritional disregard, and emotional repression. The GRC model gave rise to the widely-used Gender Role Conflict Scale (GRCS; O'Neil et al., 1986) consisting of four categories of masculinity: success, power, and competition; restricted emotionality; restricted affectionate behavior between men; and conflict between work and family relations.

Increased psychological stress associated with GRC is thought to occur both as a result of fulfilling the standards of traditional masculinity and failing to meet them. Higher GRC scores are positively correlated with anxiety, depression, and difficulty with intimacy, and low self-esteem (Sharpe & Heppner, 1991). In the context of the GRC model and mental health help-seeking behavior, I theorize that a man may experience GRC and subsequently be apprehensive towards attending counseling because (a) he feels alienated from or is uncomfortable talking about his own emotions, and does not want to feel vulnerable in front of another; (b) he is unwilling to share control over his life decisions and perspective with a professional with therapeutic authority; (c) he believes asking for help or talking about feelings is effeminate and associated with "being gay"; (d) he may fear stigmatization if he were to raise problems regarding intimacy and affection in relationships that deviate from non-traditional masculine expression; (e) he feels that seeking help and acknowledging he has issues requiring professional intervention contradict his masculine identity formed around staunch success and accomplishment; or (f) he has learned to ignore or repress personal pain as his preferred coping mechanism. Based on the above, a potential strategy to overcome GRC in prospective male counseling clients could involve downplaying focus on emotions, intimacy, and the presence of

problems while capitalizing on their agency and strive for self-improvement and achievement. These aspects will be demonstrated later in my research proposal for a male-oriented counseling brochure.

Queer Theory

Theorizing about masculinity reaffirms the "gender binary" - the existence of feminine and masculine identities that are considered normative. By extension, cisgender identities and heterosexuality are also considered the dominant versions of gender and sexuality respectively. Identities that do not fall neatly into these aforementioned categories are considered abnormal and marginalized from the dominant discourses, such as gay, lesbian, bisexual, polyamorous, intersex, and transgender identities. For example, the act of "coming out" as a non-gender binary or non-heterosexual individual exemplifies the pervasiveness of the gender binary and heteronormativity that necessitates the need to "announce" one's departure from it (Tilsen & Nylund, 2010). Queer theory "seeks to critique hegemonic assumptions about the continuities between anatomical sex, gender identity, sexual identity, sexual object choice, and sexual practice" (Tilsen & Nylund, 2010, p. 66). By deconstructing the gender binary and fixed identities, queer folks strive for inclusion and equality. In a "queer utopian" world, gender would either be eradicated or multiplied exponentially, and cisgender privilege would be unmasked and challenged (Tilsen & Nylund, 2010). While queer theory makes powerful critiques of hegemonic gender and sexual identities, its real world manifestation is somewhat unfeasible given the insidiousness yet imprecise definitions of the current gender binary in every institution within Western culture. "The struggle to articulate what constitutes maleness or femaleness may in fact expose the limits of queer theory as it may effectively de-legitimate intuitive ways of knowing that cannot be clearly articulated" (Tilsen, Nylund, & Grieves, 2007, p.51). Given the gender

binary's arbitrary rigidity and oppressive powers it wields upon people who both ascribe to and resist it, I am in full support of removing gender and sexuality constructs and living as authentic selves without worrying about conformity or comparison to what is considered "normal". However, feminine/masculine and heteronormative ways of understanding the world and our institutions are predominant. Individuals are and will continue to be subject to stigma and discrimination in their everyday life based on these omnipresent labels and what they stand for - a predicament most strongly afflicted against the LGBT community. It is my hope that analyzing and unpacking what masculinity means within the dominant culture will provide us with potential attributes mental health agencies can capitalize on to better reach men. Gender should no longer be a barrier to accessing and receiving effective therapy, or any opportunity for that matter. While it is certainly not the only setting where men can reflect on how their masculinity has informed their worldviews and behaviors, therapy can serve as that safe space to do so. Within an anti-oppressive, social justice framework, men can, if they so wish to, uncouple themselves from toxic elements of masculinity and live more authentically. In sum, this paper's focus on masculinity is a product of the hegemony that is the gender binary, however I believe that mental health research into this pervasive construct is necessary in order to understand the gender barriers that have real life implications. At the same time, providing quality therapeutic care to more men could act as a starting point for men to critically reflect on how masculinity has shaped their maladaptive habits, which is congruent with the resistance efforts born from queer theory.

Positioning

As a counseling student, I align myself with anti-oppressive, non-pathologizing, humanistic and feminist approaches. One practice of cultural competency is the process of

location of self - the transparent dialogue a counselor has with their client about how their key identities such as race, gender, class, sexual orientation, and religion could impact the therapy process (Watts-Jones, 2010). By extension, my identities and lived experiences will present biases in my critical analyses on power and oppression in this paper. I identify as a non-religious, Chinese-Canadian, able-bodied, middle-class, Western-educated, heterosexual, cisgender young adult female. I have grown up in a patriarchal society and family structure that valued men and masculinity as opposed to women and femininity. I recognize that I can only comment on the lived experience of masculinity and male GRC in so far as to how it has oppressive influences on my unprivileged identities and its contrast to some of the privileges afforded to women and femininity, such as greater acceptance of emotional expression and help-seeking. My very voice within the gender discourse that utilizes feminist theories and language is founded by dominant Western, liberal, post-secondary academia. I strive to avoid adopting the stance of superiority or contempt towards men and the constructs of masculinity given my marginalized and "educated" understanding of gender that could take on a self-righteous, overcritical tone (i.e. "man-hating"). How one performs their masculinity or femininity is a product of socialization and historical contexts that I will approach with curiosity and understanding. I will not make blanket statements about how all men should or should not be. I acknowledge that the category *men* are not a homogenous group and the importance of intersectionality in the study of masculinity to comprehensively investigate how race, class, age, and biology, and sexual orientation create nuanced issues. Therefore, I will present research (or note the lack thereof) of unprivileged identities in my literature review where available.

Literature Review

Men are more likely to hold negative attitudes towards help-seeking than women (Ang, Lim, & Tan, 2004; Caplan & Buyske, 2015; Chang & Hsiaowen, 2008; McCusker & Galupo, 2011; Nam et al., 2010; Oliver, Pearson, Coe & Gunnell, 2005) and more likely to not have sought some form of help (Oliver et al., 2005). Men who score higher on measures of traditional masculinity norms and gender role conflict are more likely to exhibit aversion to mental health help (Berger et al., 2005; Chan & Hayashi, 2010; Davis & Liang, 2014; McCusker & Galupo, 2011;). Most men prefer other sources of support over professional therapy, such as speaking with friends and family members (Chang & Hsiaowen, 2008; Oliver et al., 2005).

One measure of the Gender Role Conflict Scale that shows significant predictive power is restrictive emotionality (RE). Men who have increased RE are less likely to perceive therapy as helpful (Cusack, Deane, Wilson, & Ciarrochi, 2006) and give less favorable reviews about counseling after viewing a face-to-face counseling vignette (Rochlen, Land, & Wong, 2004). RE is also significantly correlated with self-stigmatizing perceptions of depression and alcohol abuse (Magovcevic & Addis, 2005). Men who are younger and born outside of North America are more likely to report higher levels of RE compared to older men and those born in North America, respectively (Davis & Liang, 2014).

Researchers have attempted to understand the underlying mediating factors that account for the correlation between traditional masculinity and low help-seeking attitudes. Self-stigma associated with seeking counseling appears to be a consistent mediator (Vogel, Wade, & Hackler, 2007; Pederson & Vogel, 2007). The relationship between perceived public stigma and self-stigma is stronger for men than for women, which means men may internalize public stigma

more strongly than women. "[T]raditional gender roles [may] lead society to consider counseling as something men are not supposed to need and therefore actually stigmatize men to a greater degree than women for seeking help" (Vogel et al., 2007, p. 47). A stronger association between masculine norms and self-stigma was found in heterosexual men than gay men, and European-American men than African- or Latino-American men (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Self-stigma is a major deterrent to seeking help for psychological issues among African-American men, and is directly influenced by social stigma and resiliency (Cadaret & Speight, 2018). Among Latino men, the level of perceived stigma was the highest among those who believed that depression was the result of personal transgressions, injustice, or malevolent spiritual forces (Caplan & Buyske; 2015).

To try to evaluate the help-seeking attitudes of those in need of help, studies have collected data on the participants' mental well-being or from men who are counseling clients. Clients with depression tend to score higher on socially adverse masculine and feminine traits (Holahan & Spence, 1980). Lower scores on self-reported mental and physical health status measures are correlated with higher perceived stigma (Caplan & Buyske; 2015). People with higher levels of depression are actually more likely to report negative attitudes toward help-seeking (Chang & Hsiaowen, 2008), thus those who may need therapy the most are also the most resistant to accessing it.

On the other hand, some studies have found femininity, not masculinity, as the influencer for help-seeking attitudes. Higher scores in femininity, regardless of sex, significantly influenced individuals' level of stigma tolerance among Singaporean students (Ang, Lim, & Tan, 2004). After reading a vignette about a heterosexual man with mild depressive symptoms who made an appointment for therapy, individuals tended to rate the man as more feminine than the same

vignette where the man did not make an appointment (McCusker & Galupo, 2011). These findings indicate that more research into the role of femininity and help-seeking may be as insightful as those focusing on masculinity.

Diverse Populations

Most studies on men's psychological help-seeking attitudes and masculinity have used convenience samples consisting of predominantly young, Caucasian, heterosexual, post-secondary psychology undergraduate students. More diverse populations have yielded some nuanced results. For example, older men tend to hold more positive attitudes toward psychological help-seeking and less adherence to traditional masculinity (Berger et al., 2005; Cadaret & Speight, 2018; Davis & Liang; 2014), which shows that endorsement of gender norms changes throughout one's life.

For African-American men, masculine self-reliance and perceived racial discrimination are positively associated with depressive symptomology (Matthews et al., 2013). Black youth in foster care who have greater adherence to the norm of emotional control had a lower likelihood of using informal and formal sources of help (Scott Jr., McMillen, & Snowden, 2015). African-American masculinity is influenced by John-Henryism, a stress management strategy via the employment of prolonged high-coping at the cost of one's health in the face of psychosocial factors. According to Matthews, Hammond, Nuru-Jeter, Cole-Lewis, and Melvin's study (2013), John-Henryism has a moderating effect on the positive relationship between racial discrimination and depressive symptoms, hence John-Henryism may be beneficial for African-American men's mental health by reducing depressive symptoms, though only among those who report higher scores of perceived discrimination. Self-reliance and resiliency should be leveraged as ways of

RESEARCH PROPOSAL WITH MASCULINE-ORIENTED BROCHURES

effective coping with depression. At the same time, the detrimental effects of extreme self-reliance on self-stigma and social stigma should also be addressed, as they can facilitate depressive symptoms and negative psychological help-seeking beliefs (Cadaret & Speight, 2018; Matthews et al., 2013).

Studies focusing on Latino samples show the same gender and age differences as previously mentioned. "Gender differences in help-seeking behavior can be explained by men's adherence to traditional male gender roles, which reinforce the idea that help-seeking is associated with weakness and vulnerability....Restrictive emotionality or a narrowed range of perceived emotions has been linked to *Machismo,* traditional male gender roles, and help-seeking for psychological problems" (Caplan & Buyske, 2015, p. 10464). Other barriers to accessing formal sources of help are financial barriers, lack of health insurance, language barriers, not knowing where to seek services, not being able to take time off work, long waiting times, and the fear of accessing services because of immigration status (Cabassa, 2007). Machismo has been negatively associated with help-seeking attitudes and positively correlated with restrictive emotionality and restrictive affectionate behavior between men (Davis & Liang, 2014). *Caballerismo*, a prosocial, family-oriented form of positive masculinity within Latino culture, has been found to predict greater satisfaction with social support and overall quality of life, in which the effects are boosted when combined with religious involvement (Estrada & Arciniega, 2015). However, there is no statistically significant relationship between *caballerismo* and help-seeking behavior. "The lack of findings may suggest that men who highly adhere to *caballerismo* ideology might autonomously resolve the issues through the use of a traditional healer, familial supports, or spiritual methods, before psychological services are necessary" (Davis & Liang, 2014, p.30).

The handful of studies done around help-seeking behavior and masculinity among the Asian population highlights the influence of self-stigma. European-Americans tend to have more positive views of help-seeking than Asians (Nam et al., 2010). Although traditional masculinity and help-seeking attitudes is significant among European-, African-, and Latino-American men, it was not for Asian-American men; self-stigma was the fully mediating effect between traditional masculinity and attitudes (Vogel et al., 2011). In Chan and Hayashi's (2010) study, the majority of student and employed Japanese men responded unfavorably to the prospect of seeking professional help and considered professional help futile. Men who responded more favorably tended to be older and not emotionally restrictive. It is hypothesized that these differences are due to cultural values around collectivism and shame. Asians prioritize their social circles and group harmony over individualistic needs, hence their friends and family are more influential and seeking professional help for personal issues may be considered bringing shame to the family and, by extension, themselves (Nam et al., 2010; Vogel et al., 2011). This cultural theory seems to be supported by a study done on Taiwanese students where females had more positive attitudes towards professional help-seeking, however their reported use of such services in times of stress did not significantly differ from their male counterparts (Chang & Hsiaowen, 2008). The degree of acculturation also influences immigrants' views of help-seeking. American-born Latino and Asian men are more likely to have more positive attitudes towards counselling than foreign-born immigrants of the same ethnicity (Davis & Liang, 2014; Nam et al., 2010).

There are very few studies that include an adequate sample size of non-gender binary and/or sexually creative men. In Donne et al.'s (2018) study of men who experience sexual violence that included focus groups of non-cisgender and non-heterosexual men, men reported

that feelings of stigma and shame from traditional masculine norms (e.g. men aren't supposed to be victims of rape, being gay is "asking for it", self-reliance is the only way to cope), cost of therapy, insurance, or access to services, and difficulty finding a provider they could trust and feel comfortable with as barriers to therapy. A unique study that surveyed 38 pairs of monozygotic male twins of opposing sexual orientations showed that the heterosexual men were less favorable to seeking help and expressed stronger adherence to masculine norms than their gay co-twins (Sánchez, Bocklandt, & Vilain, 2013). This study showed that socialization is what influences the attitudes and behaviors that are stereotypically masculine rather than genetics.

In light of these findings, researchers have made some recommendations of how mental health professionals might increase therapeutic engagement with men. Men may respond better to problem-focused, action- or strength-oriented therapy rather than feelings or insight-focused approaches (Cusack, Deane, Wilson, & Ciarrochi, 2006), particularly men of color (Kelly, 2014; Scott Jr., McMillen, Snowden, 2015). Therapists should frame masculine behaviors as a sign of strength and courage (Chan & Hayashi, 2010; Davis & Liang, 2014). When counseling is advertised to men, weakness or femininity should not be emphasized, but rather as problem solving or guided help (Kelly, 2014). "By communicating with the public that mental health problems do not need to be internalized as personal incompetence or something shameful, counselors might be able to reach more of those who are suffering" (Vogel et al., 2007, p.48).

Critiques

There are a number of shortcomings in the current research that investigates masculinity in relation to men's low participation in professional therapy. All studies are based on cross-sectional, self-reported data regarding one's attitudes and well-being. Many of the studies

surveyed a non-distressed population. There are no longitudinal studies that observe whether one's particular attitude actually results in more or less frequent counselling visits in one's lifetime. Attitudes from a non-clinical sample may not necessarily remain constant once one is in distress or exhibits mental health symptoms. Even positive attitudes towards help-seeking did not equate to more help-seeking in the female sample in Chang's study (2008). Help-seeking attitudes and behaviors of First Nations and creative sexual and gender identities (e.g. bisexual, transgender) have yet to be adequately researched. Given that the studies that surveyed men's preferred sources of help showed that men prefer their friends and family over professional help, research into the efficacy of men's existing coping strategies and informal help-seeking can inform the degree of concern we should have about men not showing up to therapy as much as women.

Changing Attitudes through Promotional Products

Several studies offer recommendations of how professionals can advertise and make therapy more suited for men, and there is some supportive evidence for these solutions. Robertson and Fitzgerald (1992) found that men with more negative attitudes toward help seeking and men with higher levels of gender role conflict showed more interest in seeking professional help after viewing non-traditional counseling services brochures (e.g. classes, workshops, seminars, a videotape library) as opposed to one-on-one talk therapy brochures. Blazina and Marks (2001) studied college male students' attitudes towards brochures about individual therapy, psychoeducational groups, and male support groups and found that men who were more gender-conflicted negatively reacted to all three treatment methods, especially male support groups. In a study evaluating the efficacy of the "Real Men, Real Depression" (RMRD) campaign by the National Institute of Mental Health, men with low gender role conflict and

negative help-seeking attitudes endorsed more favorable evaluations of the RMRD brochures compared to non-male-oriented brochures (Rochlen, McKelley, & Pituch, 2006). Wisch, Mahalik, Hayes, and Nutt (1995) showed that men who reported greater gender role conflict indeed respond more positively to vignettes about cognition-focused therapy than emotion-focused therapy.

However, in my review of the literature, there has yet to be experimental studies done in the real world that measure actual help-seeking *behavior* as opposed to mere self-reported attitudes. Such an experiment would strengthen the external validity of the hypothesis that help-seeking attitudes colored by male gender socialization influence men's help-seeking behavior, and efforts to alter these gendered attitudes could be the key to increasing male engagement in therapy. If an agency advertised therapy as a problem-solving, action-oriented process that tapped into one's sense of courage and strength rather than one of exploration of feelings and flaws, would more men make appointments for counseling? The final section will outline a research proposal with a quasi-experimental design to help answer this question.

Research Proposal: A Quasi-Experimental Study to Increase Men's Utilization of Counseling Using Masculine-Oriented Brochures

Hypothesis

The hypothesis of this proposed study is that a counseling agency that distributes male-oriented brochures will see an increase in adult male clients compared to a neutral brochure or control group. Furthermore, the number of female clients will not be significantly impacted, the new male clients will attend more than one session, and at the conclusion of their sessions report a positive experience to a satisfaction survey.

Method

Population and Sampling. This quasi-experimental study would take place at three different counseling agencies in the Vancouver Lower Mainland. There are several parameters and desired characteristics for an ideal sample. First, a census search would be conducted on the demographic makeup of prospective locations to determine whether there is a relatively equal ratio of adult women and men who could potentially access counseling. Second, the agencies would serve a wide variety of non-mandated, self-referred clients and provide generalized, non-gendered services. For example, agencies that focus on eating disorders (which tend to cater to women) and anger management group therapy (which tend to cater to men) would not be preferred because pre-existing programs that would attract one sex over another would likely influence the impact of our male-oriented brochure and skew the results. Third, a consultation with a statistician would confirm the size of the sample needed for each variable in order to have statistical power and sufficient effect size, then counseling agencies that match those requirements would be sought out. Fourth, the counseling agencies should not have any existing brochure materials or no redistribution of existing brochure materials in the past 12 months, and be willing to implement safe and secure data collection at intake for a total 12 month period. Fifth, intake and filing practices would need to be performed by an office administrator (not the experimenter) at each agency. Sixth, it would be ideal that all three counseling agencies offer similar modalities, pricing, and types of counseling to avoid additional variables.

Design and Data Collection. The study would have a non-equivalent pre-test and post-test control-group design. Each agency will be randomly assigned to either the control group, the neutral brochure group, or the male-oriented brochure group. Each group will serve as the

independent variables. The dependent variables will be as follows: the number of new adult male clients, the number of new adult female clients, how they heard about the agency, the number of attended sessions, client satisfaction, past counseling experience, masculinity and gender role conflict scales, and comprehensive demographic features such as age, ethnicity, educational background, income, and sexual orientation.

Data will be collected from each group for a six-month pre-test period to establish a baseline. Then, the neutral and male-oriented brochures will be distributed at the same time at the same four public locations in a self-serve manner, such as a community centre, a local gym, a church, and a college/university. The control group will have no brochures. Data will be collected during the post-test period for another six months.

Independent Variables: Design and Distribution of Brochures. The neutral brochure will include more traditional, medicalized terminology while the male-oriented brochures would encourage facing one's fears and obstacles and allowing opportunity for coaching on life skills. An operationalization of each element would need to be detailed and have equivalents on both brochures (e.g. "depression" and "mood management skills"), which will be presented in a table. Feedback from Rochlen, McKelley, and Pituch (2006)'s study about helpful and unhelpful themes for depression brochures will also be considered, such as the usefulness of materials with general information about depression, testimonials to increase the likelihood of identification, and a focus on symptoms that may serve to reduce the stigma associated with seeking help for depression.

All other brochure elements will be constant such as design layout, font, font size, and color scheme. The colors and content will be gender-neutral. The design of both brochures will

be vetted by a mental health marketing expert and a third-party mental health clinician that specializes in counseling for men to strengthen efficacy and appeal.

The distribution of the brochures to each of the locations will be done by the experimenter on the same day. Each brochure type will be displayed in the same place side-by-side. The practitioners and administrative staff of each counseling agency will be blind to the study's variables in order to remove potential threats to internal validity.

Dependent Variables: Demographics Survey and Scales. All new clients prior to their first session will complete an initial intake questionnaire that includes how they heard about the agency, a consent form, and a demographics survey. They will also complete the Gender Role Conflict Scale–I (O'Neil, Helms, Gable, David & Wrightsman, 1986) and Conformity to Masculinity Norms Inventory (Mahalik et al., 2003). There will be a number of sources in addition to the brochure that the client can choose from (internet, family/friend, mental health agency, etc.). A clause on the consent form would explain that non-identifying information of the clients' file may be used for research purposes, and only data from participants that signed the consent will be included in the study.

External and Internal Validity

The strength of this quasi-experimental design is its real-world application, while its weaknesses pertain to somewhat of a case study and a number of threats to internal validity. Implementing a marketing strategy to the public and collecting data from individuals who actually took interest and action in coming in for counseling as a result of that strategy are major steps forward from previous studies that surveyed men's self-reported beliefs and attitudes in a research setting. The duration of data collection is relatively long, thus captures an adequate

sample of participants and reduces the effects of seasonal or acute events. Threats to external validity are the singular treatment and control groups with their respective samples and settings as opposed to many different agencies in different neighborhoods for each independent variable. Internal validity was preserved in the consistent, covert measurement methods of the intake questionnaire, and the participants and clinicians being unaware of whether they were in a control or experimental group. Concerns regarding internal validity include selection bias (participants are not randomly sampled or randomly assigned), regression (such small numbers of male clients in the baseline period may have been extreme and were bound to regress towards the mean during the experiment phase), measuring the efficacy of the brochure (if a client marked that they heard about the agency from word of mouth for example, the person who made the referral could have done so after seeing a brochure and these referrals would be missing from our data) and the endless differing variables between the three counseling agencies could have influenced the results, such as quality of the facility, quality of the counseling and therapists, and scheduling availability.

Ethics

In focusing on increasing male enrollment specifically, it is important to observe whether these strategies would have an impact on female client enrollment and if this would pose ethical issues. One would hope to increase male enrollment while also increasing or maintaining the number of female clients as well. Most importantly, the counseling agency serving as the control group should also have access to the marketing resources of the treatment groups, which will be shared with them following the study. A thorough discussion regarding the ethics of the study will take place with a thesis advisor and/or an ethics board as necessary.

RESEARCH PROPOSAL WITH MASCULINE-ORIENTED BROCHURES

Results

A multivariate analysis of variance for correlated samples would examine the statistical differences between the dependent variables of the brochure experiment groups and the control group. I would also include only individual counseling clients and same-sex couples therapy clients; a combination of women and men could participate in heterosexual couples and family therapy and pinpointing the initiator of the counseling would be difficult. Consultation with a statistician will determine other appropriate statistical analyses and practices that would be most suitable for the study.

The result that would support my hypothesis would be a statistical significant increase in male enrollment between the control group and the male-oriented brochure group as well as between the neutral brochure and the male-oriented brochure group. The increase would be attributable to the reading of the male-oriented brochure, while no statistically significant decrease in female enrollment in the male-oriented brochure group compared to the baseline numbers and the other groups is observed. Additionally, observing the effects of each brochure on men and women with various demographic features and gender role conflict or masculinity ratings could yield insightful findings. For example, we might find that the male-oriented brochures tend to attract males and females who have high masculinity scores because they highlight their values of success and self-improvement rather than fixating on a problem or feelings. It would also be interesting to see if the new male clients would become return clients and if they will have positive outcomes as a result of counselling. If so, this would indicate that men can generally benefit from psychotherapy, and they just need the right lure to get their foot in the door.

Results supporting my hypotheses would confirm that carefully designed marketing materials can effectively target underserved populations. It would be a valuable tool that counseling and other health agencies can use to combat seemingly pervasive masculine norms and attitudes. Organizations can use the table of descriptors in the methods section as a template of the necessary elements one can utilize in their own marketing platforms. It is a relatively simple, cost-effective, non-intrusive technique. Changing the language of therapy may have larger implications for developing counseling techniques and frameworks that better suit men.

Future/Alternative Directions

Directions for further research would be integrating this strategy to other marketing platforms such as posters, agency websites, ads in sports or fitness magazines, and social media to see if the same effect is observed and to what degree. Health services that target predominantly male clients such as veterans and first responders, prostate cancer patients, and violent offenders can possibly reach more male clients via specialized marketing. If we can get more men interested in and willing to attend counseling, then the next step would be to keep them coming back for more sessions to optimize the effects of therapy. Should institutions adopt this strategy on a larger, longitudinal scale, it could have a sizeable impact on research on voluntary counseling populations since it would increase the size and diversity of the male client sample from which research can be conducted; theories can consequently become more representative. From a micro-sociological level, one might also study changes in the numbers of men in a given community who access health services in general and compare them to suicide, addiction, violent crime, and incarceration rates should counseling prove effective to a greater number of men.

Should the results not support the hypothesis, this too would also point at other potential areas of research that could increase male utilization in counseling. Aside from replicating the same design on a larger scale or more diverse population, other factors could be that men are not sufficiently influenced by public advertisements regarding mental health, or that men are more willing to come to counseling through other sources like referral from a trusted friend/family or health professional. Other factors impacting men's engagement in mental health services could be perceived trust with service providers, the power dynamics between patient and practitioner, and/or how service providers treat men who seek help (Richardson et al., 2017). Mental health literacy programs that teach young people and their helpers about early signs, symptoms, and normalizing seeking help could also make a difference, as they have shown positive outcomes (Kelly, Jorm & Wright, 2007). Elements of psychotherapy itself such as self-disclosure to and reliance on a professional for self-improvement can also be mediating factors. There is also a possibility that less conventional forms of therapy would better appeal to men, such as wilderness retreats. Even if some men had access and are open to counseling, they could merely prefer other ways of coping such as talking with friends/family/mentors, using drugs or alcohol, or focusing more time and energy on work or hobbies. Self-reported surveys and qualitative interviews with men who have participated in counseling would be possible research methods for these alternative hypotheses.

Conclusion

Men are disproportionately represented in many of today's mental health illnesses and negative life outcomes, however they are underrepresented in the psychotherapy client population. Masculinity and its intersections with age, race, and sexuality have been hypothesized as mediating factors to this phenomenon. In addition to diversifying the participant

samples in future studies, conducting experiments in a real-world setting would strengthen the hypothesized relationships between masculinity and therapy engagement. The proposed study strives to provide insight into the potential efficacy of male-sensitive mental health marketing through a brochure in order to increase male enrollment in counseling. Given the gendered nature of various mental health and health issues, research in this area is crucial and could have a substantial impact on providing essential services to underserved men and enrich the development of male-sensitive therapeutic frameworks and techniques.

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