An Exploration of Men's Attitudes Regarding Depression and Help-Seeking

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An Exploration of Men’s Attitudes Regarding Depression and Help-Seeking

by

Brian P. Cole

A DISSERTATION

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An Exploration of Men’s Attitudes Regarding Depression and Help-Seeking

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University of Nebraska, 2013

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Despite significantly higher risk of suicide and co-morbid substance abuse, college age men are far less likely than college age women to seek help when depressed (ACHA, 2010). This “gender gap” has led researchers to suggest that college men are experiencing a mental health crisis (Davies, Shen-Miller, & Isacco, 2010). Several theories have been suggested for this gender gap including: (a) barriers caused by male gender socialization, (b) inaccurate diagnostic criteria, and (c) men experience different symptoms when depressed (Cochran, 2005; Levin & Sanacora, 2007). Additionally, the current researcher hypothesizes that fear of femininity is a core aspect of the gender gap. The current study utilized a randomized analogue design with a series of vignettes about men with depression to identify: (a) symptoms that men believe indicate depression, (b) beliefs of about the masculinity and femininity of men experiencing depression, and (c) the influence of gender socialization on psychological help-seeking. This study also evaluated Perlick and Manning’s (2007) Model of Male Help-Seeking. Participants were men (N=366) enrolled at a Midwestern university. A series of ANOVAs revealed that men viewed a vignette character experiencing Major Depressive Disorder (MDD) as “less masculine” and “more feminine” than similar characters reporting symptoms congruent with Major Depressive Disorder-Male Type (MDD-MT; Pollack, 1998), a mix
of symptoms of MDD and MDD-MT, and career concerns. Additionally, men identified characters reporting traditional symptoms of MDD as most depressed. As well, a series of linear regressions suggest that adherence to aspects of male gender socialization (i.e., Gender Role Conflict and Conformity to Masculine Norms) are related to decreased engagement in seeking help from professionals, friends, and family as well as increased engagement in avoidant coping behaviors. Despite past suggestions that positive psychological traits (i.e., hope and well-being; Magyar-Moe, 2009) may buffer against psychological distress, hope and well-being did not moderate the relationship between male gender role socialization and help-seeking behaviors. Last, results of path analysis did not reveal support for the Model of Male Help-Seeking (Perlick & Manning, 2007). Implications for mental health practitioners, strengths and limitations of the study, and suggestions for future research are provided.
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Chapter 1

Introduction

Each fall, students across the United States make the transition from high school to college. These students bring many things along with them to the residence halls including school supplies, books, clothes, pizza money, and the latest and greatest electronic devices. However, it appears that an increasing number of these students are also bringing along clinical levels of psychological distress (ACHA, 2010). Nationally, directors of college counseling centers report significant increases in the number of students that are seeking help and in the severity of the problems they present with (Gallagher, 2010). Although college has the potential to be an exciting and rewarding experience, students are also faced with stress related to academic performance, career decision making, and developing independence from their family of origin. When these new stressors combine with pre-existing psychological distress, the results can be disastrous.

A 2010 study by the American College Health Association (ACHA) found that 8% of college students reported being diagnosed or treated for depression within the last 12 months. These students are also at risk for suicide. Across studies, approximately 6-11% of college students reported experiencing suicidal ideation within the last year (ACHA, 2010; Garlow et al., 2008). College students with depression are at risk for a variety of health problems including binge drinking, increased rates of illness, sleep problems, sexually transmitted diseases (Buchanan, Gardeswartz, & Seligman, 1999; CASA, 2003; Hojat, Gonnella, Erdmann & Vogel, 2003; Shrier, Harris, Sternberg, & Beardslee, 2001). These students may also experience academic difficulties such as lower
exam scores, lower course grades, and higher rates of dropped and incomplete courses (ACHA, 2010)

**Depression in Men**

Although the transition to college may increase the risk of psychological distress for the majority of students, it appears that men may be particularly at risk. College age men have an increased risk for completed suicide, substance abuse, and resistance to utilizing mental health services. This has led some to the belief that college men are experiencing a health crisis (Davies, Shen-Miller, & Isacco, 2010). Despite concern about the looming male health crisis, college women are far more likely to report a diagnosis of or treatment for psychological distress (ACHA, 2010; Gallagher, 2010). A similar “gender gap” in prevalence rates exists in the general population, with women receiving diagnoses of depression at approximately twice the rate of men (APA, 2009; Englar-Carlson, 2006). There is evidence that men need to be significantly more depressed than women before they are willing to seek treatment (Warren, 1983). This means that by the time men seek help, they are often experiencing severe distress and co-morbid disorders (e.g., alcohol abuse and dependence).

Despite the lower number of men who seek help for depression, the course of depression appears similar for men and women in treatment, indicating that if barriers to male help-seeking were reduced, men with depression could be treated successfully prior to the development of substance abuse and externalizing behaviors (Cochran, 2005). Researchers in the field of men and masculinity have begun to question the reasons for this gender gap and have implicated the process of gender role socialization (and the gender role conflict that may result) as culprits (Cochran, 2005; Good & Wood, 1995;
Rochlen, Whilde, & Hoyer, 2005). Gender role socialization begins at an early age, with boys being socialized to engage in norms related to emotional restriction (Levant, 2005). Many times, by adolescence, these boys have been socialized to believe that it is unacceptable to seek help or show emotional distress (Levant, 2005). Although there is diversity in the way that masculinity manifests across cultures, researchers suggest that a set of standards and expectations referred to as “traditional masculinity” or “hegemonic masculinity” also exist. These standards are rooted in the dominant culture and reinforce patriarchy by exuding beliefs about the superiority of men over women (Levant, 1996; O’Neil, 1981). Traditional masculinity is based upon four premises set forth by David and Brannon’s (1976) “Blueprint for Manhood.” These include: (a) avoidance of feminine behaviors (“no sissy stuff”), (b) striving for success and achievement (“the big wheel”), (c) never showing weakness (“the sturdy oak”), and (d) seeking adventure and risk (“give’em hell;” David & Brannon, 1976).

As a result of adherence to traditional gender norms, men may experience gender role conflict (GRC). GRC occurs when a person's socialized gender norms prevent him/her from acting in a certain way or leads her/him to feel negatively for doing so (O'Neil, 2008). This potential violation of gender roles may lead to negative social consequences and/or psychological consequences (Pleck, 1995). GRC has been associated with a greater risk for depression and with having more negative attitudes toward counseling (Good & Wood, 1995). The masculine gender norms of competence, achievement, and success are incongruent with feelings of depression and may lead to greater levels of distress (Warren, 1983). Traditional masculine norms and the presence of GRC may result in difficulty seeking help, because the type of behaviors clients
engage in while in therapy are conceptually "feminine" or at the very least "not masculine" according to traditional gender norms for self-disclosure, vulnerability, and emotional expression (Good & Wood, 1995).

In addition to hypotheses about the effects of gender role socialization, it has been suggested that depression manifests differently in men than in women. Evidence for this hypothesis comes from several significant gender differences: men are more likely to report somatic complaints than depression, men are four times more likely to commit suicide, men have higher rates of co-morbid alcohol abuse and dependence, and men typically endorse fewer diagnostic symptoms of depression than women (Leven & Sanacora, 2007; Warren, 1983). The DSM-IV-TR requires the presence of five symptoms for a diagnosis of Major Depressive Disorder (MDD) (APA, 2000), yet men do not often endorse at least five of these symptoms (Cochran & Rabinowitz, 2000). The National Institute of Mental Health (NIMH; 2009) found that men are more willing to report symptoms of MDD related to fatigue, irritability, loss of interest in work and hobbies, and sleep disturbances. This does not fit with the typical profile of depression which includes sadness, guilt, and feelings of worthlessness (NIMH, 2009). Because men are often less willing to report and/or are not experiencing the DSM-IV-TR symptoms of Major Depressive Disorder, clinicians may have difficulty assessing and diagnosing depression accurately when working with male clients. This finding led Pollack (1998) to develop a new set of diagnostic criteria for MDD for men. Major Depressive Disorder-Male Type (MDD-MT) is characterized by: (a) symptoms of social withdrawal (increased withdrawal from relationships, over-involvement at work, rigid demands for autonomy), (b) denial of pain, (c) avoiding help, (d) self-medicating behavior, (e) denial of sadness/
inability to cry, (f) harsh self-criticism, (g) depleted or impulsive moods, (h) changes to sex drive (increases or decreases), and (i) traditional physical symptoms of MDD (disturbances of concentration, sleep, and appetite/weight) (Pollack, 1998). MDD-MT builds upon the DSM-IV-TR criteria for MDD by considering the roles of avoidance, denial, and self-medicating behaviors that may help men hide their symptoms of MDD.

**Help-Seeking**

It has been suggested that men with depression experience “double jeopardy” because their experience of gender role conflict is predictive of an increase in depressive symptoms, while at the same time decreasing the likelihood that they would seek out treatment (Good & Wood, 1995). When men experience depression, they face a choice to express or suppress their feelings based upon what societal norms dictate is appropriate for the situation (Wong & Rochlen, 2008). This decision varies as a result of the degree to which men endorse male norms that may or may not be congruent with help-seeking (Addis & Mahalik, 2003). When deciding if he should seek therapy, a man may perceive that he will be judged as less masculine because aspects of help-seeking such as relying on others, asking for help, admitting the presence of a problem, and emotional expression may conflict with societal messages that men receive regarding the importance of self-reliance, toughness, and emotional restriction (Addis & Mahalik, 2003; Mahalik et al., 2003a). These internalized gender roles may act as a barrier that prevents a man from seeking help. When a man makes the decision to engage in these traditional roles, he validates, sustains, and legitimizes the relationship of the behavior to the sex, thus
reducing the likelihood that other men will seek help for similar problems (West & Zimmerman, 1987).

In an effort to better understand the way that masculine norms impact help-seeking behaviors of college men, Mahalik and Rochlen (2006) utilized a role induction vignette to explore men’s attitudes about depression. This study was interested in "(1) men's most and least likely actions in response to a vignette describing an episode of depression, (2) whether conformity to masculine norms related to the likelihood of men's responses, (3) which masculinity norms were associated with men's responses" (Mahalik & Rochlen, 2006; p. 659). Participants in the study (N=153) read a brief vignette describing an episode of major depression. They were then asked to rate the degree to which they would engage in 20 different responses (e.g., seek help in personal network, seek professional help, try to engage in self-help). Research participants then completed the Conformity to Masculine Norms Inventory (CMNI; Mahalik et al., 2003b).

Results of the study indicate that men are reluctant to seek help for depression. When they do decide to seek help, they report preferences for talking with partners and family members, or waiting to see if things get better on their own (Mahalik & Rochlen, 2006). Men in the study indicated that they are unlikely to seek professional help for depressive episodes. This finding is supported by research from ACHA (2010) which indicates that only a small minority of men seek professional help when experiencing psychological distress. The authors identified specific masculine norms that were related to specific coping reactions (e.g., higher levels of masculine norms of violence and power over women were positively correlated to substance use and negatively correlated to talking to a partner about depression) (Mahalik & Rochlen, 2006). Men in the study who
endorsed CMNI items related to Power Over Women, Dominance, and Pursuit of Status were less likely to talk with a partner about depression and were far less likely to talk with a mental health professional. They were also more likely to engage in self-medicating behaviors (Mahalik & Rochlen, 2006).

Despite men seeking help at lower rates than women, therapy has been found to be equally effective for men and women with depression (Levin & Sanacora, 2007). This has led researchers to focus on ways to reduce the barriers caused by gender role socialization and potential gender bias in the diagnosis of depression. As a result, treatment guidelines for men with depression have been developed in an effort to reduce barriers to help-seeking. These suggestions include working to change men's views of counseling, conceptualizing help-seeking as a strength, and challenging gender stereotypes about depression (Good & Wood, 1995; Rochlen et al., 2005).

Given the high prevalence of undiagnosed and untreated depressive disorders in men, interventions informed by the unique ways that depression manifests in men are critical for improving treatment outcomes and increasing male help-seeking behaviors. The proposed study examines the ways that men conceptualize depression and help-seeking. Expanding research on masculine norms and GRC by applying these concepts to specific sets of depressive symptoms and types of help-seeking may aid in the identification of variables that impact the appraisal of symptom distress and the decision to seek or avoid professional psychological help.

**The Proposed Study**

Through the use of vignettes about men with depression, the proposed study will build upon the work of Mahalik and Rochlen (2006) by exploring factors that may
preclude men to lower rates of diagnosis and help-seeking with an emphasis on exploring the impact of gender socialization related to masculinity. More specifically, participants will be college men who will be assigned to one of four vignette conditions and asked to identify symptoms of depression. Participants will also complete measures of gender role socialization, attitudes toward help-seeking, hope, and psychological well-being. The study will explore the degree to which perceptions about masculinity (of the self and of the “ideal man”) influence decision making about engagement in help-seeking. Frazier and colleagues (2004) argued that counseling psychology research would benefit from increased emphasis on the roles of mediators and moderators in the relationships between variables. Similarly, O’Neil (2008) suggested a greater focus on potential mediators and moderators of the relationship between gender role conflict and attitudes toward help-seeking. Thus, the current study will examine the moderating effects of hope and psychological well-being on the relationship between adherence to traditional masculine norms and attitudes toward help-seeking. Lastly, the study will test the model of male help-seeking behavior posited by Perlick and Manning (2007) by exploring the relationships between gender socialization, mental illness stigma, recognition of problem severity, and attitudes about help-seeking. See Appendix A for operational definitions of key constructs utilized in the study.

This chapter has asserted that the “gender gap” in depression diagnosis may be the result of gender role socialization. It has highlighted the ways that adherence to traditional masculine norms effects decisions to seek help for psychological distress. Additionally, this chapter has suggested treatment modifications that might improve the help-seeking behaviors of men with depression. Chapter 2 will further discuss the current
literature pertaining to gender role socialization, male experiences of depression, and barriers to help-seeking for psychological distress. Additionally, Chapter 2 will discuss recent movement toward examining masculinity as a strength and the potential role of positive psychological interventions in treating men with depression. Following the literature review, Chapter 3 will detail the methods utilized in the study. Chapter 3 will also elaborate on the procedures employed in the study and the statistical analyses planned. Chapter 4 will provide information on the results of the study, and Chapter 5 will provide a thorough discussion of these results, implications of the study for diagnosing and treating college men with depression, limitations of the study, and recommendations for future research.
Chapter 2

Literature Review

Although college is a time filled with excitement and new experiences, it is also a time of transition which can lead students to experience a sense of loss when separating from family and friends. When these loss experiences are combined with stress related to academic performance, career decision making, developing independence, and building new relationships, there is a high likelihood of psychological distress (Chickering & Reisser, 1993; Davies, Shen-Miller, & Isacco, 2010). Regarding college men specifically, adherence to masculine norms that value emotional restriction and independence may lead men to experience additional difficulties as they try to navigate this transition (Davis & Laker, 2004; Harper, Harris, & Mmeje, 2004; Davies et al., 2010). Davies and colleagues (2010) point to college age men’s increased risk for completed suicide, substance abuse, and resistance to utilizing mental health services as evidence that college men are experiencing a health crisis. Thus, the purpose of this study is to explore the beliefs of college men with regard to the diagnosis and treatment of depression. Given these goals, this chapter will use the lens of the “New Psychology of Men.” After a review of the gender role socialization and gender role conflict literatures, the chapter will provide an overview of depression with an emphasis on male experiences of depression. This will be followed by a survey of the help-seeking literature with a focus on the roles that gender socialization, gender role conflict, culture, and stigma play. The discussion of help-seeking will conclude with a presentation of Perlick and Manning’s (2007) Model of Male Help-Seeking. Finally, suggested improvements to treatment and positive psychological interventions will be presented.
The New Psychology of Men

For many decades, psychology was more aptly described as the “psychology of men” or more specifically, “the psychology of White men” (Levant, 1996, p.259). Most studies utilized White, middle class men as participants and the results of these studies were generalized as though they were representative of all humanity (Levant, 1996). As a result of societal changes and recognition of a need to shift away from this tendency toward the “psychology of White men,” the field of psychology began to expand by focusing more specifically on the impact of gender and culture. Concurrent with this shift in the field, researchers and practitioners started to rethink age old conceptualizations of masculinity and started to examine gender issues with the same critical eye that feminist researchers had been utilizing in studies of women (Levant & Pollack, 1995; O’Neil, 1981, 2008).

Those involved in this “New Psychology of Men” suggest that this emphasis on the psychology of masculinity is needed due to the disproportionate amount of men impacted by problems such as substance abuse, homicide, suicide, and fatal illness (Levant, 1996). A better understanding of masculinity is beneficial to all of society in part due to the potential to reduce incidents of intimate partner violence, sexual assault, child abuse, and interpersonal violence (Levant, 1996). This “New Psychology of Men” has led to new understanding of the complexity of masculinity with an emphasis on separating “sex” from “gender” and a focus on the impact of male gender socialization (Kiselica & Englar-Carlson, 2010).
The New Psychology of Men emphasizes differences between sex and gender. While sex roles are behaviors tied to biology (e.g., reproductive functioning), gender roles are behaviors that are enacted as the result of compliance with societal standards of masculinity and femininity (Englar-Carlson, 2006; Kimmel & Messner, 2004). Eisler’s (1995) gender role schema model explains how men develop gender roles. From an early age, men learn to evaluate their adequacy based upon their ability to behave in accordance with male gender norms. There is variation in the degree to which men regulate their behavior in accordance with these socially prescribed norms as a way to affirm self-worth (Eisler, 1995; Englar-Carlson, 2006).

Masculine ideology is “an individual’s internalization of cultural belief systems and attitudes toward masculinity and men’s roles. It informs expectations for boys and men to conform to certain socially sanctioned masculine behaviors to avoid certain proscribed behaviors” (Levant & Richmond, 2007, p.131). Masculine ideology develops as boys internalize social expectations about gender appropriate behavior (Thompson & Pleck, 1995). Although there is diversity in the way that masculinity is manifested across cultures, researchers argue that there is a set of standards and expectations that are rooted in the dominant culture (Pleck, 1995). These standards are often referred to as “traditional masculinity” or “hegemonic masculinity.” Traditional masculinity is based upon four premises set forth by David and Brannon’s “Blueprint for Manhood” (1976) and include: (a) avoidance of feminine behaviors (“no sissy stuff”), (b) striving for success and achievement (“the big wheel”), (c) never showing weakness (“the sturdy oak”), and (d) seeking adventure and risk (“give’em hell;” David & Brannon, 1976). These standards serve as benchmarks for men to strive for. The more closely a man conforms to these
standards, the closer they are to “being a man”. Despite the near impossible difficulty of achieving these benchmarks, David and Brannon (1976) suggest that most men compare themselves to these standards of masculinity. Although each piece of the “blueprint” has potentially negative implications for boys and men, it has been suggested that “no sissy stuff” is the most harmful as a result of emotional restriction that hinders men’s abilities to engage in meaningful relationships and to address their emotional needs (Pollack, 2005). These norms uphold societal patriarchy and influence the socialization of children (Levant, 1996; Pleck, Sonenstein, & Ku, 1994). As well, gender norms serve as cultural scripts that inform how men learn to manage emotions, cognitions, and behavior (Levant & Richmond, 2007). O’Neil (1981) suggested that these societal expectations of optimal masculinity can best be described as “The Masculine Mystique.” The ideals of The Masculine Mystique encourage men to embrace traditional masculine ideology and promote sexism and is based upon the following principles:

- men are biologically superior to women and have more human potential;
- masculinity is superior to femininity;
- power, dominance of others, competition and control are essential to proving masculinity;
- vulnerability, feelings and emotions are feminine and should be avoided;
- rational and logical thought and communication is masculine, whereas communication and thought that emphasizes emotion, feelings, and intuition are inherently feminine and should be avoided;
- while sex is a means for proving masculinity, affection and intimate behavior are feminine;
• vulnerability and affection toward other men should be avoided in an effort to avoid perceptions of homosexuality;
• work and career success are measures of masculinity;
• because men are superior employees, the man should be the provider and the woman should be the caretaker of the home (O’Neil, 1981).

This value system promotes a fear of femininity that restricts the types of behaviors in which men engage and encourages sexism through its devaluation of “feminine” values, behaviors, and attitudes (O’Neil, 1981).

**Male gender socialization.** Social constructivists argue that masculinity is not a stable trait rooted in biology, but rather a choice to express or suppress feelings and behaviors based upon perceptions of what societal norms dictate is appropriate for the situation (Wong & Rochlen, 2008). These societal norms are learned over time and include messages about the advantages and disadvantages of behaviors in society (Levant, 1996). Gender role socialization theories posit that men learn gendered behaviors from their environment by exposure to modeling, rewards, and punishment (Levant & Pollack, 1995; Wong & Rochlen, 2008). Gender role norms are determined by societal stereotypes and standards that children are socialized to early in life. Pleck (1995) eluded to the social construction of gender by asserting that there is no one standard that all men should live up to, rather masculinity varies across race, ethnicity, socioeconomic status, sexual orientation, social, and historical changes (Levant, 1996; Pleck, 1981, 1995). This view of the impact of socialization toward gender roles allows room for individual differences, culture of origin, and the fluid and situational nature of masculinity (Wong & Rochlen, 2008). Wong and colleagues (2010) suggest that
contextual factors influence how men perceive situational norms about emotions and emotional behavior. At the macro level, masculinity changes as the result of cultural, historical, socioeconomic, and societal factors, whereas at the micro level, masculinity varies as across social interactions (Wong & Rochlen, 2008). This emphasis on societal and individual contexts suggest that masculinity is not a stable trait that is instilled in the individual, but rather masculinity is socially constructed and performed through a process of choosing appropriate masculine norms to apply to specific situations (Connell & Messerschmidt, 2005; Wong & Rochlen, 2008).

West and Zimmerman (1987) suggest that gender norms constitute roles that individuals take on in specific situations. In other words, "gender is a socially scripted dramatization of the culture's idealization of feminine and masculine natures..." (West & Zimmerman, 1987, p.130). When a person "does gender" they are engaging in patterns of behavior that have some kind of social consequence and this consequence can be positive or negative depending upon potential contradictions of societal norms. As such, a person can be held accountable for their behavior in that any behaviors that do not live up to societal expectations of gender norms may lead a person to be viewed as having a less legitimate attachment to a sex category (West & Zimmerman, 1987). This may explain why some men may find it appropriate to cry after their favorite team loses a major sporting event, but not when feeling hurt or rejected by a friend or loved one (Walton, Coyle, & Lyons, 2004).

Vandello and colleagues (2008) indicated that masculinity is far less stable in the eyes of men than femininity is in the eyes of women. In their research, the majority of men and women attributed the transition from childhood to womanhood to biological
factors, however the majority of men and women in the study attributed the transition to manhood to social factors. Similarly, both women and men in the study reported that unlike womanhood, masculinity is most often lost due to nonadherence to social norms rather than changes in physical attributes. Additionally, male college students in these studies viewed masculinity as unstable and indicated that it requires social proof. With regard to the instability of masculinity, manhood is considered something that one tries to accomplish rather than something that happens to a man through a process of biological development (Vandello, Bosson, Cohen, Buraford, & Weaver, 2008; Pleck, 1981). As a result of the elusive nature of masculinity, men may feel the need to prove their masculinity through risk taking behaviors (e.g., excessive drinking, athletic performance, sexual promiscuity) and displays of success, power, and competition (e.g., bragging about income or driving expensive cars) (Vandello et al., 2008). When men in these studies were presented with task performance feedback that challenged their manhood, they reported high levels of anxiety and shame and most often reacted aggressively, defensively, and/or increasingly competitive (Vandello et al., 2008)

While “doing gender,” men engage in a variety of masculinity scripts (Mahalik, Good, & Englar-Carlson, 2003a). Mahalik et al. (2003a) defined 8 scripts, describing them as based upon societally prescribed gender norms. The “Strong and Silent Script” emphasizes the belief that men and boys should be perceived as stoic and unemotional through a process of controlling and restricting emotional expression. Similarly, the “Tough Guy Script” is associated with messages that teach boys and men to be tough by suppressing emotion and avoiding displays of vulnerability. The messages associated with these scripts encourage men to avoid expression of sadness and to find alternative
ways to cope with psychological distress (e.g., self-medicating behaviors; Eisler, 1995). The “Tough Guy” script also encourages men to act in ways that are aggressive, fearless, and invulnerable, thus increasing the risk that men who rigidly enact this script may be at higher risk of harming themselves or others (Courtenay, 2000). The “Give’em Hell” script emphasizes acceptance of violence and aggression as an avenue to power, status, and prestige. Men that rigidly endorse masculine norms related to violence and aggression are more likely to see psychological distress manifest in the form of somatic complaints and irritability (Mahalik et al. 2003b). They are also more likely to engage in abusive behaviors such as intimate partner violence in an effort to maintain power or control in relationships (Bernard, Bernard, & Bernard, 1985; Dutton & Browning, 1988; Mahalik et al., 2003a; Vass & Gold, 1995). The “Playboy” script emphasizes suppression of intimacy, care, and connection with others and replaces it with lust. Men who engage in the Playboy script are more likely to prefer inequality in romantic relationships and low levels of communication with romantic partners, as well as be more likely to have a fear of intimacy (Brooks, 1998; Good & Sherrod, 1997; Levant, 1997; Mahalik et al., 2003a). The “Homophobic” script emphasizes avoidance of feminine behavior and behaviors associated with being gay (e.g., affectionate behavior between men), whereas the “Winner” script emphasizes competition and success. Finally, the “Independent” script emphasizes rigid adherence to self-sufficiency and a lack of significant attachment in relationships (Mahalik et al., 2003a).

Although there is evidence that masculinity scripts may be adaptive and beneficial to men when they are flexible, rigid adherence to these scripts may lead to a variety of problems (Kiesler, 1983; Mahalik et al., 2003a). It has been hypothesized that when men
feel vulnerable, they fear loss of status and power and as a result, overconform to masculine norms (Mahalik & Backus, 2011). Endorsement of traditional masculine norms predicts low self-esteem (Cournoyer & Mahalik, 1995), difficulty in interpersonal relationships (Fischer & Good, 1997; Sharpe & Heppner, 1991), tendencies toward interpersonal violence (Franchina, Eisler, & Moore, 2001), and psychological distress (e.g., depression and anxiety; Cournoyer & Mahalik, 1995; Good & Mintz, 1990; Good et al., 1995; Hayes & Mahalik, 2000).

Pleck’s theory of Gender Role Strain (1981, 1995) proposed that modern day gender roles are contradictory and inconsistent. Many people violate gender roles and this leads to real and imagined psychological consequences (e.g., feelings of condemnation; Levant, 1996). These consequences appear to be more severe for men. Pleck (1995) described three types of male gender role strain: (a) discrepancy-strain, (b) dysfunction-strain, and (c) trauma-strain. Discrepancy-strain occurs when a man fails to live up to internalized expectations of the ideal man. These ideals are based upon tenets of traditional masculinity (e.g., David and Brannon’s “Blueprint for Manhood”). Dysfunction-strain occurs as the result of the negative consequences of living in accordance with potentially destructive gender norms (e.g., aggression and restrictive emotionality) that have negative consequences on the men and those closest to them. Trauma-strain is the result of extreme experiences that result from gender role strain (e.g., war; Pleck, 1995).

**Gender role conflict.** Gender role conflict is "a psychological state in which socialized gender roles have negative consequences on the person or others" (O'Neil, 2009, n.p.) Thus, gender role conflict (GRC) is the result of gender role strain and occurs
when a person's socialized gender norms prevent him/her from acting in a certain way or leads him/her to feel negatively for doing so (O'Neil, 2008). This potential violation of gender roles may lead to negative social consequences and/or psychological consequences (Pleck, 1995). Fear of these consequences may lead individuals to restrict their behaviors in such a way that prevents the person from reaching her/his full potential, or may prevent other people from reaching their full potential by devaluing those that deviate from gender norms. Gender role conflict can be experienced interpersonally through interactions with others in which the person is devalued, restricted, or violated for deviating from masculine norms. GRC can also be experienced intrapersonally as the result of gender role transitions that coincide with major life changes (e.g., puberty, getting married, becoming a father; O’Neil, 2008).

At its core, O’Neil (1981, 2008) suggests that GRC is driven by fear of femininity. As discussed previously, The Masculine Mystique promotes masculine gender norms that are marked by avoidance of behaviors that are deemed feminine and therefore inferior. These strong, negative beliefs associated with femininity are learned early in life and are formed by interactions with parents, teachers, and society (O’Neil, 1981). These beliefs play out in several ways: (a) women and children exhibiting femininity through values, attitudes, and behaviors (e.g., crying) are considered inferior and immature, and (b) men exhibiting these behaviors are considered inappropriate and inferior. By devaluing femininity and those that engage in feminine behaviors, men seek to express superiority and their own masculinity (Levinson, 1978; O’Neil, 1981). This is most often done to avoid losing the power, status, and prestige that accompanies being a
This combination of gender role socialization toward masculine norms and fear of femininity influence the occurrence of gender role conflict across four life domains including: (a) Success, Power, and Competition Issues (SPC), (b) Conflicts Between Work and Family Relations (CBWFR), (c) Restrictive Emotionality (RE), and (d) Restrictive Affectionate Behavior Between Men (RABBM) (O’Neil, 2008). SPC emphasizes social comparison and striving against others to gain personal achievement, authority, and status (O’Neil, Good, & Holmes, 1995). Men that adhere to traditional gender norms may believe that power and status are ways to prove their masculinity (Vandello et al., 2008). Norms of CBWFR relate to difficulty balancing work and family responsibilities (O’Neil, 2008). Men that enact gender roles related to CBWFR may neglect family responsibilities related to nurturing relationships in an effort to project masculinity. They may also become overly involved in their careers in an effort to exude success, power, and status. RE refers to difficulty with emotional expression, giving up emotional control, and being vulnerable (to oneself and others). Men adhering to traditional gender norms restrict emotions due to a belief that feelings and vulnerability are signs of weakness and femininity. Within this context, men that share emotions are viewed as immature, weak, dependent, and feminine (O’Neil, 1981). RABBM limits expression of emotions, affection, and physical contact between men (O’Neil et al., 1995). In addition to aspects of RABBM that are relevant to the norm for RE, men that engage in gender norms related to RABBM may be attempting to exude masculinity by avoiding behaviors that may lead them to be perceived as gay.
Societal conceptualizations of masculinity (e.g., the “Blueprint for Masculinity”) appear to play a large role in the gender role socialization of boys and men. Men actively construct masculinity through a process of “doing gender” by making choices to engage in or ignore traditional norms (e.g., toughness, independence, and emotional restriction). As a result of adherence to rigid gender norms, men may experience gender role conflict. Gender role conflict has been associated with a greater risk for depression and with having more negative attitudes toward counseling (Good & Wood, 1995). The masculine gender norms of competence, achievement, and success are incongruent with feelings of depression and may lead to greater levels of distress (Warren, 1983). Traditional masculine norms and the presence of gender role conflict may result in difficulty seeking help because the type of behaviors in which clients engage while in therapy are conceptually "feminine" or at the very least "not masculine" according to traditional gender norms for self-disclosure, vulnerability and emotional expression (Good & Wood, 1995).

**Depression**

**Overview of depression.** Depressive disorders are mood disorders that typically have sadness as a core symptom. This sadness, in combination with other symptoms, may interfere with aspects of a person’s daily life including work, school, sleep, appetite, relationships, and activities that were once enjoyable (APA, 2000, 2007; NIMH, 2011). Unipolar depression is experienced in mood disorders that are marked by depressive episodes or prolonged periods of depressive symptoms with no history of mania (APA, 2000, 2007). Several depressive disorders meet this criteria for unipolar depression including, Major Depressive Disorder (MDD), Dysthymic Disorder, and Depressive
Disorder Not Otherwise Specified (APA, 2000). This study focuses specifically upon the occurrence of MDD. To meet diagnostic criteria for MDD, a person must have experienced a Major Depressive Episode (MDE) for at least two weeks without the presence of manic features (APA, 2000, 2007). The experience of a MDE is characterized by the experience of depressed mood and/or anhedonia in conjunction with at least four of the following symptoms: (a) changes in appetite with significant weight loss or weight gain, (b) insomnia or hypersomnia, (c) fatigue, (d) feelings of worthlessness or guilt, (e) psychomotor problems, (f) difficulty with concentration, (g) and recurrent thoughts of death or self-harm (APA, 2000, 2007). These symptoms must cause significant impairment in social, occupational, and/or other important areas of functioning and must be present for at least two weeks (APA, 2000). To meet the diagnostic criteria for MDD, this MDE must not be better accounted for by the experience of Schizoaffective Disorder and there must be no history of manic episodes. Additional features of MDD can include catatonic features, melancholic features, atypical features, postpartum onset, and psychotic features (APA, 2000).

**Implications of depression.** The CDC estimates that 9% of people in the United States experience some type of depressive disorder (e.g., MDD, Dysthymia, Bipolar Disorder) each year. More specifically, approximately 7% of the adult population experience MDD annually (Kessler, Chiu, Demler, & Walters, 2005; NIMH, 2010) and of these cases, 30% are estimated to be severe (Kessler et al., 2005a). Only half of those people that experience MDD receive treatment, with the majority receiving minimally adequate treatment (Wang, Lane, Olfson, Pincus, Wells, & Kessler, 2005).
Given that role impairment is a significant diagnostic feature of MDD, it is easy to see the potential impact of depression on individuals, their families, friends, and employers. Experience of MDD is associated with withdrawal from roles as employees, parents, and partners (Birnbaum et al., 2010; Cramer & Jowett, 2010; Lovejoy, Graczyk, O’Hare, & Neuman, 2000). With regard to work interference, individuals with MDD miss approximately 27 days of work each year as the result of their depression (Kessler, Akiskal, & Ames, 2006) and depressed workers are more likely to experience reduced productivity and decreased work performance (Birnbaum et al., 2010). Experiences of depression also impacts families though lower levels of marital satisfaction, increased likelihood of negative parenting behaviors (e.g., less parental warmth), and increased risk for children to develop behavior and psychological problems (Cummings, Keller, & Davies, 2005; Middleton, Scott, & Renk, 2009).

Additional implications of depression stem from comorbid substance abuse and self-harm. Regarding co-morbid disorders, people experiencing MDD frequently have problems with alcohol abuse and dependence (Sher et al., 2008). Co-morbid substance abuse may complicate treatment of depression by masking symptoms as well as co-morbid increase suicide attempts among people experiencing MDD. For example, in a recent study of community participants with MDD, those participants with MDD and a co-morbid alcohol abuse problem were significantly more likely to report earlier onset of depression, increased severity of depressive symptoms, and a higher frequency of suicide attempts (Sher et al., 2008). In terms of self-harm, the experience of MDD is strongly correlated to suicide attempts (Bolton, Shay-Lee, Enns, Cox, & Sareen, 2008). It has been estimated that 16 to 40% of people experiencing MDD will have a nonfatal suicide
attempt during their lifetime (Malone, Hass, Sweeney & Mann, 1995; Oquendo, Currier, & Mann, 2006). To wit, a recent longitudinal study of patients with MDD found that 14.5% of participants had attempted suicide at least once within the last five years and 73% of these attempts had occurred during a Major Depressive Episode (Holma, Melartin, Haukka, Holma, Sokero, & Isometsa, 2008). Although MDD significantly increases the likelihood of suicide attempts, suicide risk appears to be mediated by the severity of symptoms, amount of time that one has been in a Major Depressive Episode, feelings of worthlessness, anhedonia, and sleep disturbances (Holma et al., 2008).

**Depression in college students.** Similar trends regarding prevalence of depression in the general adult population exist in studies of college age students. In fact, this age group may be at higher risk for depression given recent findings that adults ages 18-29 are most likely to have experienced MDD within the last year (Kessler et al., 2005). Nationally, directors of college counseling centers are reporting an increase in students presenting with severe psychological problems (Gallagher, Gill, & Sysco, 2000). More specifically, a 2010 study by the American College Health Association (ACHA) found that 8% of college students reported that they had been diagnosed with or treated for depression within the last 12 months and had a 15% lifetime prevalence of depression. Although only 8% of the sample reported receiving treatment for depression within the last year, the majority of students reported that they had experienced symptoms of depression during that time: specifically, 55% reported that they had been very lonely, 60% reported that they had been very sad, 40% reported that they were hopeless, and 90% reported that they had been severely overwhelmed. Perhaps most
alarmingly, 30% of students reported that within the last year they had been “so
depressed that it was difficult to function” (ACHA, 2010, p.14).

College students with depression are more likely to consume alcohol than their
peers that are not depressed. Similarly, college students with depression are more likely
to engage in binge drinking (CASA, 2003). These students are also at high risk for
suicide. Suicide is currently the third leading cause of death among men and women ages
15-24 (CDC, 2011). Approximately 6% of students surveyed in the latest National
College Health Assessment (ACHA, 2010) reported that they had seriously considered
suicide within the last 12 months. As well, in a study of depression among college
students at Emory University, 11% of the sample reported experiencing suicidal ideation
(SI) at the time of the survey. Moreover, there was a strong, positive correlation between
SI and depression, indicating that as depression increased in severity the prevalence of SI
also increased (Garlow et al., 2008). Feelings of desperation, such as those reported in the
ACHA survey, are highly correlated with SI (Garlow et al., 2008).

In addition to the risks associated with increased rates of suicide and substance
abuse, college students with depression are at risk for a variety of health and academic
problems. Students with depression report higher frequency of illnesses such as colds,
somatic complaints, sleep problems, and headaches (Buchanan, Gardenswartz, &
Seligman, 1999; CASA, 2003; Hojat, Gonnella, Erdmann & Vogel, 2003). Students with
depression are also at higher risk for sexually transmitted diseases as the result of higher
rates of engagement in risky sexual behaviors (Shrier, Harris, Sternberg, & Beardslee,
2001). Self-reports of students regarding the effects of depression indicate that depression
was associated with lower grades on exams, lower course grades, higher rates of dropped
or incomplete courses, and significant impairment in the ability to complete theses (ACHA, 2010). These reports mirror findings of previous studies such that students with depression earn lower grades, miss more class time, have more difficulty with concentration, and have lower levels of academic engagement (CASA, 2003; Haines, Norris, & Kashy, 1996; Heiligenstein, Guenther, Hsu, & Herman, 1996).

Recent evidence suggests that many students struggling with depression are not receiving adequate help. Despite the high degree of symptom distress present in the college students that participated in the National College Health Assessment, only half reported having received information from their college or university about depression and even fewer students (10%) reported that they had sought help from their university or college counseling center. Garlow and colleagues (2008) found that 84% of students with SI and 85% of students experiencing moderate to severe depression were not receiving any form of treatment.

The “gender gap.” It is difficult to discuss depression without considering the context of gender. Research indicates that women are more than twice as likely to be diagnosed with depression as compared to men (Angst, Gamma, Gastpar, Lepine, Mendlewicz, & Tylee, 2002; APA, 2009; Bertakis, Helms, Callahan, Azari, Leigh, & Robbins, 2001; Englar-Carlson, 2006; Hasin, Goodwin, Stinson, & Grant, 2005). Recent prevalence statistics indicate that there is a “gender gap” with relation to diagnosis and treatment of MDD. Women are 70% more likely to experience depression during their lifetime and are twice as likely to be diagnosed with depression compared to men (APA, 2009; Kessler, Berglund, Demler, Jin, & Walters, 2005). Prevalence data gathered from 2005 to 2008 indicates that women are experiencing depression at a rate that is
approximately twice that of men (SAMHSA, 2008). Similar rates of depression were found in 23 European countries (Van de Velde, Bracke, & Levecque, 2010). Despite ample evidence for the “gender gap” in MDD, only a small percentage of randomized control trials for treatment of depression analyze outcomes by gender (Weinberger, McKee, & Mazure, 2010).

This gender gap is apparent in the symptoms that college men and women report. Results of the latest National College Health Assessment (ACHA, 2010) indicate that women were more likely than men to report a diagnosis or treatment for depression and other forms of psychological distress. They were also more likely to report difficulty handling stress related to academics, career decision making, family problems, relationships, and personal health compared to men. With regard to depressive symptomology, women reported higher frequencies of hopelessness, feeling overwhelmed, loneliness, sadness, depression, and suicidal ideation (ACHA, 2010).

The gender gap that appears to exist in both the general population and college population has perpetuated the notion that men are “less depressed” than women (Cochran & Rabinowitz, 2000). As a result, men are often considered to be at a lower risk for depression. For example, a 2003 report by the National Center on Addiction and Substance Abuse at Columbia University (CASA) references gender as a risk factor for depression, but only references men when discussing the higher prevalence rates in women. While they devote attention to discussing how factors such as sexual assault, intimate partner violence, and the pressure of femininity may influence women’s increased risk for depression, there is no discussion of men’s risk for depression. Although there is ample evidence to support a focus on the risk of depression for women,
there is a growing body of literature suggesting that researchers and institutions should also give attention to the experiences of men with depression.

**Depression in Men**

Each year, approximately six million men experience a depressive disorder (e.g., MDD, Dysthymic Disorder, Bipolar Disorder) (NIMH, 2009). Men with depression experience higher rates of co-morbid alcohol abuse and dependence as compared to women with depression. They are also four times more likely to commit suicide (Levin & Sanacora, 2007). In addition to the self-inflicted damage caused by substance abuse, relationships with family, friends, and intimate partners may be damaged by the higher degree of externalizing behaviors exhibited by men with depression (Cochran & Rabinowitz, 2000).

It has been suggested that the gender differences in diagnosis for depression may not indicate a difference in prevalence across genders (Cochran, 2005; Levin & Sanacora, 2007). There are several theories about these gender differences in depression including: (a) depression may manifest differently for men, (b) DSM-IV-TR criteria may not capture male depression, (c) male gender socialization (d) gender role conflict, and (e) cultural variations in masculinity (Cochran, 2005; Good & Wood, 1995; Rochlen, Whilde, & Hoyer, 2005).

**Depression manifests differently for men.** Evidence to support the hypothesis that depression manifests differently in men than in women comes from several significant gender differences. These include: (a) men are more likely to report somatic complaints than depression, (b) men are four times more likely to commit suicide, (c) men have higher rates of comorbid alcohol abuse and dependence, and (d) men typically
endorse fewer diagnostic symptoms of depression than women (Leven & Sanacora, 2007; Warren, 1983). The DSM-IV-TR requires the presence of five symptoms for a diagnosis of MDD (APA, 2000). There is some debate about gender differences with regard to the depressive symptoms that manifest for men and women. Some researchers assert that men and women have similar experiences of depression with regard to severity, symptoms, duration, and prevalence (Cochran & Rabinowitz, 2000; Hildebrandt, Stage, & Kragh-Sorensen, 2003; Winkler, Pjrek, & Siegfried, 2005), however others contend that there are gender differences in symptom expression (Angst & Dobler-Mikola, 1984; NIMH, 2009; Nolen-Hoeksema, 2001; Pollack, 1998; Smith et al., 2008). There is evidence that women are more likely to ruminate in response to depression, whereas men are more likely to distract themselves in an effort to avoid depressed mood (Nolen-Hoeksema, 2001). Additional findings indicate that men are more willing to report symptoms of MDD related to fatigue, irritability, loss of interest in work and hobbies, and sleep disturbances (Cochran & Rabinowitz, 2000; Pollack, 1998). This cluster of symptoms differs from the typical profile of depression which includes sadness, guilt, and feelings of worthlessness (NIMH, 2009). A recent qualitative examination of depression in men found that men’s experiences of depression included both typical symptoms of a MDE, but also atypical symptoms that are not included in the DSM-IV-TR (such as substance abuse, anger management problems, and increased difficulties in interpersonal relationships (Chuick, Greenfeld, Greenberg, Shepard, Cochran, & Haley, 2009). Across studies, findings indicate that men are less likely to endorse symptoms of anxiety, somatization, and changes to sleep and appetite (Angst & Dobler-Mikola, 1984; Kornstein et al., 2000; Young et al., 1990).
In addition to differences in the way that men experience and/or report depression, it appears that they respond differently to their depressed feelings. Depressed men are more likely to report impairment at work, in social activities, and in interpersonal relationships (Angst et al., 2002; Carter, Joyce, Mulder, Luty & McKenzie., 2000; Kornstein et al., 2000). Men are also less likely to tell others about their depression, less likely to cry, and less likely to label their experience as “depression” (Kornstein et al., 2000; Warren, 1983). There is also evidence that men with depression experience higher levels of anger, impulse control problems, irritability, aggressive behavior, risk-taking (e.g., drunk driving), and avoidant behaviors (e.g., becoming overly involved at work or demanding more autonomy), as well as becoming emotionally numb, and experiencing inability or unwillingness to express emotions (i.e., alexithymia; Cochran & Rabinowitz, 2000; Cramer, Gallant, & Langlois, 2005; Oliffe & Phillips, 2008). As well, men with depression are far more likely than women to report co-morbid substance abuse problems (Angst et al., 2002). Perhaps most alarmingly, although women are more likely to engage in self-harm and to attempt suicide, men are four times more likely than women to complete suicide attempts (CDC, 2007). It has been theorized that the higher rates of completed suicide attempts are the result of the more violent means in which men engage when attempting suicide in addition to a higher likelihood that men are less likely to have received adequate care for their symptoms of depression (Cochran & Rabinowitz, 2000; Isometsa et al., 1994). As a result, suicide remains the second most frequent cause of death for men between the ages of 25-34 and the third most common cause of death for men ages 15 to 24 (CDC, 2007).
Because men are often less willing to report and/or are not experiencing the DSM-IV-TR symptoms of MDD, clinicians may have difficulty assessing and diagnosing depression accurately when working with male clients. Recent evaluations of assessments for depression found that instruments based upon DSM criteria for depression (e.g., The Beck Depression Inventory [BDI]) may not accurately measure depressive symptoms in men due to male tendencies to respond in ways that are consistent with gender stereotypes for depression (Cochran & Rabinowitz, 2000; Salokangas, Vaahtera, Pacriev, Sohlman, & Lehtinen, 2002). Men are more likely to endorse symptoms related to inability to cry and somatic complaints (Cochran & Rabinowitz, 2000). A 2001 study by Canals and colleagues found that women had significantly higher mean scores on the BDI and that there were significant differences in item endorsement by gender. Whereas women in the sample were more likely to endorse items related to sadness and behavioral changes (e.g., crying), men were most likely to report symptoms of negative cognitions (e.g., pessimism, sadness, and indecisiveness; Canals, Blade, Carbajo, & Domenech-L Lara, 2001). However, there is also evidence that practitioners may be to blame for at least part of the gap in diagnosis. A study by Bertakis and colleagues (2001) found that despite scores indicating similar severity of symptoms on the Beck Depression Inventory (BDI), women were diagnosed with depression at three times the rate of men.

The lower frequency of endorsed depressive symptoms among men has led some to the assumption that these men are "less depressed" or do not meet the criteria for a depressive disorder (Cochran & Rabinowitz, 2000). This finding led Pollack (1998) to develop a new set of diagnostic criteria for MDD for men. Major Depressive Disorder-Male Type (MDD-MT) is characterized: (a) by symptoms of social withdrawal (increased
withdrawal from relationships, over-involvement at work, rigid demands for autonomy),
(b) denial of pain, (c) avoiding help, (d) self-medicating behavior, (e) denial of
sadness/inability to cry, (f) harsh self-criticism, (g) depleted or impulsive moods, (h)
changes to sex drive (increases or decreases), and (i) traditional physical symptoms of
MDD (disturbances of concentration, sleep, and appetite/weight) (Pollack, 1998). MDD-
MT builds upon the DSM-IV-TR criteria for MDD by considering the roles of avoidance,
denial, and self-medicating behaviors that may help men hide their symptoms of MDD.
These diagnostic criteria were influenced by gender differences in reports of
symptomology, but also by knowledge about the impact of gender role conflict (Pollack,
1998).

**Gender role socialization and depression.** Gender role socialization is suspected
to play a large role in the differential diagnosis of depression in men. As previously
discussed, the socialization of boys and men reinforces norms related to restrictive
emotionality and avoidance of affect. By the time boys reach adolescence, they have
often been socialized in such a way that they believe it is unacceptable to seek help or to
show emotional distress (Levant, 2005). This tendency to hide or feel ashamed of
negative emotions and negative affect is predicted to lead to a response bias in self-
reports of depression. The response bias hypothesis of male depression states that the
gender differences present in the diagnosis of depression may reflect the tendency of men
to underreport symptoms (Sigmon et al., 2005). While men may be experiencing similar
levels of depression, it is theorized that being depressed is perceived as weak or feminine.
As a result, men are reluctant to seek help or acknowledge symptoms (Brody & Hall,
2010; Sigmon et al., 2005). Consistent with this hypothesis, Sigmon and colleagues
found that college men became less likely to report symptoms of depression as levels of follow-up or support increased. Across conditions, men were most likely to report symptoms on a self-report measure of depression when they were notified that no follow-up would occur. In conditions where participants were notified that reporting symptoms might lead to variously increasingly intrusive follow-ups (e.g., a referral would be given, the participant would be contacted, or the participant and a significant other would be contacted) if the client was at risk of severe depressive symptoms and/or self harm, the number of symptoms endorsed decreased significantly (Sigmon et al., 2005). Conversely, results of this study indicate that when men believe their results will be private and/or they think they are anonymous, they appear willing to report symptoms of depression that are similar to those of women, thus indicating that the epidemiology of depression may be similar across genders.

**Gender role conflict and depression.** As discussed previously, gender role conflict occurs as the result of rigid adherence to societal gender norms (O’Neil, 2008). Multiple studies have explored the relationship between gender role conflict (GRC) and depression (O’Neil, 2008). Although results vary across studies, the majority of findings indicate that experience of GRC has a significant and positive relationship with symptoms of depression (O’Neil, 2008). In the case of depression, the masculine gender norms of competence, achievement, and success are incongruent with feelings of depression and may lead to greater levels of distress (Warren, 1983). Socialized gender norms may prevent men from acknowledging symptoms of depression because it is not considered masculine to admit weakness and display vulnerability (Shepard, 2002). This may lead men to ignore symptoms in an effort to avoid feeling or behaving “feminine”
(Shepard, 2002). Good and colleagues (1995) explored the relationship between GRC and psychological distress in a sample of male clients at a university counseling center. The results of this study indicate that GRC has a significant impact on the male experience of depression, with GRC accounting for 15% of the variance in the psychological distress of men in the sample (Good, Robertson, O’Neil, Fitzgerald, & Stevens et al., 1995). In a follow up study using a similar clinical sample, Good and colleagues (1996) found that GRC was significantly related to depression.

Men who are socialized to behave in accordance with traditional masculine norms may have difficulty acknowledging emotional symptoms of depression. While all four factors of the Gender Role Conflict Scale (GRCS; O’Neil, Helms, Gable, David, & Wrightsman, 1986) have been found significantly related to depression, Restrictive Emotionality is the most frequent predictor of depression across studies (Blazina & Watkins, 1996; Good & Mintz, 1990; Good et al., 1995; Good, Robertson, Fitzgerald, Stevens & Bartels, 1996; O’Neil, 2008; Shepard, 2002). It appears that the masculine norm of restricting emotional expression is strongly associated with feeling a lack of self-worth, guilt, pessimism, and a sense of failure when men experience depression as a result of feeling as though they are not living up to cultural expectations of masculinity (Shepard, 2002). A study by Mahalik and Cournoyer (2000) found significant differences in GRCS item endorsement when comparing depressed and non-depressed men. More specifically, men in the sample endorsed 17 of the 37 items on the GRCS differently. Men with depression were more likely to endorse beliefs that one only has value if successful and to endorse feeling worthless if they are not superior to others. Depressed men also scored higher on the Restrictive Emotionality scale, indicating that depressed
men feel vulnerable expressing their emotions and have difficulty understanding strong emotions. As well, higher scores on Restrictive Emotionality and Restricted Affection Between Men indicates that there may be perceived consequences from sharing feelings with others (Mahalik & Cournoyer, 2000). Across studies, there appears to be a significant and positive relationship between experience of conflict between work and family (as measured by the GRCS) and depression (Good et al., 1995; Mahalik & Cournoyer, 2000). Similarly, Magovcevic and Addis (2005) found that men who place a high value on achievement are more likely to view mental illness as a sign of weakness. These findings support the hypothesis that men with depression become overly involved at work in an effort to exert control, success, and power and avoid feelings of worthlessness associated with depression (Pollack, 1998).

**Cultural variations in masculinity.** Concepts such as The Masculine Mystique and Gender Role Conflict, were initially developed and tested in samples of White men (O’Neil, 1981, 1986, 2008). Given that these theories are based upon the premise that men behave in ways that mirror culturally acceptable norms, it is important to consider cultural variations in masculinity (Carter, Williams, Juby, & Buckley, 2005; O’Neil, 2008; Wester, 2008). With regard to psychological distress, culture sets the subjective standards for determining levels of distress that should be tolerated and levels of distress that warrant reporting negative affect and symptomology (So, Gilbert, & Romero, 2005; Kleinman, 1980). Although some minority men may adhere to gender norms of the dominant culture, male gender roles may vary according to one’s race and culture (Kimmel & Messner, 2004; Wester, 2008). Men of color and gay, bisexual, and transgender (GBT) men may experience distress while trying to balance gender roles of
the dominant culture and their cultures of origin. This distress is exacerbated by racism, homophobia, and oppression (Liu, 2002; Sue, 2001; Wester, 2008).

The relationship between experiences of male GRC and depression has empirical support across races, nationality, and sexual orientation, providing ample evidence that restrictive gender norms are related to depression (Wester, 2008). Additionally, the drive for success, competition, and control appear related to depression across cultures (O’Neil, 2008). The positive correlations between GRC and psychological distress have been found in samples of African American men (Brewer, 1998; Carter et al., 2005; Wester, Vogel, Wei, & McLain, 2006), Latinos (Carter et al., 2005; Fragoso & Kashubkec, 2000; Stillson, O’Neil, & Owen, 1991), Asian American men (Carter et al., 2005), and gay men (Simonsen, Blazina, & Watkins, 2000). Experience of GRC is positively correlated with acculturation and racial identity development (Kim, O’Neil, & Owen, 1996; Liu, 2002).

More research is needed to understand the relationships between GRC and depression in men of color and GBT men (Carter et al., 2005; O’Neil, 2008; Wester, 2008).

Thus, while twice as many women are diagnosed with depression as compared to men, the research described above suggests that men may experience depression differently or that they are being underdiagnosed due to inappropriate diagnostic criteria or the impact of gender socialization and gender role conflict. There is evidence in clinical and non-clinical samples that adherence to traditional gender norms is related to higher levels of depression. This gender role conflict appears to exist across cultures. These socialized gender norms appear to impact the traditional man’s experience of depression and may prevent them from seeking help.
Help-Seeking

Courtenay (2000) presented a thorough review of the impact of gender and masculinity on physical health and help-seeking for injury, disease, and illness. In many cases, men reject healthy behaviors and healthcare in an effort to demonstrate masculinity. Men are less likely than women to engage in preventative health behaviors (e.g., doctors visits, dental check-ups, mental health visits, cancer screenings, and self-examinations). They are also less likely to comply with recommendations of their physicians (Addis & Mahalik, 2003). Historically, men have been reluctant to seek help for depression, even from informal sources such as friends (Addis & Mahalik, 2003; Padesky & Hammen, 1981; Weissman & Kleman, 1977). Similarly, in studies of college populations, twice as many women as men reported receiving information from their college about depression (ACHA, 2010). Additionally, women were more likely to consider seeking counseling for future problems and reported higher rates of past or current help-seeking for psychological distress (ACHA, 2010).

Sex and gender differences in help-seeking. Studies of sex differences seek to attribute biological causes (e.g., hormonal differences) to behavior. Similarly, psychoevolutionary theories attribute sex differences in behaviors to natural selection occurring over millennia that has led to differences in male and female genes that impact various behaviors (Wong & Rochlen, 2008). However, there is not clear evidence for biological or sex-based differences in help-seeking (Addis & Mahalik, 2003). This approach to research is flawed in that it fails to fully account for within group variability (Addis & Mahalik, 2003). The sex differences approach to research encourages an essentialist perspective on gender that treats men and women as possessing universal and
fixed attributes that are stable across time. This perspective often represents men and women as polar opposites, with women described as warm, nurturing, and supportive, while men are described as unemotional (Wong & Rochlen, 2008). This inference that gendered behaviors are stable and inevitable in men and women has led many social scientists to reject sex differences models in favor of biopsychosocial models that acknowledge the interaction of biology and socialization (Addis & Mahalik, 2003; Connell, 2005; Mahalik, 2008; Wong & Rochlen, 2008).

Recently, researchers have begun to focus on contextual and within person variables that may impact the relationship between gender role socialization and help-seeking behaviors (Addis & Mahalik, 2003; Pederson & Vogel, 2007). The decision to seek help varies as a result of the degree to which men endorse male norms that may or may not be congruent with help-seeking (Addis & Mahalik, 2003). Aspects of help-seeking such as relying on others, asking for help, admitting the presence of a problem, and emotional expression may conflict with societal messages that men receive regarding the importance of self-reliance, toughness, and emotional restriction (Addis & Mahalik, 2003; Mahalik et al., 2003a). The decision regarding when, where, and how to engage in traditional societal roles related to depression and help-seeking are influenced by external factors. While there is room for individual agency in decision making, "institutional patterns shape the alternatives and make one choice more likely than another" (Epstein, 1988, p.99). In the case of a man deciding to seek therapy, he may perceive that he will be judged as less masculine in the eyes of society, and as a result, decide to take on a gender role of denial of problems in an effort to avoid "losing masculinity." When a man makes the decision to engage in these traditional roles, they validate, sustain, and
legitimize the relationship of the behavior to the sex, thus reducing the likelihood that others will deviate from the behaviors expected by society (West & Zimmerman, 1987).

Internalized gender roles may lead to barriers to help-seeking when a man must violate masculine norms in the process of receiving support. Men experiencing high levels of GRC tend to avoid disclosure of personal information, distress, and emotions, whereas men with lower levels of GRC are more likely to disclose personal information (Berko, 2005; Pederson & Vogel, 2007, Swenson, 1999). Feelings of submission, dependence, and vulnerability associated with help-seeking may lead men to feel that they are violating masculinity scripts that may lead them to lose power and status in the eyes of other men (Mahalik et al., 2003a; Pollack, 1998). For example, men subscribing to the Winner script may feel that they are now losers as a result of attending therapy. Men subscribing to the Strong and Silent, Give’em Hell, and/or Tough-Guy scripts are likely to believe that therapy will lead to perceptions of weakness. Men subscribing to the Independent script are likely to fear being perceived as dependent (Mahalik et al., 2003a).

Gender roles are actively constructed by each individual through their decisions toward or away from healthy behaviors and beliefs. Masculinity is further demonstrated by engaging in high risk behaviors (e.g., contact sports, excessive drinking). Men who adhere to traditional masculine norms are more likely to engage in illegal drug, tobacco, and alcohol use. They are also more likely to engage in high risk sexual behaviors (e.g., unprotected sex; Courtenay, 2000). In situations where men do seek help, they are then forced to make a choice to reject societal expectations of masculinity. The barriers to help-seeking are further complicated by research indicating that endorsement of healthy behaviors and utilization of healthcare are inherently feminine ideals and behaviors
(Courtnay, 2000). As a result, men that "admit" they are sick and then go to a doctor or seek treatment are actively rejecting traditional masculine norms and are embracing behaviors that have been feminized. This may lead the individual to perceive that they have lost power and status in the eyes of those in society that have more hegemonic views of masculinity. This may be especially true for men with depression, as it is typically associated with feelings of powerlessness, diminished control, and lack of self-worth (Warren, 1983).

The impact of masculinity on help-seeking behaviors is particularly evident when exploring the help-seeking behaviors of men with mental health issues. For example, Warren (1983) found that men need to be significantly more depressed before they will ask for help or seek treatment. This means that by the time men seek help, they are often experiencing severe distress and co-morbid disorders. Additionally, men who see themselves as similar to all other men have the most negative views of help-seeking (Mendoza & Cummings, 2001; Schaub & Williams, 2007), and men who conform to traditional masculine norms (e.g., restrictive emotionality, avoidance of femininity) are more likely to have negative attitudes toward psychological help-seeking (Graef, Tokar & Haut, 2010; Levant, Wimer, Williams, Smalley, & Noronha, 2009). Regarding GRC and help-seeking, Robertson and Fitzgerald (1992) found evidence that men with high scores on Success, Power, and Competition, and Restrictive Emotionality were most likely to have negative attitudes toward help-seeking for psychological distress. Similarly, Blazina and Watkins (1996) found that GRC accounted for 15.6% of the variance in attitudes toward help-seeking. Finally, adherence to traditional masculine norms also predicts lowering willingness to seek help for psychological distress (Addis & Mahalik, 2003;
Smith, Tran, & Thompson, 2008). This finding has been found to be consistent even after controlling for level of psychological distress (Kessler, Brown, & Broman, 1981).

Regarding recent research on male help-seeking and depression, a qualitative study of men with depression in a community sample found that all of the men in the sample reported efforts to conceal their symptoms from others (Chuick et al., 2009). They indicated that they attempted to hide their symptoms as a result of societal messages that depression was not socially acceptable for men, beliefs that it is inappropriate for men to seek help for depression, and perceptions that men who seek help for depression are weak. Strategies to conceal their symptoms included substance abuse, infidelity, avoidance, and excessive focus on work roles. Participants reported that they engaged in trial and error with the above strategies while trying to find short term remedies that would alleviate distress. The majority of participants reported that these strategies eventually failed to allow them to conceal their distress. This process of trial and error often lead to escalation of depressive symptoms and additional problems that resulted from negative coping behaviors (e.g., increased difficulty in interpersonal relationships).

Men in the study reported that long-term success in coping with depression was the direct result of individual therapy, group therapy, medication, or religious counseling. They also indicated that personal engagement and increased responsibility in therapy was a key factor in therapy outcomes.

Relatedly, Mahalik and Backus (2011) conducted a qualitative study of community men’s attitudes about help-seeking for depression. The majority of men in the study reported that they would not seek help for depression, indicating that seeking help is weak, that they prefer to be self-reliant, and that they would fear how others would
react to their decision to seek help. Several men in the study also reported a lack of trust of professional help-seeking for depression with regard to confidentiality, efficacy, and trust of the provider. The men in the study appeared to have a high threshold for when professional help would be considered acceptable. Half of the men in the study reported favorable perceptions of professional help-seeking that would lead them to utilize therapy when depressed, however others reported that therapy for depression would only be acceptable when there was a clear external circumstance that led to the depression (e.g., the death of a family member). Men in this study also endorsed gender socialized beliefs that it is more acceptable for women to discuss their feelings openly and that being emotional is not masculine (Mahalik & Backus, 2011).

Furthermore, a 2006 study by Mahalik and Rochlen explored the impact of masculinity norms on various help-seeking behaviors of college men with depression. This study was interested in "(1) men's most and least likely actions in response to a vignette describing an episode of depression, (2) whether conformity to masculine norms related to the likelihood of men's responses, (3) which masculinity norms were associated with men's responses" (Mahalik & Rochlen, 2006; pp. 659). Participants in the study ($N = 153$) read a brief vignette describing an episode of major depression, and then were tasked to rate the degree to which they would engage in 20 different responses (e.g., seek help in personal network, seek professional help, try to engage in self-help; see Appendix Q for complete list). Research participants then completed the Conformity to Masculine Norms Inventory (CMNI, Mahalik et al., 2003).

By examining the mean responses, the researchers found that men were somewhat likely to seek help from a partner, family member, or to wait and see if things
got better on their own. They also found that men were somewhat unlikely to seek professional help for depressive episodes. The authors identified specific masculine norms that were related to specific coping reactions (e.g., higher levels of masculine norms of violence and power over women were positively correlated to substance use and negatively correlated to talking to a partner about depression) (Mahalik & Rochlen, 2006). Men in the study who endorsed CMNI items related to Power Over Women, Dominance, and Pursuit of Status were less likely to talk with a partner about depression, far less likely to talk with a mental health professional, and more likely to engage in self-medicating behaviors (Mahalik & Rochlen, 2006). Results of this study provide support for the elaboration of the work of Courtnay (2000) into the domain of mental health.

It is hypothesized that gender socialization influences the appraisal process in which men engage when evaluating the severity of their problems and whether or not to seek help. This decision to seek or avoid help is moderated by “(a) perceptions of the normalness of the problem, (b) the perceived ego centrality of the problem, (c) characteristics of the man’s social groups, (d) perceived loss of control” (Addis & Mahalik, 2003, p.10). Perceptions of normalness refer to the degree to which others are perceived to share an experience or engage in similar behaviors (Cialdini & Trost, 1999). Perceptions of normalness may vary across situations (e.g., hugging another man when sad vs. hugging another man after winning a sporting event; Addis & Mahalik, 2003). Perceptions of normalness influence help-seeking behaviors by preventing men from seeking help when they perceive that other men do not seek help for similar problems (or that other men do not experience similar problems). Addis and Mahalik (2003) posited that men adhering to masculine gender norms may also consider the experience of
depression to be “nonnormative” and highly internalized. Magovcevic and Addis (2005) found support for this hypothesis with results indicating that adherence to traditional masculine norms was associated with increased perceptions of depression as “nonnormative.” Experience of depression was also related to higher levels of self-stigmatization. This self-stigmatization occurs as the result of judgments about the ego centrality of a problem, which is the degree to which an individual perceives a problem to be attributed to internal characteristics (e.g., intellect, strength, effort) versus external factors (e.g., bad luck). Ego centrality of problems varies across situations and can be influenced by traditional gender norms (Addis & Mahalik, 2003). Mahalik and Backus (2011) found that men believed it was most acceptable to seek help for depression when there was a clear external cause. Another external factor, characteristics of the man’s social group play an important role in this process by informing schemas for help-seeking. Vogel and colleagues (2007) found that knowing someone that had previously sought help for psychological distress or being referred to a mental health provider by someone in one’s social network significantly increased both intention to seek help and positive attitudes about help-seeking.

Men may be at a particular risk as a result of the gender role conflict that can occur following the onset of psychological distress. Good and Wood (1995) considered these men to be experiencing “double jeopardy” because their experience of gender role conflict is predictive of an increase in depressive symptoms, while at the same time decreasing the likelihood that they would seek out treatment. GRC (i.e., high levels of Restrictive Emotionality, Restrictive Affection Between Men, and Success, Power, and Competition) also predicts the expectations that men have for therapy. Men with high
levels of GRC have high expectations for the counselor to be expert and directive while having lower expectations related to their personal responsibility for making change occur in therapy (Schaub & Williams, 2007). This is particularly troubling given recent findings that men who had successfully completed treatment for depression indicated that increasing the level of personal responsibility in treatment was a key factor in their long-term outcomes (Chuick et al., 2009).

**Other factors influencing the decision to seek help.** There are a series of other factors that appear to influence decisions to seek help including stigma, knowing someone that has sought help for mental health issues, types of help sought, and titles of the help provider. Fear of stigma is one of the largest barriers to men’s decisions to seek help (Mahalik et al., 2003). Men receive societal messages about the value of help-seeking and the stigma of mental health (Vogel et al., 2011). When men experience psychological distress, they may experience conflict related to these internalized societal messages which leads to a process of self-stigmatization (Vogel et al., 2011). Self-stigma is the belief that oneself is inadequate or weak if he wants to seek professional help (Hammer & Vogel, 2010). While societal messages about help-seeking and mental illness are not always gender specific, men engage in more self-stigma than women (Hammer & Vogel, 2010; Judd et al., 2006). This self-stigma is often the result of psychological distress and the need for help-seeking becoming a self-perceived threat to masculinity (Schaub & Williams, 2007). This may be the result of feeling a sense of failure due the inability to solve one’s own problems (Addis & Mahalik, 2003), fear of losing autonomy, or fear of being perceived as weak (Addis & Mahalik, 2003; Vogel, Wade, & Haake, 2006). The degree to which men endorse masculine ideology appears to mediate the
degree to which men experience self-stigma of help-seeking (Hammer & Vogel, 2010), with men who endorse traditional masculine ideals being most likely to experience self-stigma (Magovcevic & Addis, 2005).

Internalization of stigma (self-stigma) related to psychological help-seeking predicts both willingness to seek counseling and attitudes about the value of counseling (Vogel et al., 2006; Vogel, Wade, & Hackler, 2007). As well, stigma appears to impact the types of problems that men find acceptable for which to seek help. Men appear less likely to seek help for problems believed to be stigmatizing, uncommon, or reflective of their self-worth (Magovcevic & Addis, 2005). Conversely, men report higher frequency of engagement in healthy behaviors when they adhered less to traditional masculine norms. It also appears that perceptions that other men are engaging in health-seeking behaviors increases the likelihood that one will engage in healthy behaviors (Mahalik, Burns, & Syzdek, 2007). Thus, it is important to assess men for self-stigma in addition to attitudes toward help-seeking (Hammer & Vogel, 2010).

Knowing someone that has previously engaged in psychological help-seeking appears to promote help-seeking behaviors. Vogel and colleagues (2007) found that 75% of college students who had sought help for psychological distress did so after being prompted by others. As well, over 90% of college students who engaged in psychological help-seeking reported knowing someone who had previously sought help. Those participants who had been referred or knew a person who had previously sought help had better attitudes about help-seeking. This study has implications for college men in that getting men to talk about their experiences in therapy may help to normalize beliefs about help-seeking and reduce stigma.
Interestingly, it appears that the type of help that men are seeking to impacts their willingness to seek help (Lane & Addis, 2005). Although there seems to be a great deal of stigma related to seeking help for psychological distress, attitudes toward career counseling appear to be distinct from other forms of help-seeking (Rochlen, Mohr, & Hargrove, 1999). Overall, men are more open to engaging in career counseling than psychotherapy, however gender role socialization has an impact on help-seeking for vocational issues. For example, men who report higher levels of GRC (i.e., restrictive emotionality, and restrictive affection between men) are more likely to report stigma beliefs about seeking career counseling (Graef et al., 2010; Rochlen & O’Brien, 2002), and men who reported high adherence to norms related to anti-femininity find less value in career counseling (Graef et al., 2010). Despite evidence that career counseling appears to be less threatening to men than other forms of help-seeking, GRC (i.e., restrictive emotionality and restrictive affection between men) predicts increased stigma and decreased willingness to seek help for vocational concerns (Graef et al., 2010; Rochlen & O’Brien, 2002).

Professional titles also appear to affect the decisions that men make about when and where to seek help (Brown & Chambers, 1986). In some cases, professional titles may act as a barrier to seeking help (Mansfield, Addis, & Courtenay, 2005; Rochlen, McKelly, & Pituch, 2006). Men may perceive that traditional help-seeking approaches such as psychotherapy are inherently “feminine” due to their emphasis on emotional expression and self-disclosure (Boespflug, 2005). As a result, men may be drawn to “masculinized” professional titles such as “executive coach” because coaching is associated with a more directive and sometimes collegial relationship than media
portrayals of psychotherapy (Boespflug, 2005; Levinson, 1996). Similarly, the names of organizations that offer psychological support appear to influence the decision to seek help. Brownson (2005) reported significant increases in utilization of campus mental health services after changing the name from “Counseling and Mental Health Center” to “Behavioral Health Center.”

**Culture and help-seeking.** Although the low number of men seeking help for psychological distress is concerning, it is particularly alarming when considering the help-seeking experiences of men of color. To date, scant research had been conducted on the help-seeking behaviors of men from racial minority backgrounds, however, some research has shown that men of color seek help at lower rates than white men (Chandra, Scott, Jaycox, Meredit, Tanielian, & Burnam 2009; Constantine, Chen, & Ceesay, 1997; Husaini, Moore, & Cain, 1994; Shin, 2002; Zhang, Snowden, & Sue, 1998). More specifically, African American, Asian American, and Latino men report less willingness to seek help for psychological problems as compared to White men (Robin et al., 1997; Stanton-Salazar, Chavez, & Tai, 2001; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Regarding comparisons between men and women of color, Asian American men are less likely than Asian American women to seek mental health services (cite), and Asian American males have more negative attitudes toward mental health services than White Americans. (Chang & Subramaniam, 2008; Wester, 2008). Despite reporting similar rates of distress, Latino men seek help at lower rates than Latinas (Ramos-Sanchez & Atkinson, 2009). Similarly, African American men seek help at lower rates than African American women (Wallace & Constantine, 2005).
**Model of Male Help-Seeking.** Perlick and Manning (2007) synthesized research on gender role socialization and gender differences in help-seeking behavior to develop the Model of Male Help-Seeking (MMHS; Appendix R). The MMHS was influenced by Lazarus’ (1991) model of stress and coping. According to Lazarus (1991), coping is influenced by the individual’s assessment of the severity of the problem or stress and the individual’s perceptions of her/his ability to manage the stressor. The MMHS expanded upon this when hypothesizing about the help-seeking behaviors of men. Within this model, cultural beliefs and values about traditional masculine ideology and mental illness stigma influence the appraisal of the problem and of the decision to seek or avoid treatment. Masculine ideology and GRC influence help-seeking decisions by impacting the initial appraisal process. This process requires the ability to assess severity of the problem based upon affective and cognitive judgments (Lazarus, 1991; Perlick & Manning, 2007). This may be particularly difficult given that traditional male norms emphasize restriction of emotions, thus making it more challenging to accurately make affective judgments without the risk of increased gender role conflict.

Masculine ideology also influences the secondary appraisal, which involves acknowledging the need for help. Male norms related to self-reliance and independence may complicate this process. This secondary appraisal process is supported by studies that have found high gender role conflict predicted more negative attitudes toward help-seeking (e.g., Blazina & Watkins, 1996; Graef et al., 2010; Levant et al., 2009). During this stage, men weigh potential benefits and drawbacks to seeking treatment. One must decide if attempting to deal with problems on his own is worth it by deciding which is
more important, getting relief or avoiding increased GRC and potential loss of status (Perlick & Manning, 2007).

Within the model, acceptance of treatment is associated with short-term struggles with GRC (e.g., discomfort with disclosure, shame, fear of dependence on the therapist, fear of being perceived as weak by peers) which is most often resolved as the therapy process is normalized and therapy myths are dispelled. Once men reach this point in therapy, they have similar rates of success in treatment as women (Levin & Sanacora, 2007). When men decline or avoid treatment, they are at increased risk of GRC and self stigma which may lead to continued psychological distress (Perlick & Manning, 2007).

Changes to Treatment

Despite gender differences in rates of diagnosis and help-seeking, the course of depression is similar for men and women in treatment (Levin & Sanacora, 2007). Similarly, therapy has been found to be equally effective for men and women with depression (Levin & Sanacora, 2007). These findings indicate that if barriers to male help-seeking were reduced, men with depression could be treated successfully prior to the development of substance abuse and externalizing behaviors (Cochran, 2005). Research on the impact of GRC and conformity to masculine norms on depression has led to suggested changes to treatment that are hypothesized to decrease male resistance to help-seeking. These modifications include suggestions for engaging men in help-seeking and for lowering resistance once they enter therapy (Good & Wood, 1995; Rochlen et al., 2005).

Treatment modification will only be successful for men who decide to seek therapy. Thus, researchers and clinicians should educate society about therapy and
depression with particular attention to reaching male audiences. Mahalik and Backus (2011) suggest that psychologists should protest inaccurate representations of therapy in popular media because these representations inform schemas related to the therapy process. Similarly, it has been suggested that reframing help-seeking as a strength will decrease resistance toward therapy (e.g., by going to therapy you are exerting control over your problems; Kiselica, 2008; Kiselica & Englar-Carlson, 2010). In addition to challenging misconceptions about therapy, psychologists should challenging gender stereotypes about depression.

“The Real Men. Real Depression” campaign (RMRD) was launched by the National Institute of Mental Health (NIMH) in an effort to educate men about depression and to reduce stigma related to help-seeking through the use of websites, brochures, advertisements, and public service announcements (NIMH, 2003; Rochlen et al., 2005). This outreach project focused on themes related to masculine experiences of depression, countering beliefs that help-seeking is a feminine behavior using testimonials by a diverse sample of men that had experienced depression. RMRD integrated traditional masculine norms into their campaign by reframing help-seeking as courageous and by evoking norms related to Success, Power, and Competition (Rochlen et al., 2005). Preliminary evaluations of the effectiveness of the RMRD campaign indicate that while the majority of men provided positive evaluations of the RMRD brochure, the materials were most effective for men experiencing low levels of GRC and negative attitudes toward help-seeking. This shows that the materials may be successful in educating men about depression and help-seeking; however, it appears that the campaign lacks the potency necessary to reach men that adhere to traditional masculine norms (Rochlen,
McKelley, & Pituch, 2006). Hammer and Vogel (2010) expanded upon this research by comparing RMRD brochures to newly constructed brochures in a sample of college men who met the clinical threshold for depression but had not sought help. The new brochures integrated suggestions from research in the field of men and masculinities including: (a) utilizing language that evokes traditional gender norms (e.g., referring to therapists as “mental health consultants”), (b) describing depression by using a medical model, (c) providing testimonials from men that more clearly adhere to traditional gender norms, and (d) described counseling as an interactive process in which the client sets the agenda. This revised brochure reduced stigma beliefs and improved attitudes about help-seeking for depression at a significantly higher rate than the brochure utilized in the original RMRD campaign (Hammer & Vogel, 2010).

Once men have made the decision to seek help, there are still a number of barriers to their success in treatment. Psychologists are encouraged to develop awareness related to the impact of gender role socialization on the mental health of men (Addis & Mahalik, 2003; Mahalik et al., 2003). Rather than conceptualizing traditional men as resistant in therapy, clinicians are encouraged to consider the role of masculinity scripts and GRC. Additionally, there is a need to differentiate negative attitudes about help-seeking from fear of stigma. For example, men adhering to the Strong and Silent or Tough Guy scripts could be perceived as resistant or standoffish, but in reality may fear stigma related to engaging in therapy and opening up about emotional issues (Mahalik et al., 2003a). Liu (2005) suggested that masculine socialization is an aspect of multiculturalism, and as such, clinicians should develop knowledge, self-awareness, and skills related to working with men.
Clinicians are encouraged to enhance their work with men by integrating education about gender, framing emotional expression as a skill, helping men to build an emotional vocabulary, and addressing feelings that are masked by numbness or anger (e.g., fear and sadness) (Kilmartin, 2005). In addition to these common factors that may be beneficial to working with men, numerous treatment techniques have empirical support for use with men with depression including: (a) cognitive behavioral therapy, (b) interpersonal therapy, (c) group therapy, (d) behavioral therapy, (e) psychodynamic therapy, and (f) pharmacotherapy (Cochran, 2005; Levin & Sanacora, 2007). There is also emerging evidence for the efficacy for treatments that mirror feminist therapy models (e.g., Gender Aware Therapy) and for therapy that includes testosterone supplementation (Cochran, 2005; Kanayama, Aiaz, Seidman, & Pope, 2007). One of the more novel approaches to working with men in therapy is based upon the integration of masculine strengths and positive psychology.

Positive masculinity. Although much of the literature on men and masculinities has focused on the negative effects of gender role socialization, Kiselica and Englar-Carlson (2006) suggested that researchers should also focus on positive aspects of masculinity and gender role socialization. The Positive Psychology/Positive Masculinity (PPPM) model focuses on positive aspects of masculinity and male development and utilizes them to help men and boys learn to embrace healthier social constructions of masculinity (Kiselica & Englar-Carlson, 2010). These strengths of masculinity include: (a) male relational styles (e.g., developing relationships through activities), (b) male ways of caring (e.g., protection of loved ones), (c) generative fatherhood (e.g., helping each generation be more successful than the last), (d) male self-reliance, (e) male work
ethic/providing role, (f) male courage and risk taking (i.e., when it does not cause harm to
self or others), (g) group orientation, (h) humanitarian service through male fraternal
organizations, (i) use of humor, and (j) male heroism (Kiselica & Englar-Carlson, 2010).
Though some of these qualities can have negative consequences for men and the people
in men’s lives when taken to extremes, these strengths can benefit individuals, families,
and society when they are approached in a way that de-emphasizes hegemonic
masculinity and sexism (Englar-Carlson, 2006). It has been suggested that identifying
masculine strengths in client narratives may be a way to lower resistance and increase
engagement in therapy (Kiselica & Englar Carlson, 2006).

Despite PPPM being a promising therapy model, there is no published empirical
support to date. However, adapting other empirically supported aspects of positive
psychology into prevention work and treatment of men may be beneficial. Positive
individual traits and client strengths are at the core of positive psychological theory.
These individual traits are broadly classified as positive emotional states (e.g., happiness,
well-being, and positive affect), positive cognitive states (e.g., self-efficacy, hope, and
flow), and prosocial behaviors (e.g., empathy, forgiveness, and gratitude) (Snyder &
Lopez, 2007). It is a commonly held belief among positive psychologists that by
identifying, understanding, and utilizing client strengths based upon these positive
individual traits, clients will become more resilient and better able to manage their
weaknesses (e.g., pathology, genetic predispositions, and environmental stressors;
Magyar-Moe, 2009). More traditional treatment approaches focus primarily on client
deficits which are diagnosed and labeled, and in most cases, become the focus of
treatment. The emphasis is placed upon treating the diagnosis and fixing deficits rather
than on building strengths as buffers that are preventative and as result can be curative (Lopez et al., 2006; Magyar-Moe, 2009).

**Client strengths.** Linley and Harrington (2006) define strengths as "a capacity for feeling, thinking, and behaving in a way that allows optimal functioning in the pursuit of valued outcomes" (Snyder & Lopez, 2007, p.52). Researchers have attempted to classify and measure these strengths, much in the way that researchers have approached the classification of illnesses. The three most researched classifications include: The Gallup Themes of Talent (Buckingham & Clifton, 2001), The Values in Action Classification of Strengths (Peterson & Seligman, 2004), and The Search Institute's 40 Developmental Assets (Benson, Leffert, Scales, & Blyth, 1998). These classification systems explore individual character strengths, talents, and environmental assets (only the 40 Developmental Assets explore both). Although these three classification schemes were developed for use in different settings, all of them operationalize client strengths and abilities in a way that allows for psychometrically sound measurement (Snyder & Lopez, 2007). Each of these classification systems has its own unique terminology and provides detailed information about how to assess and apply these strengths in positive psychological interventions aimed at increasing client engagement and building satisfaction with life and well-being (Magyar-Moe, 2009). Other models of strength based counseling promote the identification of strengths within an individual context that is based primarily on each client's unique experiences and worldview (Smith, 2006; Wong, 2006).

**Positive emotions.** The study of positive emotion is also a major focus of positive psychologists. Though the majority of this research focuses on the role of happiness,
researchers such as Fredrickson (1998, 2001) have explored the cognitive and social impact of a variety of positive emotional experiences (Lopez & Edwards, 2008). Fredrickson’s Broaden and Build Theory of Positive Emotion (1998, 2001) provides a framework in which negative life events and negative emotion help clients to focus on specific problems, whereas positive life events and emotion help clients to broaden momentary thought-action repertories and allow clients to see new possibilities and perspectives. This broadened view and increase in positive emotion facilitates psychological growth and changes in the lives of clients by building self-efficacy, allowing them to positively reframe past experiences, and by helping clients to see a variety of possible outcomes and solutions (Fitzpatrick & Stalikas, 2008; Fredrickson, 2001).

In addition to information about the ability of positive emotion to lead to a process of broadening, Fredrickson (2001) found that positive emotions can reduce the impact of lingering negative emotions. This "Undoing Hypothesis" suggests that momentary thought action repertories cannot be broadened and narrowed at the same time. By emphasizing positive emotional experiences, therapists can reduce rumination and depressive symptoms and refocus clients on adaptive coping by finding solutions and strengths in their experiences (Magyar-Moe, 2009). Continued exposure to broadening and increased experience of positive emotion leads to upward spirals of well-being that build coping skills and resilience in the face of future adversity (Fredrickson, 2000). Positive emotional experience has also been linked to the ability of people to flourish in life. By exploring the role of positive emotion, Fredrickson and Losada (2005) found that
a ratio of three positive experiences to one negative experience provides a preventative buffer and promotes optimal functioning.

To date, there is sparse research that examines positive psychological aspects of men and masculinity from a non-theoretical perspective. In one of the few published empirical studies of positive aspects of masculinity, Hammer and Good (2010) explored the relationship between conformity to masculine norms and positive individual traits (i.e., courage, grit, autonomy, resilience, and subjective well-being). Results of the study indicate that endorsement of norms related to risk-taking, dominance, primacy of work, and pursuit of status were associated with higher levels of courage, autonomy, and resilience. However, conformity to norms of emotional control were related to lower levels of courage, grit, autonomy, resilience, and well-being. Similarly, identification with norms related to winning and pursuit of status were associated with lower levels of courage, grit, autonomy, and resilience (Hammer & Good, 2010).

Several studies have explored the relationship between GRC and well-being. Masculine GRC is associated with lower levels of well-being in samples of gay men (Ervin, 2005; Sanchez, Westefeld, Liu, & Vilain, 2010; Simonsen, Blazina, & Watkins, 2000). In a sample of adolescence males, Jackson (2008) found that GRC (specifically “restricted emotionality” and “conflict between work and family”) predicted lower levels of psychological well-being, self-esteem). Similarly, GRC predicted lower levels of psychological well-being (e.g., self-esteem, symptom distress, and relationship satisfaction) in samples of college men (Blazina & Watkins Jr., 1996; Sharpe & Heppner, 1991) and community men (Sharpe, Heppner, & Dixon, 1995). Additionally, Tokar and colleagues (2000) found that men who reported high levels of psychological well-being
had significantly lower GRC than men with low psychological well-being. These findings support O’Neil’s (1990) assertion that GRC is the opposite of psychological well-being because restrictive gender roles lead to devaluation, restriction, and violation of the man and others (O’Neil, 2008).

These studies of the relationship between well-being and GRC have conceptualized psychological well-being as a lack of pathology. However, Keyes and Lopez (2002) suggest that a lack of psychological distress is not an appropriate proxy for psychological well-being. The Complete State Model of Mental Health is based upon two central premises: (a) there is more to life than feeling neutral or functioning at baseline (being free of pathology) and (b) the absence of mental illness is not the same thing as the presence of mental health (Magyar-Moe, 2009; Keyes & Lopez, 2002). Within this model, mental health and mental illness exist on two different continuums and interact on an X and Y axis. Clients are assessed for levels of symptoms of mental illness using traditional screening tools (e.g., measures of depression and anxiety). They are then rated from high to low on the "mental illness continuum" using the DSM-IV-TR's Global Assessment of Functioning Rating. Clients are then assessed for levels of mental health using positive psychological assessments (e.g., measures of hope and well-being). They are then rated from high to low on the "mental health continuum" using the Global Assessment of Positive Functioning (Magyar-Moe, 2009) or measures of mental illness and mental health (e.g., the OQ-45.2 and the MHC-LF). This allows client functioning to be conceptualized into one of four categories: (a) complete mental health or flourishing (low symptoms of mental illness, high symptoms of well-being), (b) complete mental illness or floundering (high symptoms of mental health, low symptoms of well-being), (c)
incomplete mental health or languishing (low symptoms of mental health, low symptoms of well-being, (d) incomplete mental illness or struggling (high symptoms of mental illness, high levels of well-being) (Keyes & Lopez, 2002; Magyar-Moe, 2009). This conceptualization of client functioning allows practitioners to determine the degree to which positive psychological interventions should be integrated into treatment. For clients with complete mental illness or incomplete mental illness, treatment as usual (i.e., traditional empirically supported treatments) should be supplemented with positive psychology activities. For clients with complete mental health or incomplete mental health, the core of treatment should focus on positive psychology exercises that emphasize positive individual traits and positive emotional experience (Keyes & Lopez, 2002; Magyar-Moe, 2009).

**Well-being.** Well-being can be further categorized into subjective (hedonic) and psychological subtypes (eudaimonic). In the hedonic view, the emphasis is on the presence of happiness and pleasure (Lent, 2004). Campbell (1976) conducted an extensive review of well-being and concluded that life satisfaction results from perceptions about an individual’s distance from their aspirations. In other words, satisfaction with life is determined by examining how close a person is to reaching her/his goals: the closer one is to reaching her/his life goals (i.e., seeing multiple pathways to reach a goal), the higher her/his levels of life satisfaction. Additionally, Bradburn (1969) explained that happiness is the result of a balance between the positive and negative affect one has in her/his life. It was with all of this in mind that Diener (1984) described subjective well-being as the result of the presence of positive affect, the absence of negative affect, and high overall life satisfaction. This view of well-being is
based upon the subjective feelings a person has about her/his life rather than external indicators such as wealth, health, or the observations of others.

In the eudaimonic tradition, well-being is conceptualized as the outcome of positive goal pursuits and striving to reach one’s full potential (Lent, 2004). Rather than focusing on how a person feels about her/his life, the emphasis is on what the person is doing or thinking. Building upon this eudaimonic framework, Ryff (1989a) offered the concept of psychological well-being as an alternative to the more hedonic perspectives. This view of well-being is a combination of philosophy, and developmental, humanistic, and clinical psychology. Theories including Erikson’s (1959) psychosocial stages of development, Buhler’s (1935) theory of basic life tendencies, Neugarten’s (1973) theories on personality and wellness, Maslow’s (1968) self-actualization theory, and Rogers’ (1961) conception of the fully functioning person all played a role (Ryff & Keyes, 1995). Ryff (1989a) described psychological well-being as the combination of six domains: self-acceptance, positive relationships with others, autonomy, environmental mastery, purpose in life, and personal growth (Ryan & Deci, 2001; Ryff & Singer, 1996). Happiness still has a role, but it is considered a by-product rather than the main goal (Lent, 2004).

Another large difference between the two theories is that psychological well-being theory acknowledges that the path to optimal functioning is not always an easy one. There are times when people will be challenged by negative emotions and tasks that seem just outside their reach (Waterman, 1993).

As a result of the loose manner in which well-being has been operationalized across studies, the literature on the relationship between well-being and psychological distress is inconsistent. Although most of these studies utilize proxy variables (e.g., self-
esteem), several have utilized Ryff’s conceptualization of psychological well-being. Walker (2006) found that students classified as flourishing (free of mental illness and experiencing high levels of emotional, psychological, and social well-being) were happier, had better grades, and consumed less alcohol than their languishing peers (free of mental illness but experiencing low levels of well-being) (Keyes & Haidt, 2003; Keyes & Lopez, 2002). While developing the Scales of Psychological Well-Being, Ryff (1989b) found that higher levels of each of the six domains of psychological well-being were related to lower levels of depression. Similarly, in community samples, individuals with higher levels of subjective and/or psychological well-being reported lower levels of depressive symptoms and better treatment outcome at six year follow-up (Fava, Ruini, Rafanelli, Finos, Conti, & Grandi, 2004).

**Hope.** The 1950s gave rise to hope as a popular subject in psychological research as French (1952) and Menninger (1959) explored human adaptation and the role of hope in improving therapeutic outcomes and well-being (Magaletta & Oliver, 1999). Frank and Frank (1991) proposed that therapists should focus on combating client demoralization through a contextual model of therapy that builds hope. Since this time, it has been suggested that hope is the underlying process that allows for therapeutic change (Snyder, Parenteau, Shorey, Kahle, & Berg, 2002). Hope has been explored from a variety of angles by developmental psychologists, behaviorists, and existential psychologists to name just a few. Despite the many definitions of hope that have come from this line of research, conceptualizations of hope tend to fall into one of two categories: cognitive or emotional (Lopez et al., 2003). While researchers debate the origins of hope (be it in
thought or emotion), the majority see hope as a “unidimensional construct involving an overall perception that goals can be met” (Snyder et al., 1991, p. 570).

In the last few decades, a theory of hope by Snyder and colleagues (1991) has become one of the most popular. In this theory, hope is defined as “goal-directed thinking in which people perceive that they can produce routes to desired goals (pathways thinking), and the requisite motivation to use those routes (agency thinking)” (Lopez et al., 2003, p. 94). Snyder and colleagues (2005) defined goals as “the targets of mental action sequences” (Snyder, Rand, & Sigmon, 2005, p. 258). Goals are the cognitive foundation for the theory and while they can be short or long term, they must meet several criteria: (a) they must hold some value to the person; (b) they must be attainable; and (c) they must possess a degree of uncertainty (i.e., they cannot be a sure thing). People that are high in hope tend to clearly define their goals, whereas people with lower levels of hope are often uncertain about their goals (Snyder, 1994).

Pathways thinking is a person’s perceived capability to generate ways to reach their desired goal. These pathways are not concrete and may need to be reevaluated in the process should barriers occur. People that are high in hope tend to have less difficulty generating multiple routes to desired goals (Snyder, 1994). Agency thinking is the degree to which a person believes they can use the pathways they have developed to reach their goals. It is this motivational thinking that reinforces the creation and selection of alternative pathways to goals when barriers occur (Snyder et al., 2005).

This model of hope consists of cognitive and emotional components. Past experiences interact with current emotions to set the stage for goal pursuit. If a goal is of significant value, pathways and agency thinking begin. These thoughts regarding the will
and ways to reach a certain goal interact with each other throughout the journey to goal attainment. Emotions play several roles in this process. They can exist in the form of stressors (barriers) that may require the development of additional pathways and agency. Emotions also exist within a feedback loop that has influence at every stage of the process. Positive momentum toward goal achievement can provide energy going forward into each stage of the process. Negative emotions can lead to decreases in pathways and agency thinking and slow the process. Emotions traveling in this feedback loop can also impact future goal pursuit. In addition to altering mood, positive and negative emotion can alter the schemas for hope by changing our knowledge of what does and does not work (i.e., specific pathways and agency techniques) (Lopez et al., 2003).

Trait hope appears to have a variety of implications for college students related to their academic performance and mental health (Snyder, Lopez, & Teramoto Pedrotti, 2011; Snyder et al. 2005). Although hope does not significantly correlate to intelligence, students with higher levels of hope tend to set higher educational goals, believe that they will be more successful at reaching these goals (despite negative feedback), and attain higher grades than their low hope peers (Snyder et al., 1991). A six year longitudinal study of college students explored the relationship between hope, grade point average, and graduation rates. Students with high levels of hope in their first semester of college (as indicated by scores on the Adult Trait Hope Scale) had higher cumulative grade point averages, higher graduation rates, and lower rates of dismissal due to poor grades than their low hope peers. These results were maintained even after controlling for variance due to ACT scores (Snyder et al., 2002). In a study of 370 NCAA Division I student
athletes, Curry and colleagues (1997) found that trait hope levels predicted semester grade point average after controlling for cumulative grade point average.

Trait hope is also related to psychological adjustment (Snyder, 2002). Students who are high in hope report more confidence, energy, and self-worth than their low hope peers (Snyder et al., 1991). Cramer and Dyrkacz (1998) found that students with high hope reported less distress on the Minnesota Multiphasic Personality Inventory (MMPI). Additionally, college students with high hope report lower levels of depression and suicidal ideation than their low hope peers (Arnaud, Rosen, Finch, Rhudy, & Fortunato, 2007; Chang, 1998; Kwon, 2000; Range & Penton, 1994). Similarly, in community and inpatient samples, individuals with high hope report fewer symptoms of depression (Gilman, Schumm, & Chard, 2011; Peleg, Barak, Harel, Rochberg, & Hoofien, 2009; Snyder et al., 1991; Thio & Elliott, 2005), and trait hope scores have a strong negative correlation to scores on the Center for Epidemiologic Studies Depression Scale (CES-D) and moderate negative correlations to scores on the Beck Depression Inventory-II (BDI-II; Cheavens, Feldman, Gum, Michael, & Snyder, 2006; Gilman et al., 2011).

Interventions that build hope through teaching clients to improve goal, pathway, and agency thinking reduce symptoms of depression (Cheavens et al., 2006; Klausner, Snyder, & Cheavens, 2000). It is hypothesized that hopeful thinking counteracts depressive symptoms by decreasing rumination, social withdrawal, and self-criticism, while increasing adaptive coping skills (Chang & Desimone, 2001; Cheavens, 2000; Snyder et al., 1991). To date, no published studies have explored the relationship between hope and GRC. Given the buffering effects of hope, researchers should explore
the moderating effects of hope upon the relationship between GRC, depression, and help-seeking behaviors.

Conclusions

Although empirical findings on gender differences in depression are inconsistent, it appears that the subjective experience of depression may be different for men and women. The current DSM criteria for Major Depressive Disorder clearly align in a way that is more congruent with feminine social norms than masculine social norms (Kilmartin, 2005). As a result, men experience barriers to diagnosis and treatment that are not as prevalent for women. It appears that the gender role socialization process may lead some men to experience depression in a way that is not in line with the most accepted diagnostic tools and assessments (e.g., externalizing behaviors). As a result, these men often go undiagnosed as they do not meet the criteria set forth by the DSM for a diagnosis of a Major Depressive Episode. At the surface level, it may appear that these men are less depressed, however a deeper examination suggests that when depression is identified within the context of gender role socialization and masculinity, men have similar estimates of the experience of depression and that treatment is equally effective. This socialization process may lead to a variety of barriers to treatment that are not as prominent for women. These barriers combine with social pressures and differential diagnosis to contribute to the gender gap in diagnosis of depression in men.

Despite the great deal of progress that has been made toward understanding the various factors that influence the diagnosis and treatment of men with depression, there are still many unanswered questions. Though several articles have theorized about male perceptions of depression, no published studies to date have examined the degree to
which men identify with DSM-IV criteria for depression, which some believe is more in line with feminine social norms (Kilmartin, 2005). Additionally, while models of masculine depression have been developed (e.g., Mahalik’s (2008) “Biopsychosocial Model,” Pollack’s (1998) “Major Depressive Disorder-Male Type”), no published studies on these models have sought to understand the degree to which men identify with these models as compared to traditional diagnostic criteria. That said, it is unclear at this point the degree to which men consider depression to be a "feminine," "masculine", or gender neutral experience.

Also, many questions remain with regard to help-seeking behaviors. No studies to date have tested the "Model of Male Help-Seeking" set forth by Perlick and Manning (2007). This model of help-seeking emphasizes the influence of stigma, culture of origin, socialization and masculinity on help-seeking behaviors. Before public health campaigns and interventions are designed to improve the help-seeking behaviors of men with depression, it would be beneficial to understand the degree to which specific mechanisms facilitate or preclude help-seeking. While emerging evidence indicates that GRC plays a large role in the subjective experience of depression and of related help-seeking behaviors, little is known with regard to specific disorders such as depression.

There is a large movement within the field of men and masculinity to modify treatment to make them more acceptable to male clients. These suggested changes include changing men’s views of counseling, conceptualizing help-seeking as a strength, and challenging gender stereotypes about depression, among many others (Good & Wood, 1995; Mahalik, 2011; Rochlen et al., 2005). However, few if any published studies have sought to understand whether making the suggested changes would improve
treatment acceptability and/or help-seeking behaviors. With regard to the growing body of literature on "positive masculinity," little if anything is known with regard to the relationship between conformity to masculine norms, GRC, and aspects of positive functioning such as hope and well-being.

Before surging forward with a new wave of assessments, diagnostic criteria, campaigns to increase help-seeking, and modifications to treatment in an effort to increase acceptability, researchers are advised to examine these gaps in the literature to gain a better understanding of male perceptions of the experience of depression and the implications for treatment. Better understanding of how men perceive depression and the specific ingredients that increase willingness to seek help for depression will enhance the ability of researchers and clinicians to develop more effective outreach programming and interventions aimed at reducing stigma related to help-seeking. This may reduce the high prevalence of externalizing behaviors and suicide associated with men suffering from depressive disorders. Gaining additional knowledge about the ways that men conceptualize depression may also lead to the development of more accurate diagnostic criteria and assessments that will allow for improved ability to identify and treat depressive disorders in men. Expanding research on masculine norms and GRC by applying these concepts to specific sets of symptoms and types of help-seeking may bridge the gap between theory and practice. Thus, perhaps researchers and clinicians will develop additional studies that can harness the power of gender socialization to re-conceptualize help-seeking within the framework of masculine strengths.
The Proposed Study

Perceptions about same-sex health norms appear to be the biggest predictor of how men perceive illness and subsequently, of their decisions to seek or avoid professional help (Mahalik et al., 2007). Although there is a dearth of research addressing male perceptions of depression, the majority of published studies have focused on community samples. Few studies have explored how college men perceive depression and help-seeking. Thus, the current study focused exclusively on college men. Interventions informed in the unique ways that depression manifests in college men are critical for improving treatment outcomes and increasing male help-seeking behaviors. These interventions become even more important when the high rates of co-morbid alcohol abuse and suicide are considered. Through the use of vignettes about men with depression, the current study built upon the work of Mahalik and Rochlen (2006) by exploring factors that may preclude men to lower rates of diagnosis and help-seeking with an emphasis on exploring the impact of gender socialization related to masculinity. These vignettes also attempted to identify the types of symptoms that men believe are representative of depression. Frazier and colleagues (2004) argued that counseling psychology research would benefit from increased emphasis on the roles of mediators and moderators in the relationships between variables. Similarly, O’Neil (2008) suggested a greater focus on potential mediators and moderators of the relationship between GRC and attitudes toward help-seeking. Thus, the current study examined the mediating effects of hope and psychological well-being on the relationship between adherence to traditional masculine norms and attitudes toward help-seeking. Lastly, the study provided a test the Model of Male Help-Seeking posited by Perlick and Manning.
(2007) by exploring the relationships between gender socialization, mental illness stigma, recognition of problem severity, and attitudes about help-seeking. This study was designed with the following questions in mind: (a) Do men view depression as a "feminine" disorder? (b) Are certain types of help-seeking behaviors considered more or less masculine than others? (c) Do men identify a depressive disorder at higher rates when DSM-IV criteria are replaced with the criteria for "Major Depressive Disorder-Male Type" (Pollack, 1998)?
Chapter 3

Method

Given the high prevalence of undiagnosed and untreated depressive disorders in men, interventions informed by the unique ways that depression manifests in men are critical for improving treatment outcomes and increasing male help-seeking behaviors. The current study examined the ways in which men conceptualize depression and help-seeking. Expanding research on masculine norms and gender role conflict by applying these concepts to specific sets of depressive symptoms and types of help-seeking may aid in the identification of variables that impact the appraisal of symptom distress and the decision to seek or avoid professional psychological help. This chapter will describe the methods used for the current study. Participants, study procedures, research hypotheses, and instruments will be discussed.

Proposed Study

Through the use of vignettes about men with depression, the proposed study built upon the work of Mahalik and Rochlen (2006) by exploring factors that may preclude men to lower rates of diagnosis and help-seeking with an emphasis on exploring the impact of gender socialization related to masculinity. Frazier and colleagues (2004) argued that counseling psychology research would benefit from increased emphasis on the roles of mediators and moderators in the relationships between variables. Similarly, O’Neil (2008) suggested a greater focus on potential mediators and moderators of the relationship between gender role conflict and attitudes toward help-seeking. Thus, the current study examined the moderating effects of hope and psychological well-being on the relationship between adherence to traditional masculine norms and attitudes toward help-seeking. Lastly, the study provided a test of the Model of Male Help-Seeking
behavior posited by Perlick and Manning (2007) by exploring the relationships between gender socialization, mental illness stigma, recognition of problem severity, and attitudes about help-seeking. The proposed study seeks to examine the following hypotheses:

1) Men with higher levels of gender role conflict and/or conformity to masculine norms will be more likely to view depression as a “feminine disorder” than men with lower levels of gender role conflict and/or conformity to masculine norms. Specifically, more conformity to masculine norms will be associated with ratings of (1a) more femininity and (1b) less masculinity for the vignette character. Additionally, more gender role conflict will be associated with ratings of (1c) more femininity and (1d) less masculinity for the vignette character.

2) Participants will identify the men in condition B (Major Depressive Disorder-Male Type) and condition C (a mix of condition A and B) as more depressed than men in condition A (DSM-IV Major Depressive Disorder) and condition D (career decision making concerns).

3) The man described in the vignette for condition B (Major Depressive Disorder-Male Type) will receive the highest number of ratings for depression across conditions. In other words, men will be most likely to identify the man with symptoms of Major Depressive Disorder-Male Type as depressed.

4) Endorsement of traditional masculine norms will predict attitudes toward help-seeking for depression as measured by the total number of help-seeking behaviors endorsed. Specifically, more conformity to masculine norms will be associated with less willingness to seek (4a) any help, (4b) professional help, (4c) help from friends and family, (4d) self-help and more (4e) negative coping behaviors when
depressed. Additionally, more gender role conflict will be associated with less willingness to seek (4f) any help, (4g) professional help, (4h) help from friends and family, (4i) self-help and more (4j) negative coping behaviors when depressed.

5) Trait hope and psychological well-being will moderate the relationship between conformity to masculine norms/gender role conflict and attitudes toward psychological help-seeking.

6) Relations between male-role socialization, mental illness stigma, recognition of problem severity, and decisions to seek help will be consistent with Perlick and Manning’s (2007) Model of Male Help-Seeking.

Sample and Participant Selection

The participants in this study were 409 male students, enrolled at a Midwestern university. Participants were primarily recruited from the undergraduate psychology research pool. Additional participants were recruited in undergraduate courses, fraternities, and through online advertisement on Facebook. Participants from the general campus population were entered into a drawing to win one of fifteen $10 gift cards to their choice of iTunes or Amazon.com. Participants from the undergraduate psychology pool received research credit for their participation. Of the 409 participants, 20 were excluded after failing to correctly answer at least 90% of the validity items (e.g., Please answer mostly false for this question). An additional 23 participants were excluded due to elevated scores on the CES-D, indicating the presence of a major depressive episode (See Zich et al., 1990 for rationale for exclusion). This yielded a sample of 366 participants. Students ranged in age from 18 to 40 years ($M = 20.24$, $SD = 2.813$). With regard to
racial demographics, the majority of the sample described themselves as Caucasian (83.6%). Latino men made up 4.6% of the sample, 4.4% were African American, 4.4% were Asian American, 2.2% self-identified as bi-racial or multi-racial, and .8% of the sample described themselves as “Other.” Regarding sexual orientation, heterosexual men made up 94.5% of the sample, 2.7% identified as gay, 1.1% identified as bisexual, and 1.4% designated “questioning” or “other.”

**Procedures**

Prior to beginning recruitment for this study, Institutional Review Board (IRB) approval was obtained. Following acceptance into the study, participants were directed to Qualtrics, a secure online assessment website. Participants were given an overview of the study and an informed consent screen (including requirements of participation, time commitment required to participate, and potential benefits and risks associated with participation; see Appendix B). Participants were also informed that their personal information will be stored confidentially on an encrypted and secure, password protected server to which only the primary investigator (PI) and his academic advisor had access. Finally, prospective participants were informed that they may contact the PI, and/or UNL IRB with any questions about the study.

Following a brief set of demographic questions, participants were told that they were completing two unique studies. One study was interested in participants’ views on masculinity and the other study was interested in participants’ views on men’s mental health. Although all participants completed both studies, they completed them in random order in an effort to control for order effects. In the “Masculinity Study”, participants were asked to use a 100-point visual analogue scale ranging from *not masculine* to *very*
masculine, to rate the masculinity of the “ideal man,” “ideal woman,” and “how masculine are you.” Next, using a 100-point visual analogue scale ranging from not feminine to very feminine, participants rated the femininity of the “ideal woman,” “ideal man,” and “how feminine are you.” This allowed for assessment of the degree to which participants are experiencing gender role dysfunction distress (Pleck, 1995). Past research suggests that masculinity and femininity are not bipolar constructs (see Smiler & Epstein, 2010 for review) and as such, the current study asked about masculinity and femininity on separate scales. Participants then completed the Conformity to Masculine Norms Inventory-46 (CMNI-46; Parent & Moradi, 2009) and the Gender Role Conflict Scale (GRCS; O'Neil et al., 1986).

In the “Men’s Mental Health Study”, participants were asked to report past diagnosis of depression and past experiences in counseling before random assignment to one of four conditions. Each condition featured a vignette about a college student named “Michael.” In each condition, Michael was experiencing distress. All background information for Michael was consistent across conditions, however, details of his "distress" varied. Condition A read a vignette that included symptoms that fit DSM-IV-TR symptoms for a Major Depressive Episode (see Appendix L). Condition B read a vignette that included symptoms that fit Pollack’s (1998) conceptualization of Major Depressive Disorder-Male Type (see Appendix M). Chuick and colleagues (2009) suggest that men with depression often experience a mix of traditional symptoms and atypical symptoms (e.g., externalizing behaviors such as drinking and anger). Thus, in an effort to capture this mixed presentation of symptoms, Condition C read a vignette that included symptoms of both DSM-IV Major Depressive Disorder and Pollack’s (1998)
Major Depressive Disorder-Male Type (see Appendix N). Condition D served as a control group and read a vignette that includes no symptoms of depression but focused on concerns about career development and decision making (i.e., choosing a major in college; see Appendix O). These vignettes were constructed by the PI and were evaluated for construct validity by three licensed psychologists, including an expert researcher in the field of men and masculinities.

After reading the vignette, participants were asked to answer the following questions: (a) Is Michael depressed? (answered “Yes” or “No”), (b) How depressed is Michael? (answered using a 100-point visual analogue scale ranging from not depressed to very depressed) (c) Click on the words below that lead you to think that Michael is depressed (answered by clicking on words in the vignette), (d) and How masculine and feminine is Michael? (answered using a 100-point visual analogue scale ranging from not masculine to very masculine and a 100-point visual analogue scale ranging from not feminine to very feminine). They will then be presented with a list of 28 potential ways to respond to depressive symptoms (Appendix Q; Mahalik & Rochlen, 2006). They were then asked to rate the masculinity and femininity of each of these responses within the context of the vignette: "Below are some ways that Michael could react to his problem. Please indicate if you believe the behaviors are masculine or feminine by dragging them to the appropriate box. If the item is neither masculine or feminine, leave it in the column on the left." After sorting these behaviors into boxes, participants then used the visual analogue scales described above to rate the masculinity and femininity of each of the potential responses to depressive symptoms (e.g., various forms of help-seeking, distraction, self-medication; See Appendix Q for the complete list). They were then asked
to imagine that they were experiencing symptoms similar to the man in the vignette and to use a 4-point Likert-type scale to rate the likelihood that they would respond in each of the 20 response behaviors developed by Mahalik and Rochlen (2006) and 8 new response behaviors of interest to the PI. This 4-point Likert-type scale has been retained from the initial study by Mahalik and Rochlen (2006) in an effort to provide a replication. Participants were then asked to report the degree to which they identify with the conditions of the vignette. Following completion of the vignette-related questions, participants completed measures of trait hope, psychological well-being, depression, attitudes toward psychological help-seeking, and stigma related to help-seeking. In an effort to control for order effects, participants were counterbalanced such that half of the sample completed these measures prior to the vignette and vignette-related questions.

**Instruments**

**Validity Indicators.** A series of 12 validity indicators were dispersed throughout the survey. These indictors consisted of questions asking for specific responses to items (e.g., “Please answer “Moderate” for this question.”) as well as items asking how attentive participants were to the survey (e.g., “I am reading each item carefully.”). Participants were required to correctly answer a minimum of 10 of these items. Participants answering less than 10 items correctly were excluded from analyses due to “invalid” or “inconsistent” response patterns (N=20). In the current study, the mean score on the validity indicators was 11.86.

**The Conformity to Masculine Norms Inventory-46.** The Conformity to Masculine Norms Inventory-46 (CMNI-46; Parent & Moradi, 2009) is a 46-item, self-report measure of behaviors, feelings, and thoughts related to masculine gender role
conformity (Mahalik & Rochlen, 2006). The CMNI includes nine subscales: (a) Winning, (b) Emotional Control, (c) Risk-Taking, (d) Violence, (e) Playboy, (f) Self-Reliance, (g) Primacy of Work, (h) Power Over Women, and (i) Heterosexual Self-Presentation. Items are answered using a 4-point Likert-type scale ranging from 0 (strongly disagree) to 3 (strongly agree) with high scores indicating high degrees of conformity to masculine norms (Parent & Moradi, 2009).

Emotional Control measures emotional restriction and suppression (e.g., “I never share my feelings”). Winning measures drive to win (e.g., “In general, I will do anything to win”). Playboy measures desire for multiple or non-committed sexual relationships and emotional distance from sex partners (e.g., “If I could, I would frequently change sexual partners”). Violence measures proclivity for physical confrontations (e.g., “Sometimes violent action is necessary”). Self-reliance measures aversion to asking for assistance (e.g., “I hate asking for help”). Risk-taking measures the likelihood of engaging in high-risk behaviors (e.g., “I enjoy taking risks”). Power Over Women measures perceived control over women at personal and social levels (e.g., “Women should be subservient to men”). Primacy of Work measures the degree to which work is a major focus of life (e.g., “My work is the most important part of my life”). Heterosexual Self-Presentation measures aversion to the prospect of being gay, or being thought of as gay (e.g., “I would be furious if someone thought I was gay”) (Parent & Moradi, 2009).

In a study examining the use of the CMNI-46 with college males (N=229), internal consistency of the CMNI-46 ranged from .77 to .91, indicating good to excellent internal consistency reliability across subscales (Parent & Moradi, 2009). To date, no studies of test-retest reliability or discriminant validity have been published. Convergent
validity has been tested by comparing the CMNI-46 to the original version of the measure, the CMNI (CMNI; Mahalik et al., 2003), with correlations between the original CMNI subscales and CMNI-46 subscales ranging from .89 to .98, indicating a strong relationship between the measures (Parent & Moradi, 2009). Confirmatory factor analysis indicated that the original factor structure of the CMNI has been preserved in the CMNI-46. While the initial validation study of the CMNI-46 utilized a diverse sample of college age men, no additional studies have been published using the CMNI-46 with other populations or with specific ethnic groups. A mean conformity to masculine norm score was calculated for the current study (see Table 1) and both the total scale and subscales demonstrated good internal consistency reliability (Total Scale $\alpha = .89$, Winning $\alpha = .85$, Risk Taking $\alpha = .81$, Violence $\alpha = .83$, Power Over Women $\alpha = .83$), Playboy $\alpha = .82$, Self Reliance $\alpha = .87$, Heterosexual Self Presentation $\alpha = .90$, Primacy of Work $\alpha = .75$, Emotional Control $\alpha = .91$). Please see Appendix D for the complete CMDI-46 measure.

The Gender Role Conflict Scale. The Gender Role Conflict Scale (GRCS; O’Neil et al., 1986) is a 37-item, self-report measure of experience of negative consequences related to socialized masculine gender roles (O’Neil, 2009). Items on the GRCS measure psychological domains, personal experiences, and situational contexts of gender role conflict (O’Neil, 2009). There are four subscales including: (a) Success, Power, and Competition, (b) Restrictive Emotionality, (c) Restrictive Affectionate Behavior Between Men, and (d) Conflict Between Work and Family Relations (O’Neil et al., 1986). Items are answered using a 6-point Likert-type scale ranging from 1 (strongly disagree) to 6 (strongly agree) with high scores indicating expression of patterns of gender role conflict and fear of femininity (O’Neil et al., 1986).
Success, Power, and Competition measures the desire to achieve success, avoid failure, be considered superior to others, and to compete with others to gain power and success (e.g., “Moving up the career ladder is important to me.”). Restrictive Emotionality measures difficulty or fear related to expression of feelings (e.g., “I have difficulty telling others I care about them.”). Restrictive Affectionate Behavior Between Men measures discomfort with expression of feelings toward other men (e.g., “Expressing my emotions to other men is risky.”). Conflict Between Work and Family Relations measures stress that results from problems balancing work/school responsibilities with family roles and leisure activities (e.g., “My needs to work or study keep me from my family or leisure more than I would like.”) (O’Neil, 2008).

In studies of the use of the GRCS with college males, Cronbach's alpha ranged from .75 to .85 across studies, indicating adequate to strong internal consistency reliability (O’Neil et al., 1986). Four-week test-retest reliability ranged from .72 to .86 across subscales, indicating adequate to strong reliability over time (O'Neil et al, 1986). Subsequent studies of the GRCS have provided additional support for the psychometric properties of the GRCS, with Cronbach’s alphas ranging from .70 to .90 across studies (O’Neil, 2009). Convergent validity has been established by comparing the GRCS to other measures of masculinity including Masculine Gender Role Stress Scale, Masculine Role Norms Scale, Male Role Norm Inventory, and the Conformity to Masculine Norm Inventory with correlations ranging from .32 to .49 across studies, suggesting that the GRCS is related, but is measuring distinct constructs (O’Neil, 2009). Discriminant validity has been established by comparing the GRCS to sex role egalitarianism and homophobia, indicating that GRC is a contrast to beliefs about sex role equality and
homophobia. While initially validated for use in samples consisting primarily of White, college males, subsequent studies have validated the factor structure of the GRCS for use in additional age groups including adolescent boys and adult aged men (O’Neil, 2009). The factor structure of the GRCS was also studied and confirmed for use in samples of Latino, African America, and Asian American men. Reliability estimates of the measure have ranged from .71 to .91 in these studies of diverse participants. Mean GRCS scores were calculated for the current study (see Table 1) and both the total scale and subscales demonstrated good internal consistency reliability (GRCS Total Scale $\alpha = .90$, Success, Power, and Competition $\alpha = .82$, Restrictive Emotionality $\alpha = .88$, Restrictive Affectionate Behavior Between Men $\alpha = .83$, and Conflict Between Work and Family Relations $\alpha = .81$. Please see Appendix E for the complete GRCS measure.

**Center for Epidemiological Studies Depression Scale.** The Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977) is a 20 item self-report measure of cognitive (e.g., “I thought my life had been a failure”), affective (e.g., “I felt depressed”), and vegetative symptoms of depression (e.g., “I could not get going”). Items are answered using a 4-point Likert-type ranging from 0 (*rarely or none of the time*) to 3 (*most or all of the time*) with higher scores indicating greater experience of depressive symptoms. The CES-D has adequate internal consistency with an alpha coefficient of .85 (Radloff, 1977). Convergent validity of the CES-D has been established through comparison with the Beck Depression Inventory (Santor, Zuroff, Ramsay, Cervantes, & Palacios, 1995). A positive correlation of .86 to .87 was found in college and community samples (Hammer & Vogel, 2010; Santor et al., 1995). In several community samples, discriminant validity has been found between scores on the CES-D and scores on the
Bradburn Positive Affect Scale (Radloff, 1977). Eight week test-retest reliability estimates are .59, indicating adequate temporal stability (Radloff, 1977). The CES-D appears to be one of the most appropriate measures for use in evaluating depression in men (Hammer & Vogel, 2010; Sharp & Lipsky, 2002). In a community sample of men with depression, internal consistency was found to be .78, indicating adequate internal consistency reliability. Mean CES-D scores calculated for the current study (see Table 1) and demonstrated good internal consistency reliability (α = .80). Please see Appendix F for the complete CES-D measure.

**Attitudes Toward Seeking Professional Psychological Help Scale-Short**

**Form.** The Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPHS, Fischer & Farina, 1995) consists of 10 items from the original 29-item instrument. It is a self-report measure of general attitudes toward seeking professional help for psychological distress (e.g., “A person should work out his or her own problems; getting psychological counseling would be a last report;” Fischer & Farina, 1995; Fischer & Turner, 1970). The short-form correlates strongly to the original 29-item instrument, indicating that the short form is tapping similar constructs (Fischer & Farina, 1995). Items are answered using a 4-point Likert-type scale ranging from 0 (*strongly disagree*) to 3 (*strongly agree*) with higher scores indicating more positive attitudes toward seeking professional help for psychological distress. In a sample of college students, internal consistency of the ATSPPHS was .84, indicating good internal consistency reliability (Fischer & Farina, 1995). In two samples of college students, convergent validity has been established between the ATSPPHS and intent to seek help for interpersonal problems (Vogel, Wester, Wei, & Boysen, 2004). In a study of community volunteers,
discriminant validity has been found between scores on the ATSPPHS and conformity to traditional masculine norms and psychological help related stigma (McKelley & Rochlen, 2010). One month test-retest reliability estimates are .80, indicating good temporal stability (Fischer & Farina, 1995). Mean ATSPPHS scores were calculated for the current study (see Table 1) and good internal consistency reliability was demonstrated ($\alpha = .81$). Please see Appendix G for the complete ATSPPHS measure.

**Self-Stigma of Help-Seeking Scale.** The Self-Stigma of Help-Seeking Scale (SSOSH; Vogel et al., 2006) is a 10-item, self-report measure of how much a participant believes her/his self-esteem will be threatened by seeking psychological help (e.g., “I would feel worse about myself if I could not solve my own problems”). Items are answered using a 5-point Likert scale ranging from 1(*strongly disagree*) to 5(*strongly agree*). Five items are reverse scored so that higher scores indicate higher levels of self-stigma. The SSOSH shows evidence of moderate convergent validity with measures of mental health stigma and willingness to seek counseling in community and university samples of men. The SSOSH appears divergent from measures of self-esteem and psychological distress. Internal consistency reliability has been estimated to be between .80 and .90 across studies. Good temporal stability for the SSOSH has been demonstrated with two-month test-retest reliability of .72 (Vogel et al., 2006; Vogel et al., 2011). Mean SSOSH scores were calculated for the current study (see Table 1) and the measure demonstrated good internal consistency reliability ($\alpha = .88$). Please see Appendix H for the complete SSOSH measure.

**The Ryff Scales of Psychological Well-Being 54.** The Ryff Scales of Psychological Well-Being-54 (SPWB-54; Ryff, n.d.) is a 54-item self-report measure of
psychological well-being across six domains: (a) Autonomy (e.g., “I tend to worry about what other people think of me”), (b) Environmental Mastery (e.g., “I often feel overwhelmed by my responsibilities”), (c) Personal Growth (e.g., “I am not interested in activities that will expand my horizons”), (d) Positive Relations with Others (e.g., “Most people see me as loving and affectionate”), (e) Purpose in Life (e.g. “My daily activities often seem trivial and unimportant to me”), and (f) Self-Acceptance (e.g., “I like most aspects of my personality”). The 54 items were selected from the original 84 item Ryff Scales of Psychological Well-Being (Ryff, 1989a). Items are answered using a 6-point Likert-type scale ranging from 1 (strongly disagree) to 6 (strongly agree), with higher scores indicating higher levels of well-being. Internal consistency estimates range from .71 to .82 across subscales, indicating adequate internal consistency reliability. To date, no published studies have reported the test-retest reliability of the SPWB-54, however; six week estimates for the original 84 item version of the measure range from .81 to .88 across subscales (Ryff & Keyes, 2005). Although, there are no published studies of convergent or discriminant validity of the SPWB-54, the 84-item version of the measure shows evidence of convergent validity with measures of positive affect and life satisfaction and divergent validity from measures of depression and negative affect (Ryff, 1989b; Ryff, Lee, Essex, & Schmutte, 1994; Ryff & Keyes, 1995). Mean psychological well-being scores were calculated for the current study (see Table 1) and the measure demonstrated good internal consistency reliability (Total Score $\alpha = .93$, Autonomy $\alpha = .76$, Environmental Mastery $\alpha = .78$, Personal Growth $\alpha = .72$, Positive Relationship with Others $\alpha = .81$, Purpose in Life $\alpha = .71$, and Self-Acceptance $\alpha = .84$). Please see Appendix I for the complete SPW-54B measure.
**Trait Hope Scale-Revised.** The Trait Hope Scale-Revised (HSR; Shorey & Snyder, 2004) is an 18-item, self-report measure which uses three subscales (of six items each) to assess trait levels of goals (e.g., “I clearly define goals that I pursue”), pathways (e.g., “I can think of many ways to get out of a jam”), and agency thinking (“I have found that I can overcome challenges”). Items are answered using an 8-point Likert-type scale ranging from 1 (definitely false) to 8 (definitely true). Half of the items are reverse scored, with higher scores indicating higher levels of goal directed thinking, motivation to reach goals, and ability to think of multiple ways to reach goals. The revised scale appears to be more sensitive, has less kurtosis, and has stronger predictive validity (Shorey & Snyder, 2004). It also includes the addition of a goals subscale. In a study using the HSR with college students, the HSR showed convergent validity with measures of self-efficacy and well-being and discriminant validity from measures of psychological distress. Internal consistency reliability ranged from .64 to .81 across subscales and .86 to .88 for the overall scale. To date, no published studies have explored the test-retest reliability of the HSR. Mean trait hope scores were calculated for the current study (see Table 1) the measure demonstrated good internal consistency reliability (Total Scale $\alpha = .91$, Trait Goals $\alpha = .83$, Trait Pathways $\alpha = .73$, and Trait Agency $\alpha = .81$ ). Please see Appendix J for the complete HSR measure.

**Identification with Vignette Character.** The Identification with Vignette Character (IWVC; McKelly & Rochlen, 2010) is a 3-item, self-report measure of the level of identification with the character in help-seeking vignettes. Items are answered using a 5-point Likert scale ranging from 0 (not at all) to 4 (very much) with higher scores indicating identification with the character and situation presented in the vignette.
As modeled by McKelly and Rochlen (2010), items were modified for the proposed study and included: (1) The scenario faced by “Michael” in the vignette is a realistic concern in my life. (2) I can currently relate to the challenge faced by “Michael.” (3) I can see myself facing this kind of challenge at some point in my life. To date there are no published studies of validity or reliability for this measure. Please see Appendix K for the complete IWVC measure.

**Data Analysis**

First, data was screened for validity using a series of validity indicators. Next, univariate outlier analysis was conducted alongside assessment of skewness and kurtosis for the data. As well, ANOVA was conducted to ensure participant similarities across conditions. The following hypotheses were tested:

1) Men with higher levels of gender role conflict and/or conformity to masculine norms will be more likely to view depression as a “feminine disorder” than men with lower levels of gender role conflict and/or conformity to masculine norms. This hypothesis will be tested using linear regressions of the relations between scores on the GRCS, CMNI-46, and the visual analogue ratings “How masculine is Michael?” and “How Feminine is Michael?”

2) Participants will identify the men in condition B (Major Depressive Disorder-Male Type) and condition C (a mix of condition A and B) as more depressed than men in condition A (DSM-IV Major Depressive Disorder) and condition D (career decision making concerns). This hypothesis will be tested using the visual analogue rating “How depressed is Michael?” from the four depression vignette
conditions. Between Groups Analysis of Variance will be utilized to examine ratings of depression across conditions.

3) The man described in the vignette for condition B (Major Depressive Disorder-Male Type) will receive the highest number of ratings for depression across conditions. In other words, men will be most likely to identify the man with symptoms of Major Depressive Disorder-Male Type as depressed. This hypothesis will be tested using the visual analogue rating “How depressed is Michael?” from the four depression vignette conditions. Between Groups Analysis of Variance will be utilized to examine ratings of depression across conditions.

4) Endorsement of traditional masculine norms will predict attitudes toward help-seeking for depression as measured by the total number of help-seeking behaviors endorsed. This hypothesis will be tested through linear regressions that utilize the subscales of the GRCS, CMNI-46, and PRDS.

5) Trait hope and psychological well-being will moderate the relationship between gender role conflict, conformity to masculine norms, and help-seeking when depressed. This hypothesis will be tested by utilizing the HSR, PWB-54, GRCS, CMNI-46 and PRDS in a series of interaction models which will examine the relations between these variables.

6) Relations between male-role socialization, mental illness stigma, recognition of problem severity, and decisions to seek help will be consistent with Perlick and Manning’s (2007) Model of Male Help-Seeking. This hypothesis will be tested by path analysis.
Chapter 4

Results

This chapter describes and summarizes the statistical analyses used to evaluate the research questions and hypotheses established in the previous chapters. First, data screening procedures will be discussed. Next, each hypothesis will be addressed in the order presented in the previous chapters. For Hypothesis 1, a series of linear regressions examine the relations between gender socialization and beliefs about the vignette character (i.e., perceived masculinity and femininity, level of depression present in vignette). Next, a series of between groups analysis of variances examine differences in levels of depression across the four vignette conditions. Then, a series of linear regressions will examine the relations between gender socialization and help-seeking attitudes. Following this, interaction models examining the potential moderating effects of hope and well-being on gender socialization and help-seeking attitudes will be explored. Lastly, results of a path analysis to test the Model of Male Help-Seeking (Perlick & Manning, 2007) will be reported.

Data Screening

Hoaglin, Mosteller, and Tukey’s (1983) procedure for univariate outlier analysis was conducted and no outliers were found in the data. Furthermore, skewness and kurtosis for all the dependent variable measures revealed a normal distribution of scores. After these preliminary analyses were conducted, demographic frequencies were gathered and data were examined for between group differences. Although randomization in the study design provides some safeguards for confounding variables, several analyses were conducted to ensure that effective randomization occurred. Chi-square analyses indicated no significant differences across vignette conditions in ethnicity, sexual orientation, and
past experience of depression. Results from ANOVA also indicated no significant differences between groups with regard to Center for Epidemiologic Studies Depression Scale (CES-D), Gender Role Conflict Scale (GRCS), or Conformity to Masculine Norms Inventory-46 (CMNI-46). Table 4.1 provides descriptive statistics for the outcome measures utilized in the study.
Table 4.1

Means, Standard Deviations, and Correlations for Outcome Measures

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ATSPPHS</td>
<td>365</td>
<td>25.02</td>
<td>5.61</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2. SSOHS</td>
<td>365</td>
<td>27.27</td>
<td>6.92</td>
<td>.59**</td>
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<td>3. CES-D</td>
<td>366</td>
<td>9.02</td>
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<td>.10</td>
<td>--</td>
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<td></td>
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</tr>
<tr>
<td>4. CMNI-46</td>
<td>366</td>
<td>69.37</td>
<td>15.54</td>
<td>.39**</td>
<td>.34**</td>
<td>.01</td>
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<td>5. GRCS</td>
<td>366</td>
<td>136.80</td>
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<td>.26**</td>
<td>.35**</td>
<td>.15**</td>
<td>.57**</td>
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<tr>
<td>6. Trait Hope</td>
<td>365</td>
<td>111.21</td>
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<td>.59</td>
<td>-.06</td>
<td>-.46**</td>
<td>.00</td>
<td>-.12*</td>
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<td>7. Well-Being</td>
<td>366</td>
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<td>27.46</td>
<td>-.04</td>
<td>-.21*</td>
<td>-.54**</td>
<td>-.11*</td>
<td>-.29**</td>
<td>.78**</td>
<td>--</td>
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<td>8. PRDS-P</td>
<td>332</td>
<td>9.52</td>
<td>7.73</td>
<td>-.50**</td>
<td>-.26**</td>
<td>.01</td>
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<td>.03</td>
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<tr>
<td>9. PRDS-FF</td>
<td>359</td>
<td>6.28</td>
<td>2.07</td>
<td>.13*</td>
<td>-.22**</td>
<td>-.09</td>
<td>-.28**</td>
<td>-.22**</td>
<td>.18**</td>
<td>.27**</td>
<td>.30**</td>
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<td>10. PRDS-SH</td>
<td>349</td>
<td>7.28</td>
<td>3.38</td>
<td>-.21**</td>
<td>-.00</td>
<td>.06</td>
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<td>.50**</td>
<td>.16**</td>
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<td>11. PRDS-N</td>
<td>355</td>
<td>7.91</td>
<td>3.39</td>
<td>.23**</td>
<td>.29**</td>
<td>.13*</td>
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<td>-.17**</td>
<td>-.01</td>
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</tr>
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</table>

Note. *p < .05; **p < .01. Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; 0= strongly disagree, 3= strongly agree), Self-Stigma of Seeking Help (SSOHS; 1= strongly disagree, 5= strongly agree), Center for Epidemiological Studies Depression Scale (CES-D; 0= rarely or none of the time, 3= most or all of the time), Conformity to Masculine Norms Inventory-46 (CMNI-46; 0= strongly disagree, 3= strongly agree), Gender Role Conflict Scale (GRCS; 1= strongly agree, 6= strongly agree), Trait Hope Scale-Revised (Trait Hope; 1= definitely false, 8= definitely true), Ryff Scales of Psychological Well-Being-54 (SPWB-54; 1= strongly disagree, 6= strongly agree), Potential Responses to Depressive Symptoms-Professional (PRDS-P, 0= very unlikely, 3= very likely), Potential Responses to Depressive Symptoms-Friends and Family (PRDS-FF, 0= very unlikely, 3= very likely), Potential Responses to Depressive Symptoms-Self Help (PRDS-SH, 0= very unlikely, 3= very likely), Potential Responses to Depressive Symptoms-Negative Behaviors (PRDS-N, 0= very unlikely, 3= very likely).
Hypothesis 1

A series of linear regressions were conducted to test Hypothesis 1, which explored the relationships between gender socialization and gendered beliefs about the experience of depression. Hypothesis 1a stated that men with higher levels of conformity to masculine norms will be more likely to view depression as a feminine disorder than men with lower levels of conformity to masculine norms. Table 4.2 summarizes the descriptive statistics and analysis results. As indicated in the table, Playboy was the only masculine norm that positively and significantly correlated to the criterion, indicating that those with higher scores on this scale were expected to rate the vignette character as more feminine. The multiple regression model for all nine subscales of the CMNI-46 produced $R^2 = .043$, $F (9, 263) = 1.32$, $p > .05$, indicating that conformity to masculine norms does not predict views of the vignette character as feminine. It is notable that scores on the Playboy subscale predicted views of femininity, but the other eight subscales did not contribute to the multiple regression model.

Table 4.2

<table>
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<th>Variable</th>
<th>$M$</th>
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<th>Correlation with Femininity</th>
<th>$b$</th>
<th>$B$</th>
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<td>19.07</td>
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<td>.58</td>
<td>.07</td>
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<td>Power Over Women</td>
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<td>2.33</td>
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<td>Playboy</td>
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<td>2.73</td>
<td>.16**</td>
<td>1.11</td>
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<td>2.15</td>
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</tr>
<tr>
<td>Heterosexual Self Presentation</td>
<td>10.99</td>
<td>4.55</td>
<td>-.03</td>
<td>-.19</td>
<td>-.04</td>
</tr>
</tbody>
</table>

Note: *$p < .05$; **$p < .01$. Femininity (0= not at all, 100=very feminine), Winning, Emotional Control, Risk Taking, Violence, Power Over Women, Playboy, Self-Reliance, Primacy of Work, and Heterosexual Self Presentation (0= strongly disagree, 3= strongly agree).
To test Hypothesis 1b, which states that conformity to masculine norms will predict views of the vignette character as less masculine, correlation and multiple regression analyses were conducted. Table 4.3 summarizes the descriptive statistics and analysis results. As indicated in the table, Winning was positively and significantly correlated to the criterion and Playboy was negatively and significantly correlated to the criterion. The multiple regression model for all nine subscales of the CMNI-46 produced $R^2 = .06$, $F(9, 263) = 1.87$, $p > .05$, indicating that conformity to masculine norms does not predict views of the vignette character as masculine. Scores on the Winning and Playboy subscale predicted views of masculinity, but the other seven subscales did not contribute to the multiple regression model.

Table 4.3

<table>
<thead>
<tr>
<th>Variable</th>
<th>$M$</th>
<th>$SD$</th>
<th>Correlation with Masculinity</th>
<th>$b$</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masculinity</td>
<td>73.72</td>
<td>22.05</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Winning</td>
<td>10.98</td>
<td>3.39</td>
<td>.11*</td>
<td>1.01</td>
<td>.16*</td>
</tr>
<tr>
<td>Emotional Control</td>
<td>8.57</td>
<td>3.46</td>
<td>.09</td>
<td>.72</td>
<td>.11</td>
</tr>
<tr>
<td>Risk Taking</td>
<td>7.63</td>
<td>2.31</td>
<td>.07</td>
<td>.88</td>
<td>.09</td>
</tr>
<tr>
<td>Violence</td>
<td>11.01</td>
<td>3.02</td>
<td>-.06</td>
<td>-.71</td>
<td>-.10</td>
</tr>
<tr>
<td>Power Over Women</td>
<td>4.12</td>
<td>2.32</td>
<td>-.06</td>
<td>-.62</td>
<td>-.07</td>
</tr>
<tr>
<td>Playboy</td>
<td>4.09</td>
<td>2.73</td>
<td>-.12*</td>
<td>-1.07</td>
<td>-.13*</td>
</tr>
<tr>
<td>Self-Reliance</td>
<td>6.59</td>
<td>2.76</td>
<td>.02</td>
<td>-.12</td>
<td>-.02</td>
</tr>
<tr>
<td>Primacy of Work</td>
<td>5.15</td>
<td>2.15</td>
<td>.01</td>
<td>-.07</td>
<td>-.01</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>10.99</td>
<td>4.55</td>
<td>-.03</td>
<td>-.25</td>
<td>-.05</td>
</tr>
</tbody>
</table>

Note: *$p < .05$; **$p < .01$. Masculinity (0= not at all, 100=very masculine), Winning, Emotional Control, Risk Taking, Violence, Power Over Women, Playboy, Self-Reliance, Primacy of Work, and Heterosexual Self Presentation (0= strongly disagree, 3= strongly agree).

To test Hypothesis 1c, which states that gender role conflict will predict views of the vignette character as more feminine, correlation and multiple regression analyses were conducted. Table 4.4 summarizes the descriptive statistics and analysis results. As indicated in the table, none of the subscales of the GRCS were significantly correlated to
views of the vignette character as feminine. The multiple regression model for all four subscales of the GRCS produced $R^2 = .01, F (4, 268)=.758, p>.05$, indicating that gender role conflict did not predict views of the vignette character as more feminine.

Table 4.4

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Correlation with Femininity</th>
<th>b</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Femininity</td>
<td>20.99</td>
<td>19.08</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>GRCS-SPC</td>
<td>55.55</td>
<td>9.71</td>
<td>-.05</td>
<td>-.13</td>
<td>-.07</td>
</tr>
<tr>
<td>GRCS-RE</td>
<td>32.60</td>
<td>9.12</td>
<td>.03</td>
<td>.09</td>
<td>.04</td>
</tr>
<tr>
<td>GRCS-RABBM</td>
<td>26.29</td>
<td>7.93</td>
<td>-.04</td>
<td>-.09</td>
<td>-.04</td>
</tr>
<tr>
<td>GRCS-CBWL</td>
<td>22.27</td>
<td>5.61</td>
<td>.07</td>
<td>.28</td>
<td>.08</td>
</tr>
</tbody>
</table>

Note: *p < .05; **p < .01. Femininity (0= not at all, 100=very feminine). Success, Power, and Competition (GRCS-SPC), Restrictive Emotionality (GRCS-RE), Restrictive Affectionate Behavior Between Men (GRCS-RABBM), and Conflict Between Work and Leisure (GRCS-CBWL; 1= strongly agree, 6= strongly agree).

To test Hypothesis 1d, which states that gender role conflict will predict views of the vignette character as less masculine, correlation and multiple regression analyses were conducted. Table 4.5 summarizes the descriptive statistics and analysis results. As indicated in the table, Restrictive Emotionality was significantly and positively related to the criterion. The multiple regression model for all four subscales of the GRCS produced $R^2 = .03, F (4, 268)= 1.80, p>.05$, indicating that gender role conflict did not predict views of the vignette character as less masculine.

Table 4.5

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Correlation with Masculinity</th>
<th>b</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masculinity</td>
<td>73.72</td>
<td>22.05</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>GRCS-SPC</td>
<td>55.55</td>
<td>9.71</td>
<td>.08</td>
<td>.22</td>
<td>.10</td>
</tr>
<tr>
<td>GRCS-RE</td>
<td>32.60</td>
<td>9.12</td>
<td>.11*</td>
<td>.34</td>
<td>.14</td>
</tr>
<tr>
<td>GRCS-RABBM</td>
<td>26.29</td>
<td>7.93</td>
<td>-.01</td>
<td>-.35</td>
<td>-.13</td>
</tr>
<tr>
<td>GRCS-CBWL</td>
<td>22.27</td>
<td>5.61</td>
<td>.07</td>
<td>.09</td>
<td>.03</td>
</tr>
</tbody>
</table>

Note: *p < .05; **p < .01. Masculinity (0= not at all, 100=very masculine). Success, Power, and Competition (GRCS-SPC), Restrictive Emotionality (GRCS-RE), Restrictive Affectionate Behavior Between Men (GRCS-RABBM), and Conflict Between Work and Leisure (GRCS-CBWL; 1= strongly agree, 6= strongly agree).
Due to the lack of significant findings in these analyses and the variation in symptomology across vignette conditions, it was decided to examine ratings of masculinity and femininity across vignette conditions. Between groups analysis of variance was utilized to examine differences in ratings of masculinity and femininity across vignette conditions. The mean levels of masculinity and femininity for each vignette condition are summarized in Tables 4.6 and 4.7. The results of the analyses for these hypotheses are reported in Tables 4.8 and 4.9. There were significant mean differences in the level of masculinity, $F(3,359)=7.39$, Mse=407.48, $p<.001$ and femininity, $F(3,359)=6.177$, Mse=337.16, $p<.001$ across the four vignette conditions while controlling for the effects of total score on the CES-D and past diagnosis of depression. Post hoc comparisons using LSD revealed that the vignette character in the Major Depressive Disorder (MDD) condition was considered significantly less masculine and more feminine than the character in the other vignette conditions. However, there were no significant differences in reported masculinity and femininity of the vignette characters when comparing the Major Depressive Disorder-Male Type (MDD-MT), Major Depressive Disorder-Combined Type (MDD-CT), and the Control Vignette Condition.

Table 4.6

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>M</th>
<th>SE</th>
<th>M1</th>
<th>M2</th>
<th>M3</th>
<th>M4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) MDD</td>
<td>86</td>
<td>65.83</td>
<td>2.19</td>
<td>--</td>
<td>-11.65**</td>
<td>-11.65**</td>
<td>-12.53**</td>
</tr>
<tr>
<td>2) MDD-MT</td>
<td>90</td>
<td>77.48</td>
<td>2.13</td>
<td>11.65**</td>
<td>--</td>
<td>.05</td>
<td>-.88</td>
</tr>
<tr>
<td>3) MDD-CT</td>
<td>96</td>
<td>77.22</td>
<td>2.07</td>
<td>11.65**</td>
<td>-.05</td>
<td>--</td>
<td>-.88</td>
</tr>
<tr>
<td>4) Control</td>
<td>93</td>
<td>78.18</td>
<td>2.10</td>
<td>12.53**</td>
<td>.88</td>
<td>.88</td>
<td>--</td>
</tr>
</tbody>
</table>

Note: *$p < .05$; **$p < .01$. MDD = Major Depressive Disorder Vignette Group, MDD-MT= Major Depressive Disorder-Male Type Vignette Group, MDD-CT= Major Depressive Disorder Combined Type Vignette Group, Control= Control Vignette Group
Table 4.7

Pairwise Comparison of Level of Femininity Adjusted for CES-D Total Score and Past Diagnosis of Depression, by Vignette Condition

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>M</th>
<th>SE</th>
<th>M1</th>
<th>M2</th>
<th>M3</th>
<th>M4</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDD</td>
<td>86</td>
<td>27.96</td>
<td>1.99</td>
<td>--</td>
<td>8.82**</td>
<td>10.22**</td>
<td>8.25**</td>
</tr>
<tr>
<td>MDD-MT</td>
<td>90</td>
<td>18.71</td>
<td>1.94</td>
<td>-8.82**</td>
<td>--</td>
<td>1.39</td>
<td>-.57</td>
</tr>
<tr>
<td>MDD-CT</td>
<td>96</td>
<td>17.08</td>
<td>1.88</td>
<td>-10.22**</td>
<td>-1.39</td>
<td>--</td>
<td>-1.97</td>
</tr>
<tr>
<td>Control</td>
<td>93</td>
<td>19.16</td>
<td>1.91</td>
<td>-8.25**</td>
<td>.57</td>
<td>1.97</td>
<td>--</td>
</tr>
</tbody>
</table>

Note: *p < .05; **p < .01. MDD = Major Depressive Disorder Vignette Group, MDD-MT = Major Depressive Disorder- Male Type Vignette Group, MDD-CT = Major Depressive Disorder Combined Type Vignette Group, Control = Control Vignette Group

Table 4.8

Analysis of Covariance of Levels of Masculinity by Vignette Condition

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sums of Squares</th>
<th>df</th>
<th>Mean Squares</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>CES-D</td>
<td>301.56</td>
<td>1</td>
<td>301.56</td>
<td>.74</td>
</tr>
<tr>
<td>Past Depression</td>
<td>667.12</td>
<td>1</td>
<td>667.12</td>
<td>1.61</td>
</tr>
<tr>
<td>Vignette Condition</td>
<td>9033.20</td>
<td>3</td>
<td>3011.07</td>
<td>7.39**</td>
</tr>
<tr>
<td>Error</td>
<td>146284.45</td>
<td>359</td>
<td>407.48</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>22016953.46</td>
<td>365</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: CES-D = Center for Epidemiological Studies Depression Scale, Past Depression = Previously diagnosed with depression ** = p < .005

Table 4.9

Analysis of Covariance of Levels of Femininity by Vignette Condition

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sums of Squares</th>
<th>df</th>
<th>Mean Squares</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>CES-D</td>
<td>96.02</td>
<td>1</td>
<td>96.02</td>
<td>.29</td>
</tr>
<tr>
<td>Past Depression</td>
<td>513.59</td>
<td>1</td>
<td>513.59</td>
<td>1.52</td>
</tr>
<tr>
<td>Vignette Condition</td>
<td>6248.01</td>
<td>3</td>
<td>2082.67</td>
<td>6.18**</td>
</tr>
<tr>
<td>Error</td>
<td>121041.19</td>
<td>359</td>
<td>337.16</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>282012.13</td>
<td>365</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: CES-D = Center for Epidemiological Studies Depression Scale, Past Depression = Previously diagnosed with depression ** = p < .005

Hypotheses 2 and 3

Hypotheses 2 and 3 were tested using a between groups analysis of variance. The mean level of depression reported for each vignette condition is summarized in Table 4.10. The results of the analyses for these hypotheses are reported in Table 4.11. There were significant mean differences in the level of depression across the four vignette conditions, $F(3,359)=246.88$, $Mse=420.23$, $p< .001$ while controlling for the effects of total score on the CES-D and past diagnosis of depression. Hypothesis 2 stated that
vignette characters in the MDD-MT and MDD-CT conditions will be identified as more depressed than vignette characters in the MDD and Control conditions. Pairwise comparisons using LSD revealed that, consistent with Hypothesis 2, vignette characters in the MDD-MT and MDD-CT conditions had significantly higher levels of depression than the Control vignette character. However, contrary to Hypothesis 2, the rating of vignette character depression was significantly higher for the MDD condition as compared to the MDD-MT condition. Additionally, there were no significant differences in the rating of vignette character depression between the MDD-CT and MDD conditions. Hypothesis 3 stated that the vignette character in the MDD-MT condition would receive the highest rating of depression across conditions. Post hoc comparisons using LSD revealed that, consistent with Hypothesis 3, the vignette character in the MDD-MT condition was significantly more depressed than the vignette character in the Control condition. However, inconsistent with Hypothesis 3, the vignette characters in the MDD and MDD-CT conditions were rated as significantly more depressed than the character in the MDD-MT condition.

Table 4.10

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>M</th>
<th>SE</th>
<th>M1</th>
<th>M2</th>
<th>M3</th>
<th>M4</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDD</td>
<td>86</td>
<td>67.69</td>
<td>2.25</td>
<td>--</td>
<td>6.01*</td>
<td>-3.02</td>
<td>67.52**</td>
</tr>
<tr>
<td>MDD-MT</td>
<td>90</td>
<td>61.52</td>
<td>2.16</td>
<td>-6.01*</td>
<td>--</td>
<td>-9.21**</td>
<td>61.52**</td>
</tr>
<tr>
<td>MDD-CT</td>
<td>96</td>
<td>70.66</td>
<td>2.10</td>
<td>3.21</td>
<td>9.21**</td>
<td>--</td>
<td>70.73**</td>
</tr>
<tr>
<td>Control</td>
<td>93</td>
<td>-.12</td>
<td>2.13</td>
<td>-67.52**</td>
<td>-61.52**</td>
<td>-70.73**</td>
<td>--</td>
</tr>
</tbody>
</table>

Note: *p < .05; **p < .01. MDD = Major Depressive Disorder Vignette Group, MDD-MT= Major Depressive Disorder- Male Type Vignette Group, MDD-CT= Major Depressive Disorder Combined Type Vignette Group, Control= Control Vignette Group
Table 4.11

Analysis of Covariance of Level of Depression by Vignette Condition

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sums of Squares</th>
<th>df</th>
<th>Mean Squares</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>CES-D</td>
<td>256.02</td>
<td>1</td>
<td>256.02</td>
<td>.61</td>
</tr>
<tr>
<td>Past Depression</td>
<td>93.29</td>
<td>1</td>
<td>93.23</td>
<td>.22</td>
</tr>
<tr>
<td>Vignette Condition</td>
<td>311242.11</td>
<td>3</td>
<td>103747.37</td>
<td>246.88**</td>
</tr>
<tr>
<td>Error</td>
<td>150863.79</td>
<td>359</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>13633747.15</td>
<td>365</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: CES-D= Center for Epidemiological Studies Depression Scale, Past Depression= Previously diagnosed with depression **= p<.005

Hypothesis 4

Correlational and multiple regression analyses were conducted to examine the relationship between potential responses to depressive symptoms and various potential gender socialization predictors (CMNI-46 and GRCS). Table 4.12 summarizes the descriptive statistics and analysis results for Hypothesis 4a, which states that subscales of the CMNI-46 will predict lower levels of willingness to engage in help-seeking behaviors when experiencing depression (PRDS). As indicated in the table, Emotional Control, Playboy, and Self-Reliance were negatively and significantly correlated to the criterion. The multiple regression model for all nine subscales of the CMNI-46 produced $R^2 = .085$, $F (9, 262) = 2.00$, $p<.05$, indicating that conformity to masculine norms predicts decreased willingness to engage in help-seeking when depressed as measured by the Potential Responses to Depression Scale-Total (PRDS-T). The Emotional Control scale had a significant and negative regression weight, indicating that participants with higher scores on this scale were expected to report less willingness to engage in help-seeking when depressed, after controlling for the other variables in the mode. Winning, Risk Taking, Violence, Power Over Women, Playboy, Self-Reliance, Primacy of Work, and Heterosexual Self-Presentation did not contribute to the multiple regression model. Additional regression models were explored to examine the influence of CMNI-46 on
subtypes of help-seeking behaviors (i.e., Professional Help, Friends and Family, Self-Help, and Avoidant Coping Behaviors).

Table 4.12

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Correlation PRDS</th>
<th>b</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRDS Total</td>
<td>32.35</td>
<td>10.56</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Winning</td>
<td>11.01</td>
<td>3.37</td>
<td>-.03</td>
<td>.01</td>
<td>.01</td>
</tr>
<tr>
<td>Emotional Control</td>
<td>8.60</td>
<td>3.44</td>
<td>-.19**</td>
<td>-.48*</td>
<td>-.16</td>
</tr>
<tr>
<td>Risk Taking</td>
<td>7.64</td>
<td>2.32</td>
<td>-.01</td>
<td>.07</td>
<td>.01</td>
</tr>
<tr>
<td>Violence</td>
<td>11.01</td>
<td>3.03</td>
<td>-.13*</td>
<td>-.37</td>
<td>-.11</td>
</tr>
<tr>
<td>Power Over Women</td>
<td>4.12</td>
<td>2.33</td>
<td>-.03</td>
<td>-.06</td>
<td>-.01</td>
</tr>
<tr>
<td>Playboy</td>
<td>4.08</td>
<td>2.73</td>
<td>-.11*</td>
<td>-.27</td>
<td>-.07</td>
</tr>
<tr>
<td>Self-Reliance</td>
<td>6.59</td>
<td>2.76</td>
<td>-.13*</td>
<td>-.21</td>
<td>-.06</td>
</tr>
<tr>
<td>Primacy of Work</td>
<td>5.16</td>
<td>2.15</td>
<td>.02</td>
<td>.25</td>
<td>.05</td>
</tr>
<tr>
<td>Heterosexual Self Presentation</td>
<td>11.01</td>
<td>4.56</td>
<td>.06</td>
<td>.23</td>
<td>.10</td>
</tr>
</tbody>
</table>

Note: *p < .05; **p < .01. Potential Responses to Depressive Symptons (PRDS; 0= very unlikely, 3=very likely), Winning, Emotional Control, Risk Taking, Violence, Power Over Women, Playboy, Self-Reliance, Primacy of Work, and Heterosexual Self Presentation (0= strongly disagree, 3= strongly agree).

Table 4.13 summarizes the descriptive statistics and analysis results for Hypothesis 4b, which states that higher scores on subscales of the CMNI-46 will predict lower levels of willingness to engage in professional help-seeking behaviors when experiencing depression (Potential Responses to Depressive Symptoms-Professional; PRDS-P). As indicated in the table, Emotional Control, Violence, Playboy, and Self-Reliance were negatively and significantly correlated to the criterion. The multiple regression model for all nine subscales of the CMNI-46 produced $R^2 = .10$, $F (9, 241) = 3.816, p < .005$, indicating that conformity to masculine norms predicts decreased willingness to engage in professional help-seeking when depressed. The Emotional Control scale had a significant and negative regression weight, indicating that participants with higher scores on this scale were expected to report less willingness to engage in professional help-seeking when depressed, after controlling for the other variables in the

Table 4.13

| Summary Statistics, Correlations, and Results from the Regression Analysis for Hypothesis 4b (N=251) |
|---|---|---|---|---|---|---|---|---|---|
| Variable | M | SD | Correlation PRDS-P | b | B | --- | --- | --- | --- |
| PRDS-P | 10.82 | 7.94 | --- | --- | --- | --- | --- | --- | --- |
| Winning | 11.05 | 3.41 | -.12* | -.16 | -.07 | --- | --- | --- | --- |
| Emotional Control | 8.67 | 3.46 | -.24** | -.36* | -.16 | --- | --- | --- | --- |
| Risk Taking | 7.63 | 2.34 | -.08 | -.06 | .02 | --- | --- | --- | --- |
| Violence | 10.92 | 3.01 | -.15** | -.20 | -.07 | --- | --- | --- | --- |
| Power Over Women | 4.06 | 2.36 | -.10 | -.08 | -.02 | --- | --- | --- | --- |
| Playboy | 4.05 | 2.75 | -.16** | -.29 | -.10 | --- | --- | --- | --- |
| Self-Reliance | 6.65 | 2.75 | -.20** | -.33 | -.12 | --- | --- | --- | --- |
| Primacy of Work | 5.19 | 2.13 | -.02 | .20 | .06 | --- | --- | --- | --- |
| Heterosexual Self-Presentation | 10.89 | 4.62 | -.01 | .12 | .07 | --- | --- | --- | --- |

Note: *p < .05; **p < .01. Potential Responses to Depressive Symptoms-Professional Help (PRDS-P; 0= very unlikely, 3=very likely), Winning, Emotional Control, Risk Taking, Violence, Power Over Women, Playboy, Self-Reliance, Primacy of Work, and Heterosexual Self Presentation (0= strongly disagree, 3= strongly agree).

Table 4.14 summarizes the descriptive statistics and analysis results for Hypothesis 4c, which states that subscales of the CMNI-46 will predict lower levels of willingness to engage in Friends and Family help-seeking behaviors when experiencing depression (Potential Responses to Depressive Symptoms-Friends and Family; PRDS-FF). As indicated in the table, Winning, Emotional Control, Playboy, and Self-Reliance were negatively and significantly correlated to the criterion. The multiple regression model for all nine subscales of the CMNI-46 produced $R^2 = .14$, $F (9, 257) = 4.46$, $p<.005$, indicating that conformity to masculine norms predicts decreased willingness to engage in help-seeking from friends and family when depressed. The Emotional Control and Self-Reliance scales had significant and negative regression weights, indicating that participants with higher scores on these scales were expected to report less willingness to
engage in help-seeking involving their friends and family when depressed, after controlling for the other variables in the model. Winning, Risk Taking, Violence, Power Over Women, Playboy, Primacy of Work, and Heterosexual Self-Presentation did not contribute to the multiple regression model.

Table 4.14

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
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<th>Correlation PRDS-FF</th>
<th>b</th>
<th>B</th>
</tr>
</thead>
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<td>PRDS-FF</td>
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<td>---</td>
<td>---</td>
</tr>
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<td>11.01</td>
<td>3.38</td>
<td>-.11</td>
<td>.02</td>
<td>-.03</td>
</tr>
<tr>
<td>Emotional Control</td>
<td>8.59</td>
<td>3.45</td>
<td>-.30**</td>
<td>-.12*</td>
<td>-.20</td>
</tr>
<tr>
<td>Risk Taking</td>
<td>7.64</td>
<td>2.33</td>
<td>-.04</td>
<td>.02</td>
<td>.02</td>
</tr>
<tr>
<td>Violence</td>
<td>11.04</td>
<td>3.05</td>
<td>-.10</td>
<td>-.01</td>
<td>-.02</td>
</tr>
<tr>
<td>Power Over Women</td>
<td>4.05</td>
<td>2.28</td>
<td>-.13</td>
<td>-.06</td>
<td>-.07</td>
</tr>
<tr>
<td>Playboy</td>
<td>4.06</td>
<td>2.73</td>
<td>-.11</td>
<td>-.02</td>
<td>-.03</td>
</tr>
<tr>
<td>Self-Reliance</td>
<td>6.61</td>
<td>2.76</td>
<td>-.30**</td>
<td>-.15</td>
<td>-.20</td>
</tr>
<tr>
<td>Primacy of Work</td>
<td>5.14</td>
<td>2.13</td>
<td>-.06</td>
<td>.01</td>
<td>.01</td>
</tr>
<tr>
<td>Heterosexual Self Presentation</td>
<td>10.79</td>
<td>4.57</td>
<td>-.03</td>
<td>.03</td>
<td>.06</td>
</tr>
</tbody>
</table>

Note: *p < .05; **p < .01. Potential Responses to Depressive Symptoms-Friends and Family Help (PRDS-FF; 0= very unlikely, 3= very likely), Winning, Emotional Control, Risk Taking, Violence, Power Over Women, Playboy, Self-Reliance, Primacy of Work, and Heterosexual Self Presentation (0= strongly disagree, 3= strongly agree).

Table 4.15 summarizes the descriptive statistics and analysis results for Hypothesis 4d, which states that subscales of the CMNI-46 will predict lower levels of willingness to engage in self-help help-seeking behaviors when experiencing depression (Potential Responses to Depressive Symptoms-Self Help; PRDS-SH). As indicated in the table, no subscales were significantly correlated to the criterion. The multiple regression model for all nine subscales of the CMNI-46 produced $R^2 = .05$, $F (9, 252) = 1.41, p > .05$, indicating that conformity to masculine norms did not predict willingness to engage in self-help help-seeking behaviors when depressed.
Table 4.15

Summary Statistics, Correlations, and Results from the Regression Analysis for Hypothesis 4d (N=262)

<table>
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<tr>
<th>Variable</th>
<th>M</th>
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<th>Correlation PRDS-SH</th>
<th>b</th>
<th>B</th>
</tr>
</thead>
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<tr>
<td>PRDS-SH</td>
<td>7.63</td>
<td>3.46</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Winning</td>
<td>10.98</td>
<td>3.33</td>
<td>-.02</td>
<td>-.01</td>
<td>-.01</td>
</tr>
<tr>
<td>Emotional Control</td>
<td>8.63</td>
<td>3.44</td>
<td>-.10*</td>
<td>-.12</td>
<td>-.12</td>
</tr>
<tr>
<td>Risk Taking</td>
<td>7.60</td>
<td>2.34</td>
<td>-.01</td>
<td>-.01</td>
<td>.01</td>
</tr>
<tr>
<td>Violence</td>
<td>10.95</td>
<td>3.02</td>
<td>-.10</td>
<td>-.11</td>
<td>-.09</td>
</tr>
<tr>
<td>Power Over Women</td>
<td>4.15</td>
<td>2.32</td>
<td>-.04</td>
<td>-.13</td>
<td>-.09</td>
</tr>
<tr>
<td>Playboy</td>
<td>4.11</td>
<td>2.75</td>
<td>-.07</td>
<td>-.04</td>
<td>-.03</td>
</tr>
<tr>
<td>Self-Reliance</td>
<td>6.60</td>
<td>2.75</td>
<td>.01</td>
<td>.09</td>
<td>.08</td>
</tr>
<tr>
<td>Primacy of Work</td>
<td>5.09</td>
<td>2.12</td>
<td>.10</td>
<td>.21*</td>
<td>.13</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>10.99</td>
<td>4.55</td>
<td>.06</td>
<td>.09</td>
<td>.12</td>
</tr>
<tr>
<td>Presentation</td>
<td>6.60</td>
<td>2.75</td>
<td>.01</td>
<td>.09</td>
<td>.08</td>
</tr>
</tbody>
</table>

Note: *p < .05; **p < .01. Potential Responses to Depressive Symptoms-Self Help (PRDS-SH; 0= very unlikely, 3=very likely), Winning, Emotional Control, Risk Taking, Violence, Power Over Women, Playboy, Self-Reliance, Primacy of Work, and Heterosexual Self Presentation (0= strongly disagree, 3= strongly agree).

Table 4.16 summarizes the descriptive statistics and analysis results for Hypothesis 4e, which states that subscales of the CMNI-46 will predict more willingness to engage in avoidant coping behaviors when experiencing depression (Potential Responses to Depressive Symptoms-Negative Behaviors; PRDS-N). As indicated in the table, all subscales of the CMNI-46 were positively and significantly correlated to the criterion. The multiple regression model for all nine subscales of the CMNI-46 produced $R^2 = .16$, $F (9, 257) = 6.54$, $p < .005$, indicating that conformity to masculine norms predicted willingness to engage in avoidant coping behaviors when depressed. The Winning and Power Over Women scales had significant and positive regression weights, indicating that participants with higher scores on these scales were expected to report more avoidant coping behaviors when depressed, after controlling for the other variables in the mode. Emotional Control, Risk Taking, Playboy, Primacy of Work, and Heterosexual Self-Presentation did not contribute to the multiple regression model.
Table 4.1

Summary Statistics, Correlations, and Results from the Regression Analysis for Hypothesis 4e (N=267)

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Correlation PRDS-N</th>
<th>b</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRDS-N</td>
<td>8.04</td>
<td>3.29</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Winning</td>
<td>11.06</td>
<td>3.33</td>
<td>.32**</td>
<td>.19**</td>
<td>.20</td>
</tr>
<tr>
<td>Emotional Control</td>
<td>8.59</td>
<td>3.46</td>
<td>.24**</td>
<td>.11</td>
<td>.12</td>
</tr>
<tr>
<td>Risk Taking</td>
<td>7.66</td>
<td>2.32</td>
<td>.21**</td>
<td>.15</td>
<td>.10</td>
</tr>
<tr>
<td>Violence</td>
<td>11.00</td>
<td>3.02</td>
<td>.13*</td>
<td>-.04</td>
<td>-.04</td>
</tr>
<tr>
<td>Power Over Women</td>
<td>4.12</td>
<td>2.33</td>
<td>.29**</td>
<td>.20*</td>
<td>.14</td>
</tr>
<tr>
<td>Playboy</td>
<td>4.08</td>
<td>2.75</td>
<td>.11*</td>
<td>.01</td>
<td>.01</td>
</tr>
<tr>
<td>Self-Reliance</td>
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<td>2.77</td>
<td>.22**</td>
<td>.13</td>
<td>.11</td>
</tr>
<tr>
<td>Primacy of Work</td>
<td>5.13</td>
<td>2.15</td>
<td>.15**</td>
<td>.03</td>
<td>.02</td>
</tr>
<tr>
<td>Heterosexual Self Presentation</td>
<td>11.00</td>
<td>4.56</td>
<td>.22**</td>
<td>.04</td>
<td>.06</td>
</tr>
</tbody>
</table>

Note: *p < .05; **p < .01. Potential Responses to Depressive Symptoms-Negative Behaviors (PRDS-N; 0= very unlikely, 3=very likely), Winning, Emotional Control, Risk Taking, Violence, Power Over Women, Playboy, Self-Reliance, Primacy of Work, and Heterosexual Self Presentation (0= strongly disagree, 3= strongly agree).

Additional regression models were explored to examine the influence of GRCS on subtypes of help-seeking behaviors (i.e., Professional Help, Friends and Family, Self-Help, and Avoidant Coping Behaviors). Table 4.17 summarizes the descriptive statistics and analysis results for Hypothesis 4f, which states that higher scores on subscales of the GRCS will predict less willingness to engage in help-seeking behaviors when depressed.

As indicated in the table, the Restrictive Emotionality subscale was significantly and negatively correlated with scores on the PRDS while Conflict Between Work and Leisure was significantly and positively correlated with scores on the PRDS. The multiple regression model for all four subscales of the GRCS produced $R^2 = .03$, $F (4, 267)= 2.23$, $p>.05$, indicating that gender role conflict did not predict overall responses to depressive symptoms. As can be seen in Table 4.17, the Conflict Between Work and Leisure scale had a significant positive regression weight (a suppressor effect), indicating that students with higher scores on this scale were expected to endorse more willingness to engage in help-seeking behaviors when depressed. The Success, Power, and Competition,
Restrictive Emotionality, and Restrictive Affectionate Behavior Between Men subscales did not contribute to the multiple regression model.

Table 4.17

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Correlation with PRDS-T</th>
<th>b</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRDS Total</td>
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<tr>
<td>GRCS-SPC</td>
<td>55.60</td>
<td>9.69</td>
<td>-.01</td>
<td>-.02</td>
<td>-.02</td>
</tr>
<tr>
<td>GRCS-RE</td>
<td>32.65</td>
<td>9.10</td>
<td>-.10*</td>
<td>-.16</td>
<td>-.14</td>
</tr>
<tr>
<td>GRCS-RABBM</td>
<td>26.30</td>
<td>7.94</td>
<td>-.04</td>
<td>.01</td>
<td>.01</td>
</tr>
<tr>
<td>GRCS-CBWL</td>
<td>22.32</td>
<td>5.57</td>
<td>.12*</td>
<td>.29*</td>
<td>.16</td>
</tr>
</tbody>
</table>

Note: *p < .05; **p < .01. Potential Responses to Depressive Symptoms-Total Score (PRDS-T; 0= very unlikely, 3=very likely), Success, Power, and Competition (GRCS-SPC), Restrictive Emotionality (GRCS-RE), Restrictive Affectionate Behavior Between Men (GRCS-RABBM), and Conflict Between Work and Leisure (GRCS-CBWL; 1= strongly agree, 6= strongly agree).

Table 4.18 summarizes the descriptive statistics and analysis results for Hypothesis 4g, which states that subscales of the GRCS will predict lower levels of willingness to engage in professional help-seeking behaviors when experiencing depression (PRDS-P). As indicated in the table, Success, Power, and Competition, and Restricted Emotionality were negatively and significantly correlated to the criterion. The multiple regression model for all four subscales of the GRCS produced $R^2 = .06$, $F(4, 246) = 3.92$, $p < .005$, indicating that gender role conflict predicts decreased willingness to engage in professional help-seeking when depressed. The Restrictive Emotionality subscale had a significant and negative regression weight, indicating that participants with higher scores on this subscale were expected to report less willingness to engage in professional help-seeking when depressed, after controlling for the other variables in the mode. Success, Power, and Competition, Conflict Between Work and Leisure, and Restricted Affectionate Behavior Between Men did not contribute to the multiple regression model.
Table 4.18

Summary Statistics, Correlations, and Results from the Regression Analysis for Hypothesis 4g (N=251)

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Correlation with PRDS-P</th>
<th>b</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRDS-P</td>
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<td>7.94</td>
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<td>---</td>
</tr>
<tr>
<td>GRCS-SPC</td>
<td>55.46</td>
<td>9.85</td>
<td>-.11*</td>
<td>-.09</td>
<td>-.11</td>
</tr>
<tr>
<td>GRCS-RE</td>
<td>33.84</td>
<td>9.20</td>
<td>-.21**</td>
<td>-.21**</td>
<td>-.24</td>
</tr>
<tr>
<td>GRCS-RABB</td>
<td>26.21</td>
<td>8.02</td>
<td>-.07</td>
<td>.09</td>
<td>.09</td>
</tr>
<tr>
<td>GRCS-CBWL</td>
<td>22.16</td>
<td>5.58</td>
<td>.03</td>
<td>.16</td>
<td>.11</td>
</tr>
</tbody>
</table>

Note: *p < .05; **p < .01. Potential Responses to Depressive Symptoms-Professional Help (PRDS-P: 0=very unlikely, 3=very likely), Success, Power, and Competition (GRCS-SPC), Restrictive Emotionality (GRCS-RE), Restrictive Affectionate Behavior Between Men (GRCS-RABB), and Conflict Between Work and Leisure (GRCS-CBWL; 1=strongly agree, 6=strongly agree).

Table 4.19 summarizes the descriptive statistics and analysis results for

Hypothesis 4h, which states that subscales of the GRCS will predict lower levels of willingness to engage in Friends and Family help-seeking behaviors when experiencing depression (PRDS-FF). As indicated in the table, Restrictive Emotionality and Restrictive Affectionate Behavior Between Men were negatively and significantly correlated to the criterion. The multiple regression model for all four subscales of the GRCS produced \( R^2 = .06 \), \( F(4, 262)= 4.28, p<.005 \), indicating that gender role conflict predicts decreased willingness to engage in help-seeking from friends and family when depressed. The Restrictive Emotionality subscale had a significant and negative regression weight, indicating that participants with higher scores on this subscale were expected to report less willingness to engage in help-seeking behaviors utilizing their friends and family when depressed, after controlling for the other variables in the model. Success, Power, and Competition, Restrictive Affectionate Behavior Between Men, and Conflict Between Work and Leisure did not contribute to the multiple regression model.
Table 4.20 summarizes the descriptive statistics and analysis results for Hypothesis 4j, which states that higher scores on subscales of the GRCS will predict more willingness to engage in avoidant coping behaviors when experiencing depression (PRDS-N). As indicated in the table, all subscales of the GRCS were positively and
significantly correlated to the criterion. The multiple regression model for all four subscales of the GRCS produced $R^2 = .17$, $F (4, 262) = 12.90, p < .005$, indicating that gender role conflict predicted willingness to engage in avoidant coping behaviors when depressed. The Success, Power, and Competition, and Restrictive Emotionality subscales had significant and positive regression weights, indicating that participants with higher scores on these scales were expected to report more avoidant coping behaviors when depressed, after controlling for the other variables in the mode. Restrictive Affectionate Behavior Between Men and Conflict Between Work and Leisure did not contribute to the multiple regression model.

Table 4.21

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Correlation with PRDS-N</th>
<th>b</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
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<td>3.29</td>
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</tr>
<tr>
<td>GRCS-SPC</td>
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<td>.11**</td>
<td>.31</td>
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<tr>
<td>GRCS-RE</td>
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<td>.29**</td>
<td>.09**</td>
<td>.25</td>
</tr>
<tr>
<td>GRCS-RABBM</td>
<td>26.27</td>
<td>7.95</td>
<td>.20**</td>
<td>-.03</td>
<td>-.07</td>
</tr>
<tr>
<td>GRCS-CBWL</td>
<td>22.27</td>
<td>5.57</td>
<td>.13*</td>
<td>-.01</td>
<td>.01</td>
</tr>
</tbody>
</table>

Note: *p < .05; **p < .01. Potential Responses to Depressive Symptoms-Negative Behaviors (PRDS-N; 0= very unlikely, 3= very likely), Success, Power, and Competition (GRCS-SPC), Restrictive Emotionality (GRCS-RE), Restrictive Affectionate Behavior Between Men (GRCS-RABBM), and Conflict Between Work and Leisure (GRCS-CBWL; 1= strongly agree, 6= strongly agree).

**Hypothesis 5**

Multiple regression analyses were conducted to examine Hypothesis 5, which stated that trait hope and psychological well-being will moderate the relationship between gender socialization and engagement in psychological help-seeking. Significant relationships reported in Hypothesis 4 were utilized to test Hypothesis 5, as moderation can only occur if there is an established relationship between the two variables. As noted in Table 4.22 and contrary to Hypothesis 5, trait hope and psychological well-being did not moderate the relationships between gender socialization and attitudes about engaging in psychological help-seeking.
Table 4.22

*Moderating Effects of Hope and Well-Being on Relations Between Male Gender Socialization and Help-Seeking Attitudes*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Moderator</th>
<th>Outcome</th>
<th>B</th>
<th>SE</th>
</tr>
</thead>
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<td>PRDS-T</td>
<td>.012</td>
<td>.011</td>
</tr>
<tr>
<td>Emotional Control</td>
<td>Well-Being</td>
<td>PRDS-T</td>
<td>.007</td>
<td>.007</td>
</tr>
<tr>
<td>Emotional Control</td>
<td>Hope</td>
<td>PRDS-FF</td>
<td>.000</td>
<td>.002</td>
</tr>
<tr>
<td>Emotional Control</td>
<td>Well-Being</td>
<td>PRDS-FF</td>
<td>-.001</td>
<td>.001</td>
</tr>
<tr>
<td>Winning</td>
<td>Hope</td>
<td>PRDS-N</td>
<td>-.002</td>
<td>.003</td>
</tr>
<tr>
<td>Winning</td>
<td>Well-Being</td>
<td>PRDS-N</td>
<td>-.001</td>
<td>.002</td>
</tr>
<tr>
<td>Power Over Women</td>
<td>Hope</td>
<td>PRDS-N</td>
<td>-.000</td>
<td>.005</td>
</tr>
<tr>
<td>Power Over Women</td>
<td>Well-Being</td>
<td>PRDS-N</td>
<td>-.001</td>
<td>.003</td>
</tr>
<tr>
<td>Conflict Between</td>
<td>Hope</td>
<td>PRDS-T</td>
<td>-.001</td>
<td>.007</td>
</tr>
<tr>
<td>Conflict Between</td>
<td>Well-Being</td>
<td>PRDS-T</td>
<td>.001</td>
<td>.004</td>
</tr>
<tr>
<td>Work &amp; Leisure</td>
<td>Restricted Emotionality</td>
<td>Hope</td>
<td>PRDS-P</td>
<td>.000</td>
</tr>
<tr>
<td>Conflicts Between Work &amp; Leisure</td>
<td>Restricted Emotionality</td>
<td>Well-Being</td>
<td>PRDS-P</td>
<td>.000</td>
</tr>
<tr>
<td>Conflicts Between Work &amp; Leisure</td>
<td>Restricted Emotionality</td>
<td>Hope</td>
<td>PRDS-SH</td>
<td>.002</td>
</tr>
<tr>
<td>Conflicts Between Work &amp; Leisure</td>
<td>Restricted Emotionality</td>
<td>Well-Being</td>
<td>PRDS-SH</td>
<td>.000</td>
</tr>
<tr>
<td>Success, Power, &amp; Competition</td>
<td>Restricted Emotionality</td>
<td>Hope</td>
<td>PRDS-N</td>
<td>-.000</td>
</tr>
<tr>
<td>Success, Power, &amp; Competition</td>
<td>Restricted Emotionality</td>
<td>Well-Being</td>
<td>PRDS-N</td>
<td>-.001</td>
</tr>
</tbody>
</table>

*Note:* *p < .05; **p < .01. Emotional Control, Winning, and Power Over Women from the Conformity to Masculine Norms Inventory-46 (CMNI-46; 0= strongly disagree, 3= strongly agree), Conflict Between Work & Leisure, Restricted Emotionality, and Success, Power, & Competition from the Gender Role Conflict Scale (GRCS; 1= strongly agree, 6= strongly agree), Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; 0= strongly disagree, 3= strongly agree), Hope (Trait Hope Scale-Revised; 1= definitely false, 8= definitely true), Well-Being (Ryff Scales of Psychological Well-Being-54; 1= strongly disagree, 6=strongly agree), Potential Responses to Depressive Symptoms -Total (PRDS-T, 0= very unlikely, 3=very likely)Potential Responses to Depressive Symptoms-Professional (PRDS-P, 0= very unlikely, 3=very likely), Potential Responses to Depressive Symptoms-Friends and Family (PRDS-FF, 0= very unlikely, 3=very likely), Potential Responses to Depressive Symptoms-Self Help (PRDS-SH, 0= very unlikely, 3=very likely), Potential Responses to Depressive Symptoms-Negative Behaviors (PRDS-N, 0= very unlikely, 3=very likely).
Hypothesis 6

Path analysis was utilized to evaluate the Model of Male Help-Seeking (Figure 1). Direct relations between male-role socialization, mental illness stigma, recognition of problem severity, and decisions to seek help were examined. Additionally, the hypothesized relations in the model indicating that the mediating effects of recognition of problem severity explain the relations between male role socialization, mental illness stigma, and engagement in help-seeking behaviors were examined. Multicollinearity among variables was analyzed with results indicating that variance was not inflated ($VIF = 1.494$-$1.602$; Freund, Littell, & Creighton, 2003). The estimated path model that was tested is shown in Figure 1. In this model, Conformity to Masculine Norms (CMN; X1), Gender Role Conflict (GRC; X2), Attitudes Toward Seeking Professional Psychological Help (ATSPPHS; X3) and Self Stigma of Help-Seeking (SSOHS; X4) were the predictors, level of depression identified (M1) and percentage of symptoms correctly identified (M2) were the mediators, and potential responses to depressive symptoms served as outcomes (Y1 – Y4). This allowed each variable’s unique direct effects and indirect effects of predictors and mediators to be examined.

Maximum likelihood estimation within Mplus Version 6.0 (Muthén & Muthén, 1998-2010) was used to estimate the path analysis including conformity to masculine norms, gender role conflict, attitudes about seeking professional psychological help, self-stigma of mental illness, recognition of depressive symptoms, and potential help-seeking behaviors when depressed. Examining all of the variables in one path model simultaneously allowed for consideration of each variable’s unique variance while controlling for the other variables. The unstandardized direct path coefficients and errors
are depicted in Figure 2, whereas a summary of the indirect effects appear in Table 4.23. Specifically as suggested by Mallinckrodt, Abraham, Wei, & Russell (2006), 10,000 bootstrap samples were utilized to examine the significance of indirect effects. The bootstrapped unstandardized indirect path coefficients and errors and 95% bias-corrected confidence intervals are reported (Williams & MacKinnon, 2008). If the 95% confidence interval does not contain zero, then the indirect effects are considered significant and indicate mediation (see Mallinckrodt et al., 2006).

**Unique Direct Relations**

With regard to direct relations when all variables were included in the model (See Figure 1), negative direct relations emerged between ATSPPHS and PRDS-P, PRDS-SH, and reported levels of Michael’s depression. With regard to mental health stigma, a negative direct relation emerged between SSOHS and PRDS-FF. In contrast, positive direct relations emerged between SSOHS and PRDS-SH as well as SSOHS and PRDS-N. When considering masculine ideology, a positive direct relation emerged between CMNI-46 and PRDS-FF, while negative direct relations emerged between CMNI-46 and PRDS-Neg. Although relations between CMNI-46 and recognition of problem severity, PRDS-P, and PRDS-SH were in the proposed directions, they failed to meet the threshold for statistical significance. With regard to GRC, a positive direct relation emerged between GRCS and PRDS-N. Lastly, direct positive relations emerged between levels Michael’s of depression and PRDS-P and PRDS-N, while percentage of symptoms identified was not directly related to any help-seeking attitudes.
Mediation

To test the Model of Male Help-Seeking (Perlick & Manning, 2007; Figure 1) which states that the relations between cultural beliefs and values (i.e., Male-Role Socialization and Mental Illness Stigma) and acknowledgement of need to seek help are mediated by recognition of problem severity, the indirect effects of conformity to masculine norms, gender role conflict, attitudes toward seeking professional psychological help, and self-stigma of seeking help and various types of help-seeking were investigated. Results of these analyses indicate that recognition of problem severity (i.e., reported level of Michael’s depression and percentage of symptoms identified) did not significantly mediate the relations between conformity to masculine norms and help-seeking attitudes (see Table 4.23). Additionally, recognition of problem severity did not significantly mediate the relations between gender role conflict and help-seeking attitudes (see Table 4.23). As well, recognition of problem severity did not significantly mediate the relations between attitudes toward seeking professional help and help-seeking attitudes (see Table 4.23). Lastly, recognition of problem severity did not significantly mediate the relations between self-stigma of seeking help and help-seeking attitudes (see Table 4.23).
Figure 1. Empirical model of relations derived from the Male Model of Help-Seeking

Solid lines indicate a negative relationship. Dashed lines indicate a positive relationship.
Figure 2. Empirical model of relations derived from the Male Model of Help-Seeking

Solid lines indicate a negative relationship. Dashed lines indicate a positive relationship.
Table 4.23
Bootstrap Analysis of Magnitude and Significance of Indirect Effects

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Mediator 1</th>
<th>Outcome</th>
<th>B</th>
<th>SE</th>
<th>95% Confidence Interval Lower Bound</th>
<th>Upper Bound</th>
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</thead>
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<tr>
<td>CMNI-46</td>
<td>M Dep</td>
<td>PRDS-P</td>
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<td>0.02</td>
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<td>0.05</td>
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</tbody>
</table>
Note: *Confidence intervals that do not contain zero are considered significant (Mallinckrodt et al., 2006). Conformity to Masculine Norms Inventory-46 (CMNI-46; 0= strongly disagree, 3= strongly agree), Gender Role Conflict Scale (GRCS; 1= strongly agree, 6= strongly agree), Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; 0= strongly disagree, 3= strongly agree), Self-Stigma of Seeking Help (SSOSH; 1= strongly disagree, 5= strongly agree), Rating of Michael’s Depression (M Dep; 0= not depressed, 100= very depressed), Percentage of Depressive Symptoms Identified (M Symp; 0= no symptoms identified, 100= all symptoms identified), Potential Responses to Depressive Symptoms-Professional (PRDS-P, 0= very unlikely, 3=very likely), Potential Responses to Depressive Symptoms-Friends and Family (PRDS-FF, 0= very unlikely, 3=very likely), Potential Responses to Depressive Symptoms-Self Help (PRDS-SH, 0= very unlikely, 3=very likely), Potential Responses to Depressive Symptoms-Negative Behaviors (PRDS-N, 0= very unlikely, 3=very likely).
Chapter 5

Discussion

College men are experiencing a mental health crisis of depression coinciding with increased risk for substance abuse, completed suicide, and resistance to utilizing mental health services (Davies et al., 2010). Thus, it is critical to better understand men’s attitudes about depression and psychological help-seeking. The present study was developed to (a) identify the symptoms that men identify as depression, (b) determine if men believe that depression is a “feminine” disorder, and (c) better understand the implications of gender socialization and beliefs about depression on decisions to engage in various forms of psychological help-seeking. Additionally, this study served as the first known examination of Perlick and Manning’s (2007) Model of Male Help-Seeking. This chapter will discuss the results of the study presented in the previous chapter and their potential implications. First, findings of the research hypotheses will be discussed. Next, research and practice implications will be considered. Last, limitations of the current study and recommendations for future research will be presented.

Results of the Hypotheses

Hypothesis 1

With regard to Hypothesis 1, which examined the impact of masculine ideology on beliefs that depression is a “feminine disorder,” high levels of adherence to masculine norms (i.e., higher scores on the Gender Role Conflict Scale (GRCS) and Conformity to Masculine Norms Inventory-46 [CMNI-46]) did not predict views of depression as a “feminine disorder.” More specifically, scores on the GRCS and CMNI-46 did not predict participants’ ratings of Michael’s masculinity or femininity. Given the significant
differences in depressive symptoms across the vignettes, it was further hypothesized that perceptions of masculinity and femininity should be examined across conditions. Statistically significant differences did emerge across conditions. Specifically, in the Major Depressive Disorder (MDD) condition, the vignette character was rated as significantly more feminine and less masculine than the character in the other conditions. Furthermore, despite the presence of symptoms of depression on the Major Depressive Disorder-Male Type (MDD-MT) and Major Depressive Disorder-Combined Type (MDD-CT) conditions, participants in these conditions reported Michael’s masculinity and femininity at levels statistically similar to the control group. Thus, it appears that the presence of externalizing behaviors (i.e., developing a temper, getting into fights, and significantly increased alcohol use) in the MDD-MT and MDD-CT prevented the vignette character from “losing masculinity.” This finding is significant in light of past studies indicating that men feel the need to prove their masculinity (Courtenay, 2000; Mahalik & Backus, 2011). Additionally, these finding may explain the constellation of symptoms described by MDD-MT. For example, it may be that these behaviors are not symptoms of depression, but rather attempts to mask traditional symptoms of depression with traditionally masculine behaviors in an effort to save face in the eyes of society. This appears most impactful in men’s views of the character in the MDD-CT condition. Although this condition contained all of the symptoms present in the MDD condition, the presence of MDD-MT symptoms appears to have allowed Michael to successfully “prove his masculinity” through a series of externalizing behaviors that are congruent with masculine norms (i.e., restricting emotions, self-medicating, and denying the need for
help) to such an extent that he was no less masculine or more feminine than the character in the control condition.

**Hypotheses 2 and 3**

Hypotheses 2 and 3 examined the symptoms that men identify as depression. More specifically, Hypothesis 2 stated that participants would identify the characters in both the MDD-MT MDD-CT conditions as more depressed than the characters in MDD and Control conditions. Relatedly, Hypothesis 3 stated that the character in the MDD-MT condition would be rated as the most depressed across all groups. Results provide mixed support for these hypotheses. Although participants rated the character in the MDD-MT and MDD-CT conditions as more depressed than the control condition, the characters in the MDD and MDD-CT were rated as most depressed. Thus, MDD and MDD-CT were considered equally depressed, with MDD-MT rated as less depressed than the MDD and MDD-CT characters, and the control condition rated as the least depressed.

Upon further examination, it appears that this pattern of results is most likely attributed to similarities in symptoms between the MDD and MDD-CT conditions. More specifically, both conditions contain the diagnostic criteria for MDD as described in the DSM-IV-TR (APA, 2000). Thus, participants appear to gravitate toward traditional diagnostic criteria when identifying depression. Although the MDD-MT condition was rated as significantly more depressed than the control condition, the symptoms in this condition were described as less severe than MDD and MDD-CT. This is a novel finding in the research with important clinical considerations. Although past research indicates that traditional men experience symptoms of depression that are more congruent with MDD-MT (Pollack, 1998), men in this study did not identify those symptoms as indicators of the most distress. Thus, it is possible that men’s experiences of depression
are incongruent with the signs of depression that they utilize when making decisions to seek help. This finding may explain part of the gender gap found between men and women experiencing depression (APA, 2009; Englar-Carlson, 2006) by leading men to invalidate their symptoms when they do not match traditional criteria for Major Depressive Disorder. Alternatively, it is possible that gender socialization has normalized the symptoms experienced by the character in the MDD-MT condition to a point that they are not considered significant. For example, symptoms related to restricted emotionality, rigid autonomy, and denial of pain are congruent with masculine norms (Mahalik et al., 2003a; Mahalik et al., 2003b). Thus, it is possible that men in the MDD-MT condition misidentified symptoms of MDD-MT as “normal” masculine behavior. As a result, they may underestimate other men’s experiences of depression.

**Hypothesis 4**

Hypothesis 4 stated that endorsement of traditional masculine norms would predict attitudes toward help-seeking. Results of the current study indicate that gender role conflict and conformity to masculine norms did predict attitudes about psychological help-seeking behaviors. This finding mirrors past studies that have examined relations between masculine ideology and help-seeking behaviors (Addis & Mahalik, 2003; Courtenay, 2000; Levant et al., 2009; Mahalik et al., 2003a, Mahalik & Rochlen, 2006; Pederson & Vogel, 2007). Moreover, the current study expands upon this literature by examining specific types of help-seeking behaviors. Endorsement of masculine norms of Emotional Control and Self-Restraint (as measured by the CMNI-46) were associated with less willingness to engage in professional help-seeking as well as friends and family help-seeking when depressed. Similarly, endorsement of masculine norms of Restricted
Emotionality and Success, Power, and Competition (as measured by the GRCS) related to less willingness to engage in professional help-seeking and friends and family help-seeking when depressed. However, it should be noted that endorsement of masculine ideology did not predict utilization of self-help when depressed. It is possible that the high level of anonymity allowed by self-help behaviors does not lead men to experience gender role conflict or perceptions that they are violating masculine norms when they utilize self-help behaviors.

As with past studies (e.g., Chuick et al., 2009; Mahalik & Rochlen, 2006), endorsement of masculine norms did predict engagement in avoidant coping behaviors. More adherence to norms of Winning and Risk-Taking (as measured by the CMNI-46) and Restricted Emotionality and Success, Power, and Competition (as measured by the GRCS) were associated with more avoidant coping behaviors when depressed. Thus, men endorsing the above norms are more comfortable engaging in denial of pain, increased needs for autonomy, and self-medicating behaviors when depressed. This finding is in line with theoretical research on MDD-MT (e.g., Pollack, 1998) and recent qualitative data suggesting that men find seeking help for depression to be a sign of weakness and beliefs that being emotional is “not masculine” (Mahalik & Backus, 2011).

**Hypothesis 5**

Hypothesis 5 stated that hope and psychological well-being would moderate the relationship between masculine ideology and help-seeking behaviors. As discussed in Chapter 4, there was no support for this hypothesis. More specifically, total scores on the Hope Scale-Revised (HSR) and Ryff’s Scales of Psychological Well-Being-54 (PWB-54) did not moderate the relations between GRC, CMN, and potential reactions to depressive symptoms. However it should be noted that while they did not yield statistical
significance, relations were in the predicted direction. As well, participants in the current study reported moderate to high hope. Thus, it is possible that the lack of variability on measures of hope and well-being suppressed moderating effects that would be present with more diversity of scores on measures of positive functioning. In the case of psychological well-being, it is also possible that subscales of PWB-54 may be counteracting each other or suppressing results. For example, it may be that Autonomy and Environmental Mastery are congruent with traditional masculine norms and incongruent with engagement in therapy whereas Positive Relations With Others and Self-Acceptance may promote utilization of therapy and help-seeking when depressed. In the case of hope, emerging evidence suggests that domain specific hope is more likely to be related to distress than trait hope (Cole, Davidson, & Gervais, In press), thus a measure of hope for mental health or hope for therapy may be more sensitive than the trait measure utilized in the current study. In light of the lack of statistical significance, additional evaluation is necessary to better understand the potential role of positive traits in facilitating help-seeking for men endorsing high levels of masculine norms.

**Hypothesis 6**

With regard to Hypothesis 6, which was an empirical test of Perlick and Manning’s (2007) Model of Male Help-Seeking, there were no significant indirect effects of male gender role socialization or mental illness stigma on appraisal of depressive symptoms or decisions to seek help. However, multiple direct effects suggest that important relations exist between conformity to masculine norms, gender role conflict, attitudes toward professional psychological help-seeking, self-stigma of help-seeking, identification of depressive symptoms, and potential responses to depressive symptoms.
The lack of statistically significant support for the model as measured in the current research is likely due to the analogue nature of the study. It is possible that the role induction (i.e., participants pretending that they were Michael and making decisions as though they were experiencing his symptoms) was not strong enough to mirror the appraisal process of men experiencing depression. More specifically, because the men in the study were not depressed (as indicated by mean scores on the CES-D) it is possible that the decision to seek or avoid help had fewer perceived consequences. Thus, to fully examine the utility of the model, additional studies of men experiencing depression will be required.

**Clinical Implications**

The results of the current study indicate that gender socialization influences men’s attitudes about depression and help-seeking. First, the finding that men view depression as a feminine disorder may explain evidence that report depression among men less frequently and with less severity than women (ACHA, 2010). Although past research has suggested that men are “less depressed” than women (see Cochran & Rabinowitz, 2000 for a review), the current results indicate that men adhering to traditional gender norms may attempt to “prove their masculinity” by engaging in rigid denial of distress and avoidance of psychological help when depressed. As indicated by the results of the current study, men who view depression as “feminine” are less likely to seek help when depressed. Results indicate that adherence to masculine gender norms was negatively associated with utilization of professional help when depressed. Additionally, levels of gender socialization predicted men’s tendencies toward denial of symptoms, utilization of self-help materials, and engagement in avoidant coping and self-medicating behaviors.
Past research indicates that seeing other men violate gender norms related to help-seeking improves utilization of mental health services (Vogel et al., 2007), thus clinicians and researchers are encouraged to develop outreach programing and psychoeducational materials in an effort to normalize the experience of depression and utilization of psychological help-seeking when depressed. Unfortunately, men continue to experience detrimental effects of gender socialization and mental illness stigma after making the decision to seek help (Perlick & Manning, 2007). Thus, in addition to assessing symptoms of depression through formal assessments or clinical interviews, clinicians are encouraged to formally assess for experiences of gender role conflict and conformity to masculine norms when working with male clients (i.e., administer the GRCS or CMNI-46 alongside measures of depression). Additionally, clinicians are encouraged to integrate discussions of the decision to seek help, attempts at avoiding coping and self-help, and experiences of gender role conflict into the first session of therapy. As well, reframing the decision to seek help as a strength by tying it to masculine norms of courage and risk-taking may be meaningful ways to empower and engage male clients in therapy (Kiselica, 2008; Kiselica & Englar-Carlson, 2010).

After successfully engaging men in therapy, clinicians are encouraged to continue to assess for and discuss client experiences of gender role conflict related to their symptoms and/or the decision to seek help. As noted by Perlick and Manning (2007), it is possible that men will continue to experience gender role conflict throughout the course of therapy. As well, they may attempt to “prove masculinity” in therapy by minimizing symptoms and engaging in power struggles with the clinician in accordance with masculine norms of restricted emotionality, rigid autonomy, and success, power, and
competition. In addition to considerations stemming from male gender norms, clinicians are encouraged to discuss symptoms of depression through a lens of gender socialization. Men in the current study identified depression as manifested through MDD as the most depressed presentation. This finding is inconsistent with qualitative studies in which men report symptoms more congruent with MDD-MT (Mahalik & Backus, 2011; Pollack, 1998). In the current study, the presence of externalizing behaviors in the MDD-MT and MDD-CT conditions (i.e., restricting emotions, self-medicating, and denying the need for help) did not appear to concern participants and as a result they rated these vignettes as “less depressed.” Thus, clinicians should explore comorbid symptoms in detail. For example, it may be important to know if excessive drinking, increased anger, and rigid autonomy are attempts to cope with depression by “proving masculinity” rather than indicators of substance dependence or personality concerns. Relatedly, clinicians are encouraged to learn more about their clients’ knowledge of depression and to provide psychoeducation about men’s experience of depression in an effort to normalize the experiences of their clients. In turn, this may reduce externalizing behaviors by diminishing the perceived need to “prove masculinity” and could facilitate deepening of the therapeutic relationship while providing opportunities to explore core (e.g., reasons for depression) issues rather than extraneous symptoms (externalizing behaviors).

**Strengths and Limitations**

This study has several notable strengths. First, this study utilized an analogue design. Analogue design has several strengths, including a high degree of internal validity, high levels of precision in procedures, and reducing practical and ethical issues that are present in other types of experimental designs (Heppner, Wampold, & Kivlighan, 2008). Regarding the current study, an analogue design protected client privacy by
allowing the researcher to use vignettes rather than transcripts or videos of actual counseling sessions. It also allowed the researcher to increase experimental control as demographic attributes and presenting problem were uniform across vignette conditions, thus reducing the possibility of confounds by external variables. Additionally, given that men are less likely to seek therapy and that the current study is aimed at understanding this phenomena, quantitative and qualitative field study designs would be inadequate as there is not an easily assessable way to measure or explore men’s attitudes about depression and psychological help-seeking in a natural setting. Another strength of this study stems from the sampling procedures utilized. As noted by Heppner, Heppner, and Davidson (2004), diversity in sampling is a best practice in conducting dissertation research. As such, the racial diversity of the sample exceeded the racial demographics of men at the Midwestern university at which data was collected (Education Portal, 2013). Last, in line with suggestions to engage in research relevant to community agencies (Heppner et al., 2004), the design of the current study (i.e., the types of professional help-seeking included) were developed through collaboration with mental health providers at the Midwestern university. As well, data will be disseminated to these mental health service providers in an effort to enhance outreach provided to hard to reach populations (i.e., men of color).

That being said, the current study has several limitations. First, there are several important limitations associated with analogue designs. The major weakness of analogue design is related to the external validity or the ability to generalize results of the study to the population of interest (Heppner et al., 2008). There is potential for the high degree of experimental control exercised in analogue studies to result in situations that do not
correctly mirror real world circumstances. In an effort to limit this potential weakness, Heppner and colleagues (2008) recommend evaluating the resemblance of each variable in the analogue study to the way it would manifest in real world settings. By evaluating the degree to which client variables, counselor variables, and counseling process and setting variables resemble real-life, researchers are better able to determine the generalizability of an analogue study. In the case of the current study, it is particularly important to consider the resemblance of client variables. Heppner et al., (2008) suggest that these variables should be evaluated for (a) expectations of change, (b) motivation and distress level, (c) selection of treatment, (d) presenting problem, and (e) knowledge of problem. Given the exploratory nature of the current study (e.g., examining attitudes of participants and potential relationships between the variables described above), the participants are likely to have a low degree of resemblance to men that have been diagnosed with depression and/or men that choose to seek therapy due to a high level of symptom distress. Selection of treatment is considered irrelevant in the current study as participants are randomly assigned to conditions that are exploring attitudes rather than conditions providing an intervention. As the current study is not an intervention, client expectations of change are also considered irrelevant as related to the potential weakness of the study. It is hypothesized that presenting problems and knowledge of the problem (i.e., depression) have a moderate to high degree of resemblance to real life settings. Additionally, the current study is concerned with examining the relationship between gender role socialization, recognition of depression, and attitudes about help-seeking behaviors. As this study is exploratory in nature and is not exclusively interested in understanding men with depression or men that choose to go to therapy, it is assumed that
random assignment will allow the researcher to generalize the results to male undergraduate students at Midwestern universities.

Additional concerns stem from the lack of racial and sexual orientation diversity of the sample obtained. Although men of color were sampled at rates similar to the racial makeup of the University of Nebraska-Lincoln (Education Portal, 2013), the majority of participants were Caucasian. Additionally, the majority of men in the study self-identified as heterosexual. The lack of diversity in the sample limits the ability to generalize the current findings to populations that are more racially and sexually diverse. Moreover, the lack of diversity did not allow for comparisons of the hypotheses between Caucasian and racial minority participants or among heterosexual versus sexual minority men. Future studies would benefit from increased racial and sexual diversity.

Lastly, the current study is limited by potential sampling bias and the use of self-report measures. The study was advertised as a “Men’s Health Study.” Thus, it is possible that men who participated in the study have more interest in these issues than the general population as indicated by their voluntary participation in the study. Relatedly, participants completed a series of self-report measures. The use of self-report data raises questions with regard to the accuracy of responses as a result of the potential for a response bias in which participants seek to present themselves in certain ways to the researcher (e.g., appearing more masculine or less depressed). The current study attempted to reduce response bias by integrating validity items and reverse-scored items that encouraged participants to read each item carefully and to answer honestly rather than to endorse floor or ceiling items on measures (i.e., the lowest or highest scores on each item).
Future Directions for Research

The current study provides the foundation for several future studies. First, the current study provides evidence that fear of femininity may be at the core of men’s attitudes about depression and help-seeking. Due to the analogue nature of this study, future studies would benefit from exploring these relationships in men that are depressed. Specifically, it would be beneficial to test Perlick and Manning’s (2007) Model of Male Help-Seeking in an experimental sample with men that meet diagnostic criteria for depression. Second, future studies would benefit from exploring cultural variations in masculinity. Although some minority men may adhere to gender norms of the dominant culture, male gender roles may vary according to one’s race and culture (Kimmel & Messner, 2004; Wester, 2008). Men of color and gay, bisexual, and transgender (GBT) men may experience distress while trying to balance gender roles of the dominant culture and their cultures of origin. This distress is exacerbated by racism, homophobia, and oppression (Liu, 2002; Sue, 2001; Wester, 2008). In light of these findings, measures of acculturation and cultural identity may provide additional information about societal norms that influence men’s experiences of depression and attitudes about help-seeking. Similarly, the current study would benefit from replication with other populations of men. In addition to studying culturally diverse men, it may be beneficial to replicate the study in populations of very traditional men. For example, given the high rates of depression and post traumatic stress disorder with comorbid depression experienced by veterans, it may be helpful to better understand the relationships between gender socialization and attitudes about depression and help-seeking in military populations. Last, the current study provides evidence that socialization to gender norms is a significant factor in
shaping men’s views about depression and psychological help-seeking. Past research shows that positive social media interventions, which are based upon social learning theory and presented in popular media formats (e.g., radio shows, soap operas, internet based interactive experiences), are effective at engaging people in change behaviors (PCI Media Impact, 2013). Thus, positive social media interventions based in social learning theory should be designed and evaluated in an effort to impact men’s beliefs about depression as a feminine disorder as well as their resistance to help-seeking.

Conclusion

The current study examined college men’s attitudes about depression and help-seeking for depression. By examining the relations between gender socialization, identification of depressive symptoms, and potential responses to depressive symptoms, the current study aimed to provide foundational support for addressing the mental health crisis experienced by college men (Davies et al., 2010). Results of this study suggest that men view depression, as characterized by MDD, as a “feminine” disorder. Relatedly, socialization to masculine gender norms predicted barriers to utilization of professional and personal means of help-seeking when experiencing depression. As well, traditional masculine behaviors such as restrictive emotionality, denial of pain, and self-medicating behaviors were endorsed as normatively masculine and less indicative of depression than symptoms of MDD. This study provides a number of clinical implications for work with college men experiencing depression. Given the disparate number of college men that utilize services when experiencing mental health concerns (ACHA, 2010; Gallagher, 2010), the present study provides a foundation for future studies in the field of men and masculinity. Researchers and clinicians are urged to examine men’s experiences of depression through the lenses of gender socialization, cultural context, and mental illness.
stigma in an effort to close the gender gap in the diagnosis and treatment of depression on college campuses.
References


doi:10.4088/JCP.v69n0714


doi:10.1037/0022-0167.33.2.155


doi:10.1037/1522-3736.2.1.210a


Nemeroff, C. B. (2008). Depression, desperation, and suicidal ideation in college
students: Results from the American Foundation for Suicide Prevention College
Screening Project at Emory University. Depression and Anxiety, 25, 482-488.
doi:10.1002/da.20321

treatment of posttraumatic stress disorder. Psychological Trauma: Theory,
Research, Practice, and Policy, doi:10.1037/a0024252

21.

masculine role conflict and psychological distress in male university counseling


lifespan. In R. Levant & G. Brooks (Eds.), Men and sex: New psychological
perspectives (pp. 182–204). New York: Wiley.


Appendix A

**Operational Definitions of Key Factors**

**Depression**: For the purpose of this study, depression is defined as “any of the mood disorders that typically have sadness as one of their symptoms. They include Dysthymic Disorder, Major Depressive Disorder, and Depressive Disorder not otherwise specified” (APA, 2007, p.269).

**Femininity/Feminine**: For the purpose of this study, femininity is defined as the “possession of social-role behaviors that are presumed to be characteristic of a girl or woman” (APA, 2007, p. 372).

**Gender Role**: In the current study, a gender role is defined as “the pattern of behavior, personality traits, and attitudes that define masculinity or femininity in a particular culture” (APA, 2007, p. 402).

**Gender Role Socialization**: In the current study, gender role socialization is conceptualized as “the conditioning of individuals to the roles, expectations, and behaviors that society prescribes for males and females” (APA, 2007, p. 402).

**Gender Role Conflict**: Gender role conflict is conceptualized as "a psychological state in which socialized gender roles have negative consequences on the person or others” (O'Neil, 2009, n.p.).

**Help-seeking**: For the purpose of this study, help-seeking is defined broadly as a behavior or behaviors that an individual engages in, in an effort to reduce symptom distress. The current study is interested more narrowly in help-seeking behaviors that require a man to talk to another person (e.g., partner, friend, therapist, clergy) about their symptoms in an effort to find relief from distress.
**Hope:** Hope is conceptualized as “goal-directed thinking in which people perceive that they can produce routes to desired goals (pathways thinking), and the requisite motivation to use those routes (agency thinking)” (Lopez et al., 2003, p. 94).

**Masculinity/Masculine:** For the purpose of this study, masculinity is defined as the “possession of social-role behaviors that are presumed to be characteristic of a man” (APA, 2007, p. 555).

**Well-Being:** In the current study, well-being is conceptualized as optimal human functioning that results from experiences of autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance (Ryff, 1989a).
INFORMED CONSENT FORM

Identification of Project: Beliefs and Behaviors

Purpose of the Research:
The purpose of this study is to examine the relationship between different beliefs and behaviors among college men. This study will take approximately 45 to 60 minutes to complete. You were selected as a participant because you are a student in a psychology course at the University of Nebraska or because you volunteered. We ask that you read this form. If you have any questions now or when the study is over, you may contact Brian Cole (bpcole@huskers.unl.edu) or the University of Nebraska-Lincoln Institutional Review Board (402-472-6965). This study is being conducted by Brian Cole, a doctoral student (and his dissertation committee) in the Department of Educational Psychology at the University of Nebraska-Lincoln, Lincoln, NE 68588.

Procedures:
During this experimental session you will be asked to provide some basic demographic information about yourself. You will then be asked to read a vignette and complete a survey that includes several psychological questionnaires. These questionnaires assess your thoughts, feelings, and beliefs about yourself, other people, and different situations and issues. Some of the questions will ask for attitudes on both routine and more sensitive topics. Other questions may ask your opinions. It is possible that some of the questions will remind you of positive feelings and memories while others will remind you of unpleasant memories or adverse events in your life.

Risks and/or Discomforts:
There are minimal risks associated with your agreement to participate in this research. However, this research, like much research in psychology, may contain some questions that you may find sensitive or personal. On occasion people experience mild distress when completing psychological questionnaires like the ones in this study. Also, because of the length of the survey, you may also find it boring or tedious. You may skip any questions without penalty. You may also withdraw from the study at any time without penalty. In the event of problems resulting from your participation in the study, psychological treatment is available at free or reduced cost at the UHC Counseling and Psychological Services Center, which can be reached at (402) 472-5000. It is also available on a sliding fee scale at the UNL Counseling and School Psychology Clinic, available at (402) 472-1152.

Benefits:
Although there are no direct benefits to participation, this study will allow you to experience psychological survey research. Beyond these benefits, this study adds to the knowledge about the psychology of men in general. If you so desire, you may also contact the researcher at the e-mail address listed to obtain information about the results of the study.
Confidentiality:
The records in this study will be kept confidential. Your responses will be stored in a database on a password protected secure server. All research records will be kept in a locked file in a locked office for five years after the study is completed. Only the researchers will have access to the records.

Compensation:
If you are completing this study through Experimetrix, you will receive 2 research credits for participating in this study. You will receive credit even if you choose to leave certain questions unanswered or if you choose to discontinue participation. If you choose to discontinue participation at any time in the session, you will receive credit. If you are NOT completing this study through Experimetrix, you will be entered into a raffle to win one of fifteen $10 gift cards to your choice of Amazon.com or iTunes. You will be entered into the raffle even if you choose to leave certain questions unanswered or if you choose to discontinue. Odds of winning a gift card will vary based upon the number of students that participate. Odds are estimated at 7% to 9%. Raffle winners will be contacted via email no later than 12/31/2012.

Opportunity to Ask Questions:
The primary researchers conducting this study are Brian Cole and Dr. Meghan Davidson. You may contact Brian Cole at bpcole@huskers.unl.edu with any questions you have. If you have questions about your rights as a research participant that have not been answered by the researcher, or if you have concerns regarding the study and would like to talk to someone other than the researcher(s), contact the University of Nebraska-Lincoln Institutional Review Board at (402) 472-6965.

Freedom to Withdraw:
Your decision whether or not to participate will not affect your current or future relations with the University of Nebraska-Lincoln, the Department of Psychology or Educational Psychology, or the researchers. If you decide to participate, you are free to withdraw at any time without affecting those relationships. If you feel that any questions are too embarrassing or personal, you may skip those items or stop completing the survey without penalty. Your decision whether or not to participate will not result in any loss of benefits to which you are otherwise entitled.

Consent, Right to Receive a Copy:
You are voluntarily making a decision whether or not to participate in this research study. Clicking below certifies that you have decided to participate having read and understood the information presented. If you would like a hard copy of the consent form please contact Brian Cole (bpcole@huskers.unl.edu).

I have read the consent form

I understand the information above and AGREE to take part in the survey.

I understand the information above and DO NOT AGREE to take part in the survey.
Appendix C

Demographic Questions

For each of the items below, please select the response that best describes you.

Age:

Gender:

I identify with my gender. Please move the slider to indicate your answer.

<table>
<thead>
<tr>
<th>Not Like Me</th>
<th>Somewhat Like Me</th>
<th>Very Much Like Me</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>30</td>
<td>40</td>
<td>50</td>
</tr>
<tr>
<td>60</td>
<td>70</td>
<td>80</td>
</tr>
<tr>
<td>90</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Year in School:

Racial or ethnic background:

What is your religious preference (if any)?

Please indicate your sexual orientation:

Please indicate your political affiliation:

Please indicate your current relationship status:

Please list the top career/occupation you are currently interested in pursuing.

What is your current major?

Please indicate your parents' socio-economic-status:

Are you a member of a fraternity?

- [ ] Yes
- [ ] No
Appendix D

Conformity to Masculine Norms Inventory-46

The following pages contain a series of statements about how men might think, feel or behave. The statements are designed to measure attitudes, beliefs, and behaviors associated with both traditional and non-traditional masculine gender roles.

**Thinking about your own actions, feelings and beliefs**, please indicate how much you **personally agree or disagree with each statement** by circling SD for "Strongly Disagree", D for "Disagree", A for "Agree," or SA for "Strongly agree" to the left of the statement. There are no right or wrong responses to the statements. You should give the responses that most accurately describe your personal actions, feelings and beliefs. It is best if you respond with your first impression when answering.

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>SD</th>
<th>D</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>In general, I will do anything to win</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>If I could, I would frequently change sexual partners</td>
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<td></td>
<td></td>
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<tr>
<td>3</td>
<td>I hate asking for help</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I believe that violence is never justified</td>
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<tr>
<td>5</td>
<td>Being thought of as gay is not a bad thing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>In general, I do not like risky situations</td>
<td></td>
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<tr>
<td>7</td>
<td>Winning is not my first priority</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8</td>
<td>I enjoy taking risks</td>
<td></td>
<td></td>
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<tr>
<td>9</td>
<td>I am disgusted by any kind of violence</td>
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<tr>
<td>10</td>
<td>I ask for help when I need it</td>
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<tr>
<td>11</td>
<td>My work is the most important part of my life</td>
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<tr>
<td>12</td>
<td>I would only have sex if I was in a committed relationship</td>
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<tr>
<td>13</td>
<td>I bring up my feelings when talking to others</td>
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<tr>
<td>14</td>
<td>I would be furious if someone thought I was gay</td>
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<td></td>
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<tr>
<td>15</td>
<td>I don’t mind losing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I take risks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>It would not bother me at all if someone thought I was gay</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>18</td>
<td>I never share my feelings</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Sometimes violent action is necessary</td>
<td></td>
<td></td>
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<tr>
<td>20</td>
<td>In general, I control the women in my life</td>
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<tr>
<td>21</td>
<td>I would feel good if I had many sexual partners</td>
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<tr>
<td>22</td>
<td>It is important for me to win</td>
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<tr>
<td>23</td>
<td>I don’t like giving all my attention to work</td>
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<tr>
<td>24</td>
<td>It would be awful if people thought I was gay</td>
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<tr>
<td>25</td>
<td>I like to talk about my feelings</td>
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<tr>
<td>26</td>
<td>I never ask for help</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>More often than not, losing does not bother me</td>
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<tr>
<td>28</td>
<td>I frequently put myself in risky situations</td>
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<td></td>
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<tr>
<td>29</td>
<td>Women should be subservient to men</td>
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<tr>
<td>30</td>
<td>I am willing to get into a physical fight if necessary</td>
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<tr>
<td>31</td>
<td>I feel good when work is my first priority</td>
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</tr>
<tr>
<td>32.</td>
<td>I tend to keep my feelings to myself</td>
<td>SD D A SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>Winning is not important to me</td>
<td>SD D A SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>Violence is almost never justified</td>
<td>SD D A SA</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>35.</td>
<td>I am happiest when I’m risking danger</td>
<td>SD D A SA</td>
<td></td>
<td></td>
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<tr>
<td>36.</td>
<td>It would be enjoyable to date more than one person at a time</td>
<td>SD D A SA</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>37.</td>
<td>I would feel uncomfortable if someone thought I was gay</td>
<td>SD D A SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38.</td>
<td>I am not ashamed to ask for help</td>
<td>SD D A SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39.</td>
<td>Work comes first</td>
<td>SD D A SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40.</td>
<td>I tend to share my feelings</td>
<td>SD D A SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41.</td>
<td>No matter what the situation I would never act violently</td>
<td>SD D A SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42.</td>
<td>Thing tend to be better when men are in charge</td>
<td>SD D A SA</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>43.</td>
<td>It bothers me when I have to ask for help</td>
<td>SD D A SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44.</td>
<td>I love it when men are in charge of women</td>
<td>SD D A SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45.</td>
<td>I hate it when people ask me to talk about my feelings</td>
<td>SD D A SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46.</td>
<td>I try to avoid being perceived as gay</td>
<td>SD D A SA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix E

Gender Role Conflict Scale

Instructions: In the space to the left of each sentence below, write the number that most closely represents the degree that you Agree or Disagree with the statement. There is no right or wrong answer to each statement; your own reaction is what is asked for.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Strongly Disagree</th>
<th>1</th>
</tr>
</thead>
</table>

1. ____ Moving up the career ladder is important to me.
2. ____ I have difficulty telling others I care about them.
3. ____ Verbally expressing my love to another man is difficult for me.
4. ____ I feel torn between my hectic work schedule and caring for my health.
5. ____ Making money is part of my idea of being a successful man.
6. ____ Strong emotions are difficult for me to understand.
7. ____ Affection with other men makes me tense.
8. ____ I sometimes define my personal value by my career success.
9. ____ Expressing feelings makes me feel open to attack by other people.
10. ____ Expressing my emotions to other men is risky.
11. ____ My career, job, or school affects the quality of my leisure or family life.
12. ____ I evaluate other people’s value by their level of achievement and success.
13. ____ Talking about my feelings during sexual relations is difficult for me.
14. ____ I worry about failing and how it affects my doing well as a man.
15. ____ I have difficulty expressing my emotional needs to my partner.
16. ____ Men who touch other men make me uncomfortable.
17. ____ Finding time to relax is difficult for me.

18. ____ Doing well all the time is important to me.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>Strongly Disagree</th>
<th>1</th>
</tr>
</thead>
</table>

19. ____ I have difficulty expressing my tender feelings.

20. ____ Hugging other men is difficult for me.

21. ____ I often feel that I need to be in charge of those around me.

22. ____ Telling others of my strong feelings is not part of my sexual behavior.

23. ____ Competing with others is the best way to succeed.

24. ____ Winning is a measure of my value and personal worth.

25. ____ I often have trouble finding words that describe how I am feeling.

26. ____ I am sometimes hesitant to show my affection to men because of how others might perceive me.

27. ____ My needs to work or study keep me from my family or leisure more than would like.

28. ____ I strive to be more successful than others.

29. ____ I do not like to show my emotions to other people.

30. ____ Telling my partner my feelings about him/her during sex is difficult for me.

31. ____ My work or school often disrupts other parts of my life (home, family, health leisure.

32. ____ I am often concerned about how others evaluate my performance at work or school.
33. ____ Being very personal with other men makes me feel uncomfortable.

34. ____ Being smarter or physically stronger than other men is important to me.

35. ____ Men who are overly friendly to me make me wonder about their sexual preference (men or women).

36. ____ Overwork and stress caused by a need to achieve on the job or in school, affects/hurts my life.

37. ____ I like to feel superior to other people.
Appendix F

Center for Epidemiological Studies Depression Scale (CES-D)

DIRECTIONS: Below is a list of the ways people feel or behave. Please indicate how often you have felt this way DURING THE PAST WEEK.

<table>
<thead>
<tr>
<th>Rarely or none of the time (less than 1 day)</th>
<th>Some or a little of the time (1-2 days)</th>
<th>Occasionally or a moderate time (3-4 days)</th>
<th>Most or all of the time (5-7 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

During the past week:
1. _____ I was bothered by things that usually don’t bother me…

2. _____ I did not feel like eating; my appetite was poor…

3. _____ I felt that I could not shake off the blues even with help from my family or friends…

4. _____ I felt that I was just as good as other people…

5. _____ I had trouble keeping my mind on what I was doing…

6. _____ I felt depressed…

7. _____ I felt that everything I did was an effort…

8. _____ I felt hopeful about the future…

9. _____ I thought my life has been a failure…

10. _____ I felt fearful…

11. _____ My sleep was restless…

12. _____ I was happy…

13. _____ I talked less than usual…

14. _____ I felt lonely…

15. _____ People were unfriendly…

16. _____ I enjoyed life…

17. _____ I had crying spells…

18. _____ I felt sad…

19. _____ I felt that people disliked me…

20. _____ I could not get going…
Appendix G

Attitudes Toward Seeking Professional Psychological Help Scale - Short Form

To what extent do you agree or disagree with the statements below:

<table>
<thead>
<tr>
<th>Agree</th>
<th>Partly Agree</th>
<th>Partly Disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

1. ____ If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
2. ____ The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
3. ____ If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
4. ____ There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.
5. ____ I would want to get psychological help if I were worried or upset for a long period of time.
6. ____ I might want to have psychological counseling in the future.
7. ____ A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.
8. ____ Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
9. ____ A person should work out his or her own problems; getting psychological counseling would be a last resort.
10. ____ Personal and emotional troubles, like many things, tend to work out by themselves.
Appendix H

Self-Stigma of Help-Seeking Scale

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = Agree 5 = Strongly Agree

1. _____I would feel inadequate if I went to a therapist for psychological help.

2. _____My self-confidence would NOT be threatened if I sought professional help.

3. _____Seeking psychological help would make me feel less intelligent.

4. _____My self-esteem would increase if I talked to a therapist.

5. _____My view of myself would not change just because I made the choice to see a therapist.

6. _____It would make me feel inferior to ask a therapist for help.

7. _____I would feel okay about myself if I made the choice to seek professional help.

8. _____If I went to a therapist, I would be less satisfied with myself.

9. _____My self-confidence would remain the same if I sought professional help for a problem I could not solve.

10. _____I would feel worse about myself if I could not solve my own problems.
Appendix I

Scales of Psychological Well-Being (54 item)

The following set of questions deals with how you feel about yourself and your life. Please remember that there are no right or wrong answers.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Moderately Disagree</td>
<td>Slightly Disagree</td>
<td>Slightly Agree</td>
<td>Moderately Agree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

1.) I am not afraid to voice my opinions, even when they are in opposition to the opinion of most people. 1 2 3 4 5 6

2.) In general, I feel I am in charge of the situation in which I live. 1 2 3 4 5 6

3.) I am not interested in activities that will expand my horizons. 1 2 3 4 5 6

4.) Most people see me as loving and affectionate. 1 2 3 4 5 6

5.) I live life one day at a time and don't really think about the future. 1 2 3 4 5 6

6.) When I look at the story of my life, I am pleased with how things have turned out. 1 2 3 4 5 6

7.) My decisions are not usually influenced by what everyone else is doing. 1 2 3 4 5 6

8.) The demands of everyday life often get me down. 1 2 3 4 5 6

9.) I don't want to try new ways of doing things--my life is fine the way it is. 1 2 3 4 5 6

10.) Maintaining close relationships has been difficult and frustrating for me 1 2 3 4 5 6

11.) I tend to focus on the present, because the future nearly always brings me problems. 1 2 3 4 5 6

12.) In general, I feel confident and positive about myself. 1 2 3 4 5 6

13.) I tend to worry about what other people think of me. 1 2 3 4 5 6

14.) I do not fit very well with the people and the community around me. 1 2 3 4 5 6

15.) I think it is important to have new experiences that challenge how you think about yourself and the world. 1 2 3 4 5 6

16.) I often feel lonely because I have few close friends with whom to share my concerns. 1 2 3 4 5 6

17.) My daily activities often seem trivial and unimportant to me. 1 2 3 4 5 6
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>18.) I feel like many of the people I know have gotten more out of life than I have.</td>
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<td>19.) Being happy with myself is more important to me than having others approve of me.</td>
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<tr>
<td>20.) I am quite good at managing the many responsibilities of my daily life.</td>
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<td>21.) When I think about it, I haven't really improved much as a person over the years.</td>
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<td>22.) I enjoy personal and mutual conversations with family members or friends.</td>
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<tr>
<td>23.) I don't have a good sense of what it is I'm trying to accomplish in life.</td>
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<td>24.) I like most aspects of my personality.</td>
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<td>25.) I tend to be influenced by people with strong opinions.</td>
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<td>26.) I often feel overwhelmed by my responsibilities.</td>
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<td>27.) I have the sense that I have developed a lot as a person over time.</td>
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<td>28.) I don't have many people who want to listen when I need to talk.</td>
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<td>29.) I used to set goals for myself, but that now seems like a waste of time.</td>
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<td>30.) I made some mistakes in the past, but I feel that all in all everything has worked out for the best.</td>
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<td>31.) I have confidence in my opinions, even if they are contrary to the general consensus.</td>
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<td>32.) I generally do a good job of taking care of my personal finances and affairs.</td>
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<tr>
<td>33.) I do not enjoy being in new situations that require me to change my old familiar ways of doing things.</td>
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<td>34.) It seems to me that most other people have more friends than I do.</td>
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<td>35.) I enjoy making plans for the future and working to make them a reality.</td>
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<td>36.) In many ways, I feel disappointed about my achievements in life.</td>
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<td>37.) It's difficult for me to voice my own opinions on controversial matters.</td>
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<tr>
<td></td>
<td>Strongly</td>
<td>Moderately</td>
<td>Slightly</td>
<td>Slightly</td>
<td>Moderately</td>
<td>Strongly</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Agree</td>
<td>Agree</td>
<td></td>
</tr>
</tbody>
</table>

38.) I am good at juggling my time so that I can fit everything in that needs to get done. 1 2 3 4 5 6

39.) I gave up trying to make big improvements or changes in my life a long time ago. 1 2 3 4 5 6

40.) People would describe me as a giving person, willing to share my time with others. 1 2 3 4 5 6

41.) I am an active person in carrying out the plans I set for myself. 1 2 3 4 5 6

42.) My attitude about myself is probably not as positive as most people feel about themselves. 1 2 3 4 5 6

43.) I have difficulty arranging my life in a way that is satisfying to me. 1 2 3 4 5 6

44.) I often change my mind about decisions if my friends or family disagree. 1 2 3 4 5 6

45.) There is truth to the saying you can't teach an old dog new tricks 1 2 3 4 5 6

46.) I have not experienced many warm and trusting relationships with others. 1 2 3 4 5 6

47.) Some people wander aimlessly through life, but I am not one of them. 1 2 3 4 5 6

48.) The past had its ups and downs, but in general, I wouldn't want to change it. 1 2 3 4 5 6

49.) I judge myself by what I think is important, not by the values of what others think is important. 1 2 3 4 5 6

50.) I have been able to build a home and a lifestyle for myself that is much to my liking. 1 2 3 4 5 6

51.) For me, life has been a continuous process of learning, changing, and growth. 1 2 3 4 5 6

52.) I know that I can trust my friends, and they know they can trust me. 1 2 3 4 5 6

53.) I sometimes feel as if I've done all there is to do in life. 1 2 3 4 5 6

54.) When I compare myself to friends and acquaintances, it makes me feel good about who I am. 1 2 3 4 5 6
Appendix J

Revised Trait Hope Scale

Directions: Read each item carefully. Using the scale shown below, please select the number that best describes YOU and put that number in the blank provided.

|---|--------------------|----------------|------------------|-----------------|-----------------|-----------------|---------------|-------------------|

___ 1. I have trouble getting what I want in life
___ 2. I have found that I can overcome challenges
___ 3. I clearly define the goals that I pursue
___ 4. I’m not good at planning how to get things done
___ 5. I can think of many ways to get out of a jam
___ 6. I have many goals that I am pursuing
___ 7. I prefer easy goals over hard goals
___ 8. I have what it takes to get the job done
___ 9. I have difficulty finding ways to solve problems
___ 10. I do not have very many goals
___ 11. I give up easily
___ 12. I’m not good at coming up with solutions
___ 13. I’m good at coming up with new ways to solve problems
___ 14. I’m successful at getting what I want
___ 15. I create alternate plans when blocked
___ 16. I do not try hard enough to overcome challenges
___ 17. I go after goals that are difficult and challenging
___ 18. I do not care about the goals I am pursuing
Appendix K

Identification with Vignette Character

<table>
<thead>
<tr>
<th>Not at All</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
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<td>0</td>
<td>1</td>
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<tr>
<td>2</td>
<td>3</td>
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</tbody>
</table>

(1) _____ The scenario faced by “Michael” in the vignette is a realistic concern in my life.

(2) _____ I can currently relate to the challenge faced by “Michael.”

(3) _____ I can see myself facing this kind of challenge at some point in my life.
Appendix L

Vignette for Major Depressive Disorder

Michael is a sophomore in college and is majoring in business. Michael has noticed a change in his mood during the last month. He is sad most of the time and has lost interest in almost all of the activities he used to enjoy. He is sleeping more than usual, but still wakes up feeling very tired. Michael has been ignoring his friends’ suggestions that he “talk to someone” and tells them that he does not have a problem. He is unable to concentrate in class and is starting to fall behind. Michael is also finding it difficult to make decisions and is feeling worthless because he cannot seem to “snap out of it.”

1) Is Michael Depressed?
   a. Yes
   b. No

2) How depressed is Michael?

<table>
<thead>
<tr>
<th>Not Depressed</th>
<th>Very Depressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-----------------------------------------------100</td>
<td></td>
</tr>
</tbody>
</table>

3) How masculine and feminine is Michael?

   a. How Masculine

      | Not At All | Very |
      |----------------|----------------|
      | 0-----------------------------------------------100 |

   b. How Feminine

      | Not At All | Very |
      |----------------|----------------|
      | 0-----------------------------------------------100 |
Appendix M

Vignette for Major Depressive Disorder- Male Type

Michael is a sophomore in college and is majoring in business. Michael has noticed a change in his mood during the last month. He has been spending less time with his friends and now prefers to spend time alone in his apartment. Michael’s friends have been telling him that he is starting to develop a bad temper. He has recently been in two fights. One with a coworker and the other with man he was arguing with at a bar. He has been ignoring his friends’ suggestions that he “talk to someone” and tells them that he does not have a problem. Although Michael usually drinks alcohol on the weekends with his friends, he is now drinking most days of the week. He is having trouble falling asleep at night and is finding it difficult to concentrate in class. Michael has become increasingly self-critical because he cannot seem to “snap out of it.”

1) Is Michael Depressed?
   a. Yes
   b. No

2) How depressed is Michael?

Not Depressed
0-------------------------------------------------100

Very Depressed

3) How masculine and feminine is Michael?
   a. How Masculine

Not At All
0-------------------------------------------------100

Very

b. How Feminine

Not At All
0-------------------------------------------------100

Very
Appendix N

Vignette for Major Depressive Disorder Combined Type (MDD-CT)

Michael is a sophomore in college and is majoring in business. Michael has noticed a change in his mood during the last month. He is sad most of the time and has lost interest in almost all of the activities he used to enjoy. He is sleeping more than usual, but still wakes up feeling very tired. He is having difficulty concentrating in class and is starting to fall behind. Michael usually drinks alcohol on the weekends with his friends, but he is now drinking most days of the week. Michael’s friends have been telling him that he is starting to develop a bad temper. He has recently been in two fights. One with a coworker and the other with man he was arguing with at a bar. Michael also appears less interested in spending time with them. He has been ignoring his friends’ suggestions that he “talk to someone” and tells them that he does not have a problem. Michael has become increasingly self-critical because he cannot seem to “snap out of it.”

1) Is Michael Depressed?
   a. Yes
   b. No

2) How depressed is Michael?

   Not Depressed ........................................ Very Depressed
   0--------------------------------------------------100

3) How masculine and feminine is Michael?
   a. How Masculine

   Not At All ........................................ Very
   0--------------------------------------------------100

   b. How Feminine

   Not At All ........................................ Very
   0--------------------------------------------------100
Appendix N

**Control Vignette (Career concerns with no depression)**

Michael is a sophomore in college and is majoring in business. Michael has been feeling stressed during the last month. He recently decided that he no longer wants to major in business, but is unsure of what he should change his major to. He is feeling anxious about telling his parents because he fears they will stop paying his tuition. Michael is overwhelmed as he has no idea what he wants to do with his life.

1) Is Michael Depressed?
   a. Yes
   b. No

2) How depressed is Michael?

<table>
<thead>
<tr>
<th>Not Depressed</th>
<th>Very Depressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-------------</td>
<td>100</td>
</tr>
</tbody>
</table>

3) How masculine and feminine is Michael?

   a. How Masculine

<table>
<thead>
<tr>
<th>Not At All</th>
<th>Very</th>
</tr>
</thead>
<tbody>
<tr>
<td>0----------</td>
<td>100</td>
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</table>

   b. How Feminine

<table>
<thead>
<tr>
<th>Not At All</th>
<th>Very</th>
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<tbody>
<tr>
<td>0----------</td>
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</table>
Appendix P

Vignette Packet for Content Raters

Participants will be randomly assigned to one of the four vignette conditions described below. These vignettes are intended to examine the types of symptoms that men believe are representative of depression. There are four vignette conditions. Vignette 1 consists of DSM-IV-TR criteria for Major Depressive Disorder (MDD). Vignette 2 consists of criteria for Major Depressive Disorder- Male Type (MDD-MT). Vignette 3 consists of a mix of DSM-IV-TR criteria for MDD and Major Depressive Disorder- Male Type. Vignette 4 is intended to serve as a control condition with no symptoms of depression.

Diagnostic Criteria for MDD (from DSM-IV-TR)

To meet diagnostic criteria for MDD, a person must have experienced a Major Depressive Episode (MDE) for at least two weeks without the presence of manic features (APA, 2000, APA, 2007). The experience of a MDE is characterized by the experience of depressed mood and/or anhedonia in conjunction with at least four of the following symptoms: (a) changes in appetite with significant weight loss or weight gain, (b) insomnia or hypersomnia, (c) fatigue, (d) feelings of worthlessness or guilt, (e) psychomotor problems, (f) difficulty with concentration, (g) and recurrent thoughts of death or self-harm (APA, 2000; APA, 2007). These symptoms must cause significant impairment in social, occupational, and/or other important areas of functioning and must be present for at least two weeks (APA, 2000).

Diagnostic Criteria for Major Depressive Disorder- Male Type

Major Depressive Disorder- Male Type (MDD-MT) is characterized: (a) by symptoms of social withdrawal (increased withdrawal from relationships, over-involvement at work, rigid demands for autonomy), (b) denial of pain, (c) avoiding help, (d) self-medicating behavior, (e) denial of sadness/ inability to cry, (f) harsh self-criticism, (g) depleted or impulsive moods, (h) changes to sex drive (increases or decreases), and (i) traditional physical symptoms of MDD (disturbances of concentration, sleep, and appetite/weight) (Pollack, 1998). MDD-MT builds upon the DSM-IV-TR criteria for MDD by considering the roles of avoidance, denial, and self-medicating behaviors that may help men hide their symptoms of MDD. These diagnostic criteria were influenced by gender differences in reports of symptomology, but also by knowledge about the impact of gender role conflict (Pollack, 1998).

1) Vignette for Major Depressive Disorder

Michael is a sophomore in college and is majoring in business. Michael has noticed a change in his mood during the last month. He is sad most of the time and has lost interest in almost all of the activities he used to enjoy. He is sleeping more than usual, but still
wakes up feeling very tired. Michael has been ignoring his friends’ suggestions that he “talk to someone” and tells them that he does not have a problem. He is unable to concentrate in class and is starting to fall behind. Michael is also finding it difficult to make decisions and is feeling worthless because he cannot seem to “snap out of it.”

2) **Vignette for Major Depressive Disorder- Male Type**

Michael is a sophomore in college and is majoring in business. Michael has noticed a change in his mood during the last month. He has been spending less time with his friends and now prefers to spend time alone in his apartment. Michael’s friends have been telling him that he is starting to develop a bad temper. Michael’s friends have been telling him that he is starting to develop a bad temper. He has recently been in two fights. One with a coworker and the other with man he was arguing with at a bar. He has been ignoring his friends’ suggestions that he “talk to someone” and tells them that he does not have a problem. Although Michael usually drinks alcohol on the weekends with his friends, he is now drinking most days of the week. He is having trouble falling asleep at night and is finding it difficult to concentrate in class. Michael has become increasingly self-critical because he cannot seem to “snap out of it.”

3) **Vignette for Major Depressive Disorder Combined Type (MDD-CT)**

Michael is a sophomore in college and is majoring in business. Michael has noticed a change in his mood during the last month. He is sad most of the time and has lost interest in almost all of the activities he used to enjoy. He is sleeping more than usual, but still wakes up feeling very tired. He is having difficulty concentrating in class and is starting to fall behind. Michael usually drinks alcohol on the weekends with his friends, but he is now drinking most days of the week. Michael’s friends have been telling him that he is starting to develop a bad temper. He has recently been in two fights. One with a coworker and the other with man he was arguing with at a bar. Michael also appears less interested in spending time with his friends. He has been ignoring his friends’ suggestions that he “talk to someone” and tells them that he does not have a problem. Michael has become increasingly self-critical because he cannot seem to “snap out of it.”

4) **Control Vignette (Career concerns with no depression)**

Michael is a sophomore in college and is majoring in business. Michael has been feeling stressed during the last month. He recently decided that he no longer wants to major in business, but is unsure of what he should change his major to. He is feeling anxious about telling his parents because he fears they will stop paying his tuition. Michael is overwhelmed as he has no idea what he wants to do with his life.
Appendix P

Potential Responses to Depressive Symptoms (adapted from Mahalik & Rochlen, 2006)

Below are some ways that Michael could react to his problem. Please rate the masculinity of Michael if he reacted to his problem in the following ways:

<table>
<thead>
<tr>
<th>Very Feminine</th>
<th>Very Masculine</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
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</table>

1) _____ Contact a physician about the problem
2) _____ Contact a clergy member or spiritual healer
3) _____ Talk to your wife or partner
4) _____ Talk to a family member (not your wife or partner)
5) _____ Talk to a best friend (not your wife or partner)
6) _____ Contact a mental health professional
7) _____ Try to learn more about what you are experiencing through books, video, or the internet
8) _____ Do nothing
9) _____ Join an anonymous internet chat room to discuss the problem
10) _____ Exercise/workout
11) _____ Wait to see if it goes away
12) _____ Have a few drinks
13) _____ Distract self through activities
14) _____ Look into taking a class or workshop that seems relevant to your symptoms
15) _____ Try to help yourself feel better by using problem solving exercises from a self-help book
16) _____ Meditate/pray
17) _____ Contact a personal coach
18) _____ Throw yourself into work
19) _____ Talk to an expert about the problem on the telephone
20) _____ Use a computer program to monitor mood and learn ways to improve it

Potential Responses Added to the Proposed Study

21) _____ Visit the campus Men’s Center
22) _____ Visit the university health center
23) _____ Visit the university counseling center
24) _____ Join a campus men’s group
25) _____ Visit blogs or message boards related to the problem
26) _____ Talk to a counselor
27) _____ Talk to a therapist
Now, imagine that you are experiencing a problem similar to Michael’s. How likely would you be react to the problem in the following ways:

<table>
<thead>
<tr>
<th>Option</th>
<th>Very Unlikely</th>
<th>Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>0) Talk to a psychologist</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>1) Contact a physician about the problem</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>2) Contact a clergy member or spiritual healer</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>3) Talk to your wife or partner</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>4) Talk to a family member (not your wife or partner)</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>5) Talk to a best friend (not your wife or partner)</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>6) Contact a mental health professional</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>7) Try to learn more about what you are experiencing through books, video, or the internet</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>8) Do nothing</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>9) Join an anonymous internet chat room to discuss the problem</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>10) Exercise/workout</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>11) Wait to see if it goes away</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>12) Have a few drinks</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>13) Distract self through activities</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>14) Look into taking a class or workshop that seems relevant to your symptoms</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>15) Try to help yourself feel better by using problem solving exercises from a self-help book</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>16) Meditate/pray</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>17) Contact a personal coach</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>18) Throw yourself into work</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>19) Talk to an expert about the problem on the telephone</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>20) Use a computer program to monitor mood and learn ways to improve it</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>21) Visit the campus Men’s Center</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>22) Visit the university health center</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>23) Visit the university counseling center</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>24) Join a campus men’s group</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>25) Visit blogs or message boards related to the problem</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>26) Talk to a counselor</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>27) Talk to a therapist</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>28) Talk to a psychologist</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix R

Model of Male Help-Seeking (Perlick & Manning, 2007)
Appendix S
Fraternity Recruitment Announcement

Dear Fraternity Members,

You are being invited to participate in a research study examining the health beliefs and behaviors of men on our campus. This project is being conducted by Brian Cole, M.S. and Dr. Meghan Davidson in the Educational Psychology Department and Dr. Sarah Gervais in the Psychology Department. The goal of this research is to better understand the health needs of men on our campus. This study has been approved by the Institutional Review Board at UNL.

The survey packet is online and takes approximately 45 minutes to one hour to complete. All responses will be kept confidential. This study is COMPLETELY VOLUNTARY and you can choose to skip any question.

For your participation, you will be entered into a raffle to win one of 15 $10 gift cards to your choice of Amazon.com or iTunes. Raffle winners will be contacted via email no later than 12/31/2012. If you are interested in participating in this study, please contact us at bpcole@huskers.unl.edu or visit www.facebook.com/UNLMHS.

Thank you!
Appendix T
Men’s Programs Recruitment Announcement

Dear Men’s Advisory Group Members-

My name is Brian Cole and I am a fourth year Doctoral Student in the Counseling Psychology program at UNL. I am writing to ask for your help in recruiting men on campus to participate in an online study. This study is my dissertation and has been approved by the Institutional Review Board at UNL. I am examining men’s attitudes about depression and help-seeking. The goal of my research is to better understand the health beliefs and behaviors of men on our campus. In an effort to understand the experiences of a variety of men on campus, I am reaching out to you through the Men’s Advisory Group/Men @ Nebraska listserv.

I have created an online survey that takes approximately 45 minutes to one hour to complete. In exchange for participation, students will be entered in a raffle to win one of 15 $10 gift cards to their choice of Amazon.com or iTunes. Raffle winners will be contacted via email no later than 12/31/2012.

It is my hope to gather information from a variety of men on campus and would greatly appreciate it if you would share this information with any male students you work with. Please ask any students that are interested to visit www.facebook.com/UNLMHS or to contact me via email at bpcole@huskers.unl.edu.

Thank you,

Brian

Brian P. Cole, M.S.
Doctoral Candidate in Counseling Psychology
University of Nebraska-Lincoln
Appendix U
Classroom Recruitment Announcement

Dear Instructor-

My name is Brian Cole and I am a fourth year Doctoral Student in the Counseling Psychology program at UNL. I am writing to ask for your help in recruiting men on campus to participate in an online study. This study is my dissertation and has been approved by the Institutional Review Board at UNL. I am examining men’s attitudes about depression and help-seeking. The goal of my research is to better understand the health beliefs and behaviors of men on our campus. In an effort to understand the experiences of a variety of men on campus, I am reaching out to you and your students.

I have created an online survey that takes approximately 45 minutes to one hour to complete. In exchange for participation, students will be entered in a raffle to win one of 15 $10 gift cards to their choice of Amazon.com or iTunes. Raffle winners will be contacted via email no later than 12/31/2012.

It is my hope to gather information from a variety of men on campus and would greatly appreciate it if you would share this information with any male students you work with. Please ask any students that are interested to visit www.facebook.com/UNLMHS or to contact me via email at bpcole@huskers.unl.edu.

Thank you,

Brian

Brian P. Cole, M.S.
Doctoral Candidate in Counseling Psychology
University of Nebraska-Lincoln
Appendix V

Experimetrix Recruitment Announcement

PARTICIPATE IN THIS ONLINE STUDY AND EARN 2 CREDITS!

Are you a male that is interested in learning more about men’s health? The purpose of this study is to better understand men’s health beliefs and behaviors. This study takes approximately 45 minutes to 1 hour to complete and you get 2 research credits.


<table>
<thead>
<tr>
<th>About</th>
<th>Basic Info</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is an official university study that has been approved by the Institutional Review Board at UNL.</td>
<td>Joined: 01/27/2012</td>
</tr>
<tr>
<td>Men that are currently enrolled at UNL are invited to participate in a study of attitudes about men's health. In exchange for your participation you will be entered into a drawing to win one of fifteen $10 gift cards to your choice of Amazon.com or iTunes. Contact <a href="mailto:jholec@brukers.unl.edu">jholec@brukers.unl.edu</a> for more information.</td>
<td>Facebook</td>
</tr>
</tbody>
</table>

Facebook Recruitment Page
Appendix X

Facebook Recruitment Advertisements

UNL Men's Health Study
Share your opinions about men's health for a chance to win a $10 gift card to iTunes or Amazon.

UNL Men's Health Study
Take our survey and you could win a $10 gift card to iTunes or Amazon.

UNL Men's Health Study
MEN AT UNL: Take our survey for a chance to win a $10 gift card to iTunes or Amazon.