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REDEFINING WHAT'S MANLY: USING MASCULINE ATTRIBUTES TO

DESCRIBE COUNSELING SERVICES FOR MEN

An Abstract of a Thesis

Submitted

in Partial Fulfillment

of the Requirements for the Degree

Master of Arts

Riley Nicholas Rodemaker

University of Northern Iowa

May 2021

ABSTRACT

Men are diagnosed with mental illness at a similar rate to women, and men deal with similar levels of impairment (Kessler et al., 1994). Despite this impairment, men do not seek help for their mental health as often as women do (Smith et al., 2013). One reason may be that counseling is seen as feminine. In this thesis, I describe an experimental study that examined the effect of using masculine attributes to describe counseling services on men's attitudes. Adult male participants ages 18 to 35 ($N = 818$) read a short story that featured a conversation with a friend that described counseling services as courageous, as a path to success, or neutrally and imagined themselves in that situation. Participants then indicated how likely they would be to call the counseling center and their attitudes toward seeking mental health services and completed an adherence to traditional masculinity measure and a gender role conflict measure. I hypothesized that the participants who read the short stories where counseling is described as "courageous" or "leading to success" would have more positive attitudes toward seeking help compared to men who read a short story with a more neutral or traditional view of counseling. I also hypothesized that gender role conflict and traditional masculinity would moderate the effect of the short story on men's attitudes toward seeking help. Men who read the courageous or success short stories did not report more positive attitudes toward mental health services compared to men who read the neutral short story. Similarly, men who read the courageous or success short story were not more likely to call the counseling center compared to men who read the neutral short story. Strong adherence to traditional masculinity ideology and more gender role conflict

were associated with more negative attitudes toward seeking help; however, traditional masculinity ideology and gender role conflict did not moderate the effect of the counseling descriptions on attitudes toward mental health services across conditions. The lack of an effect for the counseling frames could be the result of a very small effect size or not enough changes to the description of counseling. Because the participants self-reported their attitudes after reading a fictional scenario that they may have never been in, it is also possible that participants would respond differently if they were actually in the situation. In conclusion, the use of masculine attributes to describe counseling services did not seem to have an effect on men's attitudes. There was also no evidence of a negative effect of using masculine attributes, however, suggesting that it may be useful as a low-cost method to try to make some men slightly more comfortable with therapy.

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This study by: Riley Nicholas Rodemaker

Entitled: Redefining What's Manly: Using Masculine Attributes to Describe Counseling

Services for Men

has been approved as meeting the thesis requirement for the

Degree of Master of Arts

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| _____ | _____ |
| Date | Dr. William Fleming, Thesis Committee Member |

| _____ | _____ |
| Date | Dr. Jennifer Waldron, Dean, Graduate College |

DEDICATION

This thesis is dedicated to my late father, Ron Rodemaker. I am the person that I am

today, because of all that you taught me.

ACKNOWLEDGEMENTS

There is not enough space on this page to acknowledge everyone that has helped get me to this point in my academic career. First off, I would like to acknowledge my mother, Christina Rodemaker, and my younger siblings, Abbi and Brady Rodemaker for all their enduring love and support. Similarly, I owe a major debt of gratitude to my fiancé, Amna Husic, for without whom I could not have gotten through this rigorous program. I would also like to acknowledge the most formative teacher of my younger years, Dr. Clark Porter, for introducing me to the wonders of the world and instilling in me a passion for lifelong learning. I would also like to acknowledge the psychology faculty, particularly Dr. Helen Harton, Dr. Elizabeth Lefler, and Dr. Seth Brown for their patience with me and their passion for providing a competitive education. Lastly, I just want to give an acknowledgement to my fellow cohort for helping me push through those long nights of studying and countless conversations about our futures.

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INTRODUCTION

Approximately 450 million individuals around the world will deal with a mental illness during a 12-month period (World Health Organization, 2001). In the United States alone, there are nearly 46.6 million people who are living with a mental illness (National Institute of Mental Health, 2019b). For those people dealing with mental illnesses, there are real and debilitating effects that range from lower educational attainment and lower work-related productivity to a potentially greater chance of becoming homeless (Kessler et al., 1995; Marcotte & Wilcox-Gök, 2001; Substance Abuse and Mental Health Services Administration, 2011).

The negative outcomes associated with mental illnesses can have a significant effect on both men and women. Despite this, women seek professional help for their mental health more often than men (National Institute of Mental Health, 2019b). One reason why men may seek help less for their mental health could be due to gender norms -- specifically, the belief that seeking help is feminine. Men may be particularly less likely to seek help for an illness that they perceive as "feminine" (e.g., depression). In this study, I tested whether describing counseling for depression using masculine attributes leads men to have more positive attitudes toward seeking professional help for their mental health, which may increase the likelihood that men seek counseling. Prior to introducing the study, I review literature on the prevalence of mental illnesses for men and women, help-seeking, the influence of gender norms on help-seeking, and how framing effects, such as using masculine attributes to describe counseling, can be used to change people's attitudes.

Mental Illness and Gender

Prevalence

       The lifetime risk for developing a mental illness is fairly equal for both men and women at 48.7% for men and 47.3% for women (Kessler et al., 1994); however, men and women are at risk for developing different mental illnesses. There are a wide variety of mental illnesses described in the *Diagnostic and Statistical Manual of Mental Health Disorders* (5th edition; American Psychiatric Association, 2013). One potential way to separate them is by internalizing versus externalizing symptoms (Eaton et al., 2011). Internalizing symptoms such as isolation and self-deprecation tend to be more commonly seen in disorders such as anxiety and depression. The opposite of internalizing is externalizing symptoms, which include aggression and substance use, and these are more commonly associated with disorders such as antisocial personality disorder and conduct disorder (Eaton et al., 2011). Nationally representative survey research has shown that women are more at risk for developing internalizing disorders, such as anxiety and depression (Kessler et al., 1994; Kessler et al., 2005). Men, on the other hand, are at greater risk for developing externalizing disorders, such as substance use disorder and antisocial personality disorder (Kessler et al., 1994; Kessler et al., 2005). Women's greater likelihood to develop internalizing disorders compared to externalizing disorders may be part of the reason why men view depression as more feminine and less severe compared to other disorders (Cole & Davidson, 2019).

       Even though men are statistically more at risk for developing externalizing disorders, this is not to say that men do not develop internalizing disorders such as

depression. In the United States, 17.3 million adults reported at least one major depressive episode in 2017 (National Institute of Mental Health, 2019a). Of the individuals surveyed, 8.7% of the female respondents and 5.3% of the male respondents reported a depressive episode in the past 12 months (National Institute of Mental Health, 2019a). These prevalence rates are also similar to a 12-month global prevalence of major depression (7.2% in females vs. 3.9% in males; Ferrari et al., 2013).

Among those 17.3 million people in the United States, those who were between the ages of 18 to 25 reported the highest prevalence of major depressive episodes (National Institute of Mental Health, 2019a). The majority (64%) of the individuals who reported at least one major depressive episode also reported that the episode resulted in severe impairment (National Institute of Mental Health, 2019a). Therefore, despite a higher prevalence of depression in women there are still a large number of men, especially between the ages of 18-25, who cope with depression.

<u>Help-Seeking</u>

Despite the equal rate of mental illnesses overall, women seek help more often than men. In this context "help" refers to willingly seeking out professional assistance (e.g., from a psychologist, psychiatrist, social worker, mental health counselor) in dealing with a mental health related problem. According to data from the Substance Abuse and Mental Health Services Administration (SAMHSA), only 34.8% of men with any mental health condition received services in the past year compared to 47.6% of women with any mental health condition (National Institute of Mental Health, 2019b). It is problematic that less than 50% of all individuals dealing with a mental illness reported seeking help

for their mental health in the past year; however, men reported even less help-seeking compared to women. The term "services" refers to inpatient and outpatient treatment or counseling, as well as prescription medications for problems with nerves, emotions, and mental health (National Institute of Mental Health, 2019b). The data from SAMHSA show that men seek help less than women, and that individuals age 18 to 25 seek help less than individuals older than 25 (National Institute of Mental Health, 2019b). Another study showed that in one sample of men and women, the men utilized general mental health services much less than the women did (13.3% vs. 22.3%; Smith et al., 2013).

Overall, men seek help less often for their mental health compared to women; however, men who identify as non-White and heterosexual are even less likely to seek help compared to women. In a national survey, 9% of men aged 18 to 44 reported daily symptoms of anxiety or depression yet of those 9% of men, only 26.4% of non-Hispanic Black and Hispanic men compared to 45.4% of non-Hispanic White men utilized mental health services (Blumberg et al., 2015). Further, a smaller percentage of men who identified as Black or Mexican American sought help for their mental health in a 12-month period compared to men who identified as White or European American (Parent et al., 2018). Finally, men who identified as heterosexual also reported seeking mental health services less in a 12-month period compared to non-heterosexual men (Parent et al., 2018). In general, men do not seek help as often for their mental health; however, some groups of men may be even less likely to utilize mental health services.

Instead of utilizing mental health services, such as counseling, men may instead choose to cope with their mental illness (e.g., depression) on their own. This mentality of

self-reliance may exacerbate common symptoms of depression such as isolation and low mood (American Psychiatric Association, 2013). The exacerbation of underlying symptoms of mental illness may lead to men feeling hopeless, which in turn may be directly related to men's disproportionately higher likelihood of dying by suicide (Hedegaard et al., 2018; Wang et al., 2005). In fact, recent data show that 4 of 5 suicides in Iowa during 2017 were men (Carver-Kimm, 2019). However, this problem goes beyond just one rural state; across 27 different states between 2014-2016, 76.8% of all the suicides were men (Stone et al., 2018). The high suicide rate for men is not contained to the United States either. In fact, the international age-standardized male to female ratio for suicide was 1.8 in 2016 (i.e., men accounted for more of the suicides; World Health Organization, 2018). The number of age-standardized international suicides by gender was 13.89 per 100,000 for men compared to 6.28 per 100,000 for women (Ritchie et al., 2020). Men's higher rates of suicide may be in part due to their lower likelihood to seek professional help.

The mentality of self-reliance associated with masculinity can also lead to repressed emotions and overwhelming stress, which may get taken out on other people in the form of violence (Brooks, 2001). In 2018, there were 3.3 million victims of violent crime in the United States (Bureau of Justice Statistics, 2019). Men are more often perpetrators of violence, often against other men, except in cases of sexual assault and rape, in which women are disproportionately victimized by men (Bureau of Justice Statistics, 2019). Although violence is not a mental illness itself, it may be exacerbated by an underlying mental illness or substance use problem, and it can also lead to mental

illness (e.g., Post Traumatic Stress Disorder) in women and other men who are victimized (Brooks, 2001). Therefore, untreated mental illness in men may also increase violent behavior toward others (Brooks, 2001).

<u>Summary</u>

In summary, men suffer from mental illnesses at equal rates to women (Kessler et al., 1994; Kessler et al., 2005), and yet men do not seek professional help as often as women (National Institute of Mental Health, 2019b). The fact that men often do not seek professional help for their mental health has consequences that affect more than just the individual (Brooks, 2001; Hedegaard et al., 2018). One potential reason that men may not seek help as often as women is related to the social construction of gender.

<div align="center">Social Constructionist Theory of Gender</div>

Social constructionist theories of gender state that gender is not an innate, biological construct; rather, gender is actively created through a person's behavior during interactions with others (Courtenay, 2000; West & Zimmerman, 1987). In essence, people's actions act as a form of currency that contributes to their construction of masculinity or femininity. Over time, certain thoughts and behaviors became associated with masculinity or femininity (e.g., men are the stronger sex, women are the caregivers; Courtenay, 2000). These thoughts and behaviors led to the development of gender stereotypes, which are beliefs and ideas about how men and women should think and act (Courtenay, 2000; Eagly & Steffen, 1984). These gender stereotypes influence how men and women are treated by society. Specifically, this happens when an individual compares another person's behaviors against their understanding of cultural gender

norms in an attempt to identify and categorize the individual's gender identity

(Courtenay, 2000). Gender stereotypes constrain the behavior of both men and women;

however, for the purposes of this study I focused on the particular types of pressure that

men experience because of expectations of masculinity. Overall, these gender stereotypes

may shift during times of societal change, but the basic content of gender stereotypes has

remained fairly constant since at least the 1980's (Haines et al., 2016).

 The wide agreement of members of a society on the content of gender stereotypes

(i.e., what is masculine or feminine; Nesbitt & Penn, 2000) influences how men choose to

construct their masculinity (Courtenay, 2000). The content of these male stereotypes is

often referred to as traditional masculinity ideology. Traditional masculinity ideology is

operationalized as restrictive emotionality, courage, self-reliance, status (i.e., success,

power), negativity towards sexual minorities, avoidance of femininity, importance of

sexual intercourse, toughness, and dominance (David & Brannon, 1976; Levant et al.,

2010; O'Neil, 1981). These ideals set the standard for dominant and submissive forms of

masculinity (Connell & Messerschmidt, 2005). As such, individuals who identify as

male are socialized from birth to adopt these ideals and enact them in their everyday

thoughts and behaviors as a way of establishing their masculine gender identity and

maintaining the system of patriarchy that benefits men (Courtenay, 2000).

<div align="center">Men's Attitudes Toward Seeking Help</div>

 One way that men may actively construct and define their gender identity is

through their health beliefs and behaviors (Courtenay, 2000). Men may behave in certain

ways, such as drinking heavily or avoiding doctor visits, as a way of visibly enacting

masculine values of strength and self-reliance and communicating their masculine identity to others (Courtenay, 2000). Men may also actively avoid seeking medical care as a way of demonstrating their masculinity (i.e., toughness, self-reliance; Courtenay, 2000). Men demonstrating their masculinity by avoiding doctor visits may be one reason why women account for significantly more visits to the doctor (Bertakis et al., 2000; Pinkhasov et al., 2010).

Men's gender roles may also affect their attitudes toward seeking mental health care. A common form of mental health care is referred to as counseling. According to the National Health Services in the United Kingdom, "counselling is a talking therapy that involves a trained therapist listening to you and helping you find ways to deal with emotional issues" (National Health Service, 2020). As this description of counseling illustrates, services commonly focus on the act of processing and talking about emotional problems, which may be in opposition to traditional masculine ideals. Specifically, the act of working through emotions may be viewed as a feminine task, which is in opposition to traditional masculine values of self-reliance and restrictive emotional expression (David & Brannon, 1976). In support of this idea that traditional descriptions of therapy may be less attractive to at least some men, more traditionally masculine men prefer more action-oriented therapy as opposed to basic talk therapy (Seidler et al., 2016). Some men also perceive counseling for depression to be ineffective as they believe they cannot be helped (Brownhill et al., 2002). Thus, masculine ideals may conflict with traditional views of counseling.

The disconnect between masculine ideals and traditional descriptions of counseling services may contribute to both boys' and men's more negative attitudes toward psychological help-seeking compared to those of women. Boys, particularly those 14 to 19 years old with a higher depression symptomology score, reported significantly more negative attitudes on a questionnaire assessing attitudes toward seeking help compared to same age girls (Garland & Zigler, 1994). College men also reported more negative attitudes on a questionnaire assessing attitudes toward seeking psychological help compared to same-age women (Leong & Zachar, 1999).

These attitudes toward seeking help for mental health issues affect more than just likelihood of obtaining therapy and affect many types of men. In a large, stratified sample from the UK, men reported more negative attitudes toward seeking mental health help from family and friends, as well as from general practitioners (Oliver et al., 2005). These negative attitudes that men hold are also not unique to one race or ethnicity. European American, Asian, and Asian American men have more self-reported negative attitudes toward seeking help for their mental health compared to same-age women (Nam et al., 2010). The idea that men do not seek help also extends to men of varying ages; men in their 50s to 70s still reported viewing help-seeking as going against their idea of masculinity (Tannenbaum & Frank, 2011). In general, research has consistently shown that men of various ages, races, and ethnicities have more self-reported negative attitudes toward seeking help for their mental health from any source compared to women.

Although men tend to hold negative attitudes about seeking help across ethnicity and age, there is variance in men's attitudes. Two psychological constructs, traditional

masculinity ideology and gender role conflict, are associated with men's attitudes and may have a moderating effect on men's attitudes toward seeking psychological help.

Traditional Masculinity Ideology

The concept of traditional masculinity ideology "…refers to beliefs about the importance of men adhering to culturally defined standards for male behavior." (Pleck et al., 2004, p. 85). The "culturally defined standards" are the established ideals of how traditional men should think and behave: "no sissy stuff (i.e., avoid anything feminine), be a big wheel (i.e., success, power, status), be a sturdy oak (i.e., tough, confident, courageous), give 'em hell" (i.e., aggression, violence; David & Brannon, 1976, p. 12). In other words, it is not about the specific traits that a man has, but about how important the man thinks it is to live up to the cultural norms of masculinity. For example, a man might strongly believe that men should never show their emotions; however, that same man may still show his emotions at certain times despite his belief about men and restrictive emotionality (e.g., during sporting events).

The strength with which men adhere to traditional masculinity ideology is associated with multiple negative outcomes. Men who strongly endorse traditional masculinity ideology are more likely to suffer from alexithymia, or an inability to describe their emotions (Levant et al., 2003). In male teenagers, strong endorsement of traditional masculinity ideology is associated with a greater number of sexual partners in the past year, less frequent condom use, and the belief that impregnating a woman is masculine (Pleck et al., 1993). Endorsement of traditional masculinity ideology is also associated with men's attitudes toward psychological help-seeking. Men who adhere

more strongly to traditional masculinity ideology have more negative attitudes toward psychological help-seeking compared to men who adhere less to traditional masculinity ideology (Berger et al., 2005; McCusker & Galupo, 2011).

Gender Role Conflict

Gender role conflict, on the other hand, is a psychological feeling of distress that occurs when a man believes that traditional masculinity ideology is important and yet he is aware that his own thoughts and behavior do not align with the traditionally dominant gender ideology (O'Neil, 1982). In other words, gender role conflict can occur when men view a discrepancy between the way they demonstrate masculinity and their interpretation of the cultural expectations of masculinity. For example, a man may experience gender role conflict in a situation where he expresses his emotions despite a strong belief that men should never express their emotions. This gender role conflict can then lead to the development of gender role strain, which can ultimately involve the restriction of one's full potential (O'Neil, 1981).

It has long been established that gender role conflict is associated with many negative outcomes. College men with high gender role conflict have lower psychological well-being as measured by multiple scales assessing self-esteem, anxiety, depression, and social intimacy (Sharpe & Heppner, 1991). College men with high gender role conflict also scored higher on a measure of trait anger and reported more frequent alcohol consumption compared to college men with less gender role conflict (Blazina & Watkins, 1996).

Men who experience gender role conflict may have more negative attitudes toward seeking help, because they may view help-seeking as a "feminine" behavior, which is in opposition to the traditional masculine norms that they believe men should follow. In fact, gender role conflict is associated with more negative attitudes toward seeking help for their mental health on self-report questionnaires among various populations of men, including college students (Wahto & Swift, 2016), community samples including broad age ranges (Berger et al., 2005), men who are homeless (Nguyen et al., 2012), and gay men (Simonsen et al., 2000), although one study did suggest that gender role conflict was less related to negative attitudes than endorsement of traditional masculine ideology (Berger et al., 2005). The internal conflict that men experience when their personal thoughts and behaviors do not align with their understanding of traditional masculine norms (i.e., gender role conflict) seems to be one factor that helps explain why men are less likely to seek help.

<u>Summary</u>

In summary, men have more negative attitudes toward seeking help compared to women (Leong & Zachar, 1999; Nam et al., 2010), possibly due to gender roles and viewing help-seeking as feminine. Men's negative attitudes toward seeking help may be moderated by endorsement of traditional masculinity ideology and gender role conflict (Berger et al., 2005; Wahto & Swift, 2016). Changing the perceptions of help seeking as "feminine" to "masculine" may thus make it more likely that men will seek help. In the next section, I discuss how framing effects might be used toward this purpose.

Framing Effects

One way to potentially change people's attitudes is with framing effects. A framing effect refers to the "framing" or describing of a particular thing in either a positive or negative way in an attempt to change or modify a person's attitude (Levin et al., 1998). Essentially, differently worded but equivalent descriptions may result in different attitudes toward the thing being described (Levin et al., 1998; Tversky & Kahneman, 1981). For example, people had more positive attitudes toward public welfare when it was framed in humanitarian terms (i.e., restrictions hurt the poor) compared to individualistic terms (i.e., strict work requirements are good; Shen & Edwards, 2005). There are three types of framing: risky choice framing, attribute framing, and goal framing (Levin et al., 1998). In this study the focus is specifically on attribute framing.

Attribute framing refers to the wording of specific characteristics of something as a way of getting different evaluations of the thing being described (Levin et al., 1998). For example, participants rated the quality of a meat higher if the packaging was positively framed (75% lean) compared to if the packaging was negatively framed (25% fat; Levin & Gaeth, 1988). Participants in another study reported a greater likelihood of condom use to prevent HIV when the advertisement used a positive attribute frame (i.e., 90% success rate for preventing HIV versus a 10% failure rate to prevent HIV; Linville et al., 1993). Participants have also rated the HPV vaccine as more effective when they were presented with the information that the vaccine is effective against 70% of cervical cancers versus that the vaccine is not effective against 30% of cervical cancers (Bigman et al., 2010).

At least two studies have used attribute framing to examine how descriptions of mental health services affect men's attitudes. In one study, men with depression read either a male-sensitive brochure that described depression symptoms more common in men (e.g., substance use, anger), used more traditionally masculine language (e.g., mental health consultant), and used a medical model of depression (i.e., not due to a weak will) or a gender-neutral brochure that used broad statistics and symptoms common in both men and women. The male-sensitive brochure was associated with more positive attitudes toward seeking help and less stigma among men compared to the gender-neutral brochure (Hammer & Vogel, 2010). In another study, White men from three West Coast colleges provided input on a brochure that described counseling in a traditional sense or one that described "nontraditional, alternative services (classes, workshops, seminars, circulating videotape library; Robertson & Fitzgerald, 1992, p. 241)". The brochures were similar in terms of the problems described, graphics, size, length, use of headings, and style. Despite the similarities between brochures and service descriptions, men with higher gender role conflict had more positive attitudes toward services that were more aligned with masculine ideals (e.g., workshops, classes) compared to traditional counseling services (Robertson & Fitzgerald, 1992). Therefore, it appears that at least some men may have more positive attitudes toward services when they are framed in such a way as to highlight traditional masculine ideals.

Current Study

Men have rates of mental illnesses that are equivalent to those of women (Kessler et al., 1994), and yet men, particularly men aged 18 to 25 years old, do not seek help as

often as women (Kessler et al., 1981; Kessler et al., 1994; Kessler et al., 2005). Men who adhere more strongly to traditional masculine ideology or who have higher gender role conflict also tend to have more negative attitudes toward seeking professional psychological help, which suggests that gender roles may help explain the differences in help seeking. Men may be especially less likely to seek help for mental health issues because they view help seeking as "feminine."

One way to modify or change men's attitudes, then, may be to frame counseling in more masculine terms. Consistent with this idea, two studies found that descriptions that framed mental health content as masculine resulted in more positive attitudes toward services for at least some men compared to when they were described in a more traditional or neutral manner (Hammer & Vogel, 2010; Robertson & Fitzgerald, 1992). These previous studies examined whether male friendly descriptions of mental illness or using different types of services would lead to men reporting more positive attitudes toward seeking help. One study (Hammer & Vogel, 2010) used several types of modifications to descriptions (e.g., "manly" depression symptoms, male prevalence rates), making it difficult to determine which change may have led to the effect. The other study's use of workshops and classes for men's mental health may have another potential disadvantage - mainly that men may feel their masculinity is at risk when in the presence of a group of men (Blazina & Marks, 2001). The current study improves upon the previous studies by focusing on different, but parallel, ways to describe a single mental health service that is typical of most counseling centers, as opposed to focusing on

multiple types of services that may not be as acceptable to men or changing several service descriptions.

The current study used attribute framing to describe counseling services in three short stories that highlighted counseling as courageous or as a path to success compared to a more traditional description that described counseling as a process of expressing emotions and thoughts to improve well-being. These attributes, courage and success, were chosen based on the self-reliance, dominance, and toughness ideals that are associated with traditional masculinity ideology (Levant et al., 2010) as well as based on their ability to be incorporated into descriptions of counseling services. These attributes are an important start to begin investigating a potentially cost-effective way to market counseling services to men and get more men into counseling.

In this study, the focus was on depression in men who are aged 18 to 35. The focus was on one particular mental illness, depression, for two reasons. One reason is that prevalence rates of depression were used in a previous study on men's preference for treatment for depression (Hammer & Vogel, 2010), so the specific mental illness was used for comparison purposes. Focusing on one commonly known mental illness also reduces the chance that the type of mental illness influences men's attitudes toward seeking help. As for the specific age range, 18 to 35, national survey data have shown that men age 18 to 25 report the highest prevalence of mental illness and the least amount of help-seeking across 12 months (National Institute of Mental Health, 2019b). I initially planned to target men between the ages of 18 to 25 for this study; however, this resulted in a limited sample size because of low participation rates. Because there are also a

significant number of men aged 26 to 49 who do not utilize mental health services despite

reporting symptoms of a mental illness in the past 12 months (National Institute of

Mental Health, 2019b), I chose to increase the participant age range to 18 to 35 years old.

I also examined two possible moderators of these effects, traditional masculinity

ideology and gender role conflict. One study found that traditional masculinity ideology

and gender role conflict were associated with more negative attitudes toward seeking

help; however, traditional masculinity ideology was more closely related to negative

attitudes toward seeking help compared to gender role conflict (Berger et al., 2005).

Another study found that men with lower gender role conflict did not have a preference

between alternative services (e.g., workshop, class) and traditional counseling, whereas

men with higher gender role conflict preferred the alternative services (Robertson &

Fitzgerald, 1992). Therefore, men with a stronger endorsement of traditional masculinity

ideology and greater gender role conflict may benefit more from masculine sensitive

descriptions of counseling services.

<div align="center">Hypotheses</div>

Hypothesis 1: Men who read the short stories that utilize traditionally masculine

attributes (i.e., courage, success) will have more positive attitudes toward seeking

psychological help than the men who read the more traditional description of counseling

services.

Hypothesis 2: Men who read the short stories that utilize traditionally masculine

attributes (i.e., courage, success) will report a greater likelihood to call the counseling

center compared to the men who read the more traditional description of counseling services.

Hypothesis 3: Gender role conflict will moderate the effect of the counseling descriptions on attitudes toward seeking psychological help. More specifically, men who are higher in gender role conflict will show a stronger effect of the counseling description on attitudes toward seeking help than will men who are lower in gender role conflict.

Hypothesis 4: Endorsement of traditional masculinity ideology will moderate the effect of the counseling descriptions on attitudes toward seeking psychological help. More specifically, men who have stronger endorsement of traditional masculinity ideology will show a stronger effect of the counseling description on attitudes toward seeking help than will men who have lower endorsement of traditional masculinity ideology.

METHOD

Design

This study was a between-subjects experiment. The independent variable was the counseling descriptions, with three levels (i.e., courage, success, traditional). The dependent variables were attitudes toward seeking mental health services and likelihood to call the counseling center. This study also included two potential moderators: gender role conflict and traditional masculinity ideology. Prior to starting, the study and planned analyses were pre-registered on OSF (https://osf.io/kqavb/).

Participants

The initial sample of male participants consisted of 818 individuals who were recruited from Amazon Mechanical Turk (mTurk; $n = 455$), a University of Northern Iowa listserv ($n = 269$), the undergraduate research pool (SONA; $n = 45$), Facebook ($n = 46$), and Twitter ($n = 3$). During data cleaning, a total of 285 participants were excluded, which resulted in a final sample of $n = 533$, including 146 from the university listserv, 342 from mTurk, 30 from SONA, 14 from Facebook, and 1 from Twitter. The final combined sample of participants was predominantly Non-Hispanic (89.9%), White/European American (80.7%), cis-gender male (98.5%), and between the ages of 18 to 26. Less than half the participants reported a past history of mental health services (45.4%) and a little more than a quarter of participants reported a previous diagnosis of depression (27.0%; Table 1).

The survey was made available to mTurk participants who identified as male, were between the ages of 18 to 25 (initially, then increased to 18 to 35 due to limited

participation), were a U.S. citizen, had at least a 99% HIT approval, and had completed at

least 100 surveys. The University of Northern Iowa listserv email was sent to a random

selection of 2,100 male students who were at least 18 years old and U.S. citizens, with an

equal distribution of freshmen, sophomores, juniors, and seniors. As I initially expected

about a 20% response rate (Stilgenbauer, 2020), this listserv invitation should have

provided me with an approximate total of 420 participants which would have left some

room for potential exclusions; however, my response rate was only 13% ($n = 269$).

Participants from the University of Northern Iowa undergraduate research pool were

included if they identified as male, were at least 18 years old, and were a U.S. citizen.

Lastly, postings of the study description with a link to the study were also made available

on the author's personal Facebook and Twitter pages and shared on those of my lab

mates. Participants from social media were included if they identified as male, were

between the ages of 18-35, and were a U.S. citizen. The participants collected through

mTurk were compensated $1.00 for their time, the participants from the UNI listserv had

the option to be entered into a raffle for a chance to win one of two $25.00 Visa gift

cards, and the research pool participants received 0.5 research credit toward a psychology

course. There was no compensation for participants recruited through Facebook and

Twitter.

Previous research that examined framing effects and men's attitudes has found

effect sizes ranging from $\eta^2 = .008$ (really small effect; Hammer & Vogel, 2010) to $d =$

.28 (medium effect; Robertson & Fitzgerald, 1992). Therefore, an effect size of $\eta^2 = 0.02$

(small to medium effect) was used in calculating the target sample size. Using G*Power

(v. 3.1) for an ANOVA: Fixed effects, special, main effects, and interactions with an effect size $f = 0.1428571$ ($\eta^2 = 0.02$); $\alpha = .05$; numerator df $= 2$; and the number of groups $= 3$, the suggested sample sizes for this experiment were 760, 624, or 476 participants for power of .95, .90, or .80, respectively. I initially planned for 95% power by attempting to recruit at least 800 participants, which would have allowed for excluding some participants during data cleaning; however, data cleaning resulted in a sample of 533 participants, which is a little more than .80 power to detect a small to medium effect.

Table 1

Participant Demographics by Sample

	Demographic	Listserv *n = 146*	MTurk *n = 342*	SONA *n = 30*	Social Media *n = 15*	Total *N = 533*
Ethnicity	Hispanic, Latino, Spanish Origin	6.2%	12.7%	6.7%	0%	10.1%
Race	Alaska Nat/Amer Indian	0.7%	0.3%	0%	0%	0.4%
	Asian/Asian American	1.4%	13.1%	0%	0%	8.8%
	Black/African American	2.1%	9.9%	0%	0%	6.9%
	Multi-Racial	0.7%	1.5%	3.3%	0%	1.3%
	Other Race/Ethnicity	1.4%	1.5%	3.3%	0%	1.5%
	White/European American	92.4%	73.8%	93.3%	100%	80.7%
Gender	Male	100%	98%	100%	100%	98.7%
	Transgender Male	0%	2.0%	0%	0%	1.3%
Age	*M*	19.77	26.33	19.30	23.92	24.09 4.54
	SD	1.65	3.91	1.06	2.96	
SES	Avg. SES Rank (1-7)	3.96	3.70	4.50	3.50	3.81
Mental Health Services	History of Mental Health Services	39.3%	48.7%	40.0%	40.0%	45.4%
	Previous Depression Diagnosis	15.2%	31.8%	26.7%	33.3%	27.0%

Procedure

mTurk participants located the study description and link on Amazon Mechanical Turk. The University of Northern Iowa listserv participants received an email inviting them to participate in a study on health attitudes with a link for the study, and the University of Northern Iowa research pool participants found the study description and link available on SONA (i.e., web-based research pool system). Lastly, participants recruited through social media (e.g., Facebook, Twitter) were able to access the study through a study description and link that was posted on the respective social media platform.

After clicking the study link, all participants initially read an informed consent, and upon agreeing, they were then randomly assigned to read one of three short stories about counseling services. The three short stories (See Appendix B) were author-generated descriptions of an individual who was dealing with six clear symptoms of Major Depressive Disorder from the *DSM-5* and as a result, had a conversation with a friend about counseling. The depression symptoms were the same across all three short stories; however, there were three different conversations with the friend. In one short story the friend described counseling as courageous, whereas in the second short story the friend described counseling as a path towards success. The third description was a more traditional (feminine) view of counseling as being a way of dealing with your emotions. All three short stories were revised and approved by two professionals in the field of psychology to verify the accuracy of the depression symptoms. Similarly, the short stories were pilot tested in a graduate student research lab to ensure that the descriptions

appropriately described masculine attributes (i.e., graduate student researchers came to an agreement that the descriptions appropriately emphasized "courage", "success", and "traditional"). The short stories had a one-minute delay on them, meaning that participants were not able to move forward in the questionnaire until one minute had passed.

After at least one minute of reading the short story, the participants then completed an attention check item, the likelihood to call the counseling center item, and the manipulation check item. After these items, participants completed the Inventory of Attitudes Toward Seeking Mental Health Services (Mackenzie et al., 2004), the Male Role Norms Inventory – Short Form (including an attention check; Levant et al., 2013), the Gender Role Conflict Scale – Short Form (including an attention check; Wester et al., 2012), and the Patient Health Questionnaire-9 (Kroenke et al., 2001). After those measures were completed, participants provided some basic demographic information (e.g., age, ethnicity, gender, race, socioeconomic status), and answered two questions related to past depression diagnoses and personal utilization of mental health services. Lastly, the participants commented on what they thought the purpose of the study was and had the opportunity to leave any comments in an open-ended text box. mTurk participants were also asked to report their worker ID for the purposes of compensation, after which the IDs were deleted. The participants recruited from the UNI listserv were asked if they would like to report their email for the purposes of the gift card raffle, after which the emails were deleted. Lastly, all participants were debriefed (i.e., told that the purpose of the study was to test whether different descriptions of counseling services

affected men's attitudes toward counseling services) and provided with appropriate counseling resources (i.e., National Suicide Prevention Lifeline, UNI Counseling Center information).

<div align="center">Measures</div>

Attention Checks

There were three items placed throughout the questionnaire that served as attention checks (See Appendix B). The first item was "What was the short story that you just read about?" and the responses were "Two friends talking about counseling", "Two friends talking about their weekend plans", "Two friends talking about an upcoming exam", and "Two friends talking about their dating life." The item was placed on the page directly after the short story. The second item, "It's important that you pay attention to this study. Please tick 'Strongly Disagree', was placed randomly among the items in the Male Role Norms Inventory – Short Form (Prolific, 2018). The third item, "Going to the spa is difficult for me. Please mark "Somewhat disagree." was placed randomly among the Gender Role Conflict – Short Form items.

Likelihood to Call the Counseling Center

The participant's self-reported likelihood to call the counseling center was measured with a single author-generated item (See Appendix C). The item was "How likely would you be to call the counseling center in the situation you read about?" with the following responses: "Very unlikely", "Somewhat unlikely", "Neutral", "Somewhat likely", and "Very likely".

Manipulation Check

The manipulation check consisted of one semantic differential item, "How do you feel counseling was described in the short story?" with the following semantic differentials: for men – not for men, welcoming – not welcoming, manly – not manly, good – bad, courageous – weak, and successful – not successful (See Appendix D).

Inventory of Attitudes Toward Seeking Mental Health Services

The Inventory of Attitudes Toward Seeking Mental Health Services (IATSMHS; Mackenzie et al., 2004; See Appendix E) is a self-report measure that consists of 24 items that assess self-reported attitudes, subjective norms, and perceived behavioral control (e.g., "People should work out their own problems; getting professional help should be a last resort"; Mackenzie et al., 2004). Seventeen of the 24 items were taken directly from the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS), and the remaining items were created and validated by Mackenzie et al. (2004). Items are rated on a Likert scale from 0 (*disagree*) to 4 (*agree*), with higher scores indicating more positive attitudes toward seeking help for mental health. Factor analyses showed support for a three-factor model, which is similar in content to the factors found using the ATSPPHS (Mackenzie et al., 2004). The internal consistency was $\alpha = .87$ for the full scale, and $\alpha = .82, .76, .79$ for the three individual factors (Mackenzie et al., 2004). Across two samples at two different points in time, intentions to seek mental health services and past utilization of mental health services were positively correlated with the IATSMHS ($r = .38$ and $r = .33$; Mackenzie et al., 2004). In the current study, the

Inventory of Attitudes Toward Seeking Mental Health Services had a Cronbach's alpha

of .728.

Male Role Norms Inventory – Short Form

The Male Role Norms Inventory – Short Form (Levant et al., 2013; See Appendix

F) is a self-report measure that consists of 21 items from the Masculine Role Norms

Inventory – Revised (e.g., "A man should never admit when others hurt his feelings.";

Levant et al., 2013). The items assess men's endorsement of traditional masculinity

ideology, with each item rated on a 7-point Likert scale from 1 (*strongly disagree*) to 7

(*strongly agree*). Potential scores range from 21 to 147, where higher scores indicate

greater endorsement of traditional masculinity ideology. The measure has good internal

consistency (α = .79 to .94; Levant et al., 2013). Multiple types of confirmatory factor

analyses have also been conducted and have provided data showing that the measure is

still able to assess the same factor structure as the full-length Male Role Norms Inventory

– Revised (Levant et al., 2013). While there do not seem to be any studies specifically

assessing the validity of this measure, there is validity evidence for the MRNI-R, which is

where these items were taken from. Convergent validity was established by showing that

MRNI-R scores are positively related to the Masculine Role Attitudes Scale, whereas

discriminant validity was established by comparing scores on the MRNI-R to the

Personal Attributes Questionnaire-Masculinity Scale (i.e., no positive relationship

between the two measures; Levant et al., 2010). Similarly, concurrent validity was

established by showing that MRNI-R scores are positively related to scores on the

Conformity to Masculine Norms Inventory, the Gender Role Conflict Scale, and the

Normative Male Alexithymia Scale (Levant et al., 2010). In the current study, the

Masculine Role Norms Inventory – Short Form had a Cronbach's alpha of .938.

Gender Role Conflict Scale – Short Form

The Gender Role Conflict Scale – Short Form (Wester et al., 2012; See Appendix

G) is a self-report measure that consists of 16 of the highest loading items from the

original Gender Role Conflict Scale – I (O'Neil et al., 1986). The items assess men's

attitudes, thoughts, and behaviors related to gender role norms (e.g., "I do not like to

show my emotions to other people."; Wester et al., 2012). The 16 items load on to four

factors: success, power, and competition; restrictive emotionality; restrictive affectionate

behavior between men; and conflicts between work and family relations. The items are

rated on a 6-point Likert scale from 1 (*strongly disagree*) to 6 (*strongly agree*), with final

scores ranging from 16 to 96. Higher scores indicate greater gender role conflict. The

measure has been found to have adequate internal consistency (α = .77 to .80; Hammer et

al., 2018). Confirmatory factor analyses also showed that the four-factor model was still a

good fit using the short version of the measure. Wester et al. (2012) also calculated

correlations between the original Gender Role Conflict Scale – I and the Gender Role

Conflict Scale – Short Form and found that the four factors from the short form were

significantly correlated with the original four factors. In the current study, the Gender

Role Conflict Scale – Short Form had a Cronbach's alpha of .839.

Patient Health Questionnaire-9 (PHQ-9)

The Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001) is a 9 item

self-report instrument that assesses frequency of *DSM-5* symptoms of Major Depressive

Disorder (e.g., "Over the last 2 weeks, how often have you been bothered by little interest or pleasure in doing things?"; See Appendix H). The instrument has strong internal reliability (α = .86, .89; Kroenke et al., 2001), and has been shown to have good construct validity as an increase in reported symptoms often reflects worse functioning (Kroenke et al., 2001). In the current study, the Patient Health Questionnaire-9 had a Cronbach's alpha of .906.

Demographics

The items pertained to the participants' age, ethnicity, race, socioeconomic status, sex, gender, college enrollment (mTurk) and year in school (UNI). Participants were also asked to provide responses to two mental-health related questions that assessed previous diagnoses for depression and past utilization of mental health services (See Appendix I).

Additional Questions

At the end of the questionnaire, participants were also asked to comment on what they thought the purpose of the study was, and they had the opportunity to leave comments in an open-ended text box (See Appendix J).

RESULTS

Exclusion Criteria and Tests of Assumptions

Participants' data were excluded based on multiple pre-registered criteria

(https://osf.io/kqavb/). Of the 455 mTurk participants, 60 participants did not report their

gender, 40 did not provide a reasonable idea of what the purpose of the study was (e.g., to

measure people's use of social media) 11 completed the survey in less than 5 minutes or

more than 1 hour, and 2 had extreme scores on the Masculine Role Norms Inventory –

Short Form (i.e., outliers). Therefore, data from 342 participants from mTurk were

included in the analyses. Of the 269 UNI listserv participants, 104 did not report their

gender, 1 did not provide a reasonable purpose for the study, 11 participants completed

the study in less than 5 minutes or more than 1 hour, and 7 participants failed at least 2

out of 3 attention checks. Therefore, data from 146 participants were included in the

analyses. Of the 45 SONA participants, 10 did not report their gender, 3 did not provide a

reasonable purpose, and 2 failed at least 2 out of the 3 attention check items. Therefore,

data from 30 participants were included in the analyses. Of the 46 Facebook participants,

30 did not report their gender, 1 completed the survey in less than 5 minutes or more than

1 hour, and 1 did not provide a reasonable purpose for the study. Therefore, data from 14

participants were included in the analyses. Of the three Twitter participants, 2 participants

did not report their gender. Therefore, data from 1 participant was included in the

analyses.

Prior to conducting further analyses, relevant variables were assessed to ensure

that statistical assumptions were not violated. The histograms for attitudes across each

condition appeared normally distributed, which supports the normality assumption. The Normal Q-Q plot of observed value and expected normal for attitudes across conditions were linear. The Shapiro-Wilk test was not significant for attitudes toward seeking mental health services across conditions (Courageous Statistic = .990, p = .264; Success Statistic = .986, p = .070; Control Statistic = .989, p = 207); however, the Shapiro-Wilk test was significant for likelihood to call the counseling center across conditions (Courageous Statistic = .813, p < .001; Success Statistic = .820, p < .001; Control Statistic = .822, p < .001). Similarly, the Levene's Test was also insignificant for attitudes toward seeking mental health services across conditions and likelihood to call the counseling center across conditions (Levene Statistic = .981, p = .376; Levene Statistic = 2.23, p = .109). Together, these analyses suggest that the data for attitudes toward seeking mental health services were normally distributed, but that likelihood to call the counseling center was not normally distributed (i.e., positively skewed); however, analysis of variance is fairly robust against violations of the assumption of normality (Gravetter & Wallnau, 2008), so there were no transformations done on the data. Furthermore, homogeneity of variance was not violated for either of the variables. Therefore, the main statistical assumptions for analysis of variance were met. Additionally, the residuals versus fitted values plots for both gender role conflict, traditional masculinity ideology, and attitudes toward seeking mental health services showed constant error variance (i.e., randomly distributed around the zero line). Therefore, the assumptions for moderation analyses were also met. I conducted all analyses using SPSS v. 27.

Data Analysis Plan

I first tested whether my framing effect was effective using t-tests. Specifically, a t-test was used to examine whether responses to the courageous semantic differential item were significantly different between the courageous and neutral conditions. Another t-test was used to examine whether responses to the success semantic differential item were significantly different between the success and neutral conditions. Then I conducted a one-way analysis of variance, comparing whether participants reported any of the three short stories as being more "manly" than the other short stories. Next, I conducted multiple exploratory correlations. Specifically, correlations were run to assess the associations between attitudes toward seeking help, likelihood to call the counseling center, gender role conflict, and traditional masculinity ideology within each of the three conditions separately to ensure that condition effects did not mask relationships between the variables.

To address my first two hypotheses, I conducted two ANOVAs, comparing whether participants reported different attitudes toward seeking mental health services or a different likelihood to call the counseling center depending on which short story the participants read. The first one-way analysis of variance was conducted with the total Inventory of Attitudes Toward Seeking Mental Health Services as the dependent variable and the author-generated short stories as the independent variable with three levels. Then the second ANOVA was conducted with the likelihood to call the counseling center item as the dependent variable and the author generated short story as the independent variable. To address my third and fourth hypotheses, two moderation analyses were

conducted to assess whether gender role conflict and/or traditional masculinity ideology moderated the effect of the short story on men's attitudes toward seeking mental health services. The two moderations were conducted using the PROCESS macro in SPSS (Hayes, 2017). PROCESS is an SPSS macro used to conduct a variety of moderation and mediation analyses. I used PROCESS Model 1 (Simple Moderation) with bootstrapping set at 1000 as the estimation method and a 95% confidence interval.

<div align="center">Manipulation Checks</div>

To test whether participants viewed the short stories as they were intended to, I compared ratings from semantic differential items across conditions. Participants rated the short story as being more "courageous" in the courageous condition ($M = 4.34$, $SD = 0.86$) compared to participants in the neutral condition ($M = 3.74$, $SD = 0.87$; $t(353) = 6.54$, $p < .001$, 95% CI of M Diff. [0.42, 0.78], $d = .694$, 95% CI [.479, .908]). Participants did not rate the short story as being significantly more "successful" in the success condition ($M = 3.94$, $SD = .91$) compared to participants in the neutral condition ($M = 3.88$, $SD = .82$), although the means were in the expected direction, $t(351) = .670$, $p = .503$, 95% CI of M Diff. [-.12, .24], $d = .071$, 95% CI of d [-.14, .28]. This finding suggests that the success framed short story may not have been an effective manipulation.

To test whether the courageous and success short stories were viewed as more masculine than the neutral story, I compared ratings on the two "manly" semantic differential items (correlated with each other at $r = .638$, $p < .001$) across conditions using an ANOVA. Participants in the courageous condition reported that the short story was more "manly" than the participants in the neutral condition (See Table 2), $F(2, 525)$

$= 4.46$, $p = .012$, $\eta^2 = .017$, 90% CI [.002, .037]. Ratings of participants in the success

condition did not differ from those of participants in the courageous or neutral conditions.

Even though the success framed short story did not seem to be effective, I retained it in

further analyses as the means between success and the neutral condition were still in the

expected direction and the success short story was viewed as equally manly to the

courageous short story.

Table 2

Average Rating of Short Story Being Manly

Stats	Courageous	Success	Neutral
Mean	3.52_a	3.35_{ab}	3.30_b
SD	0.77	0.76	0.72
95% CI	[3.41, 3.64]	[3.23, 3.46]	[3.19, 3.40]

Note. Items with different subscripts differ at $p < .05$.

Exploratory Correlations

To contribute to the established literature on masculinity and health attitudes, I

conducted multiple exploratory correlations within conditions. Participants who reported

a greater likelihood to call the counseling center tended to have more positive attitudes

toward seeking mental health services, lower adherence to traditional masculinity

ideology (only in the courageous condition), and less gender role conflict (only in

courageous and success conditions; See Table 3). Similarly, participants who reported

more positive attitudes toward seeking mental health services tended to have lower

adherence to traditional masculinity ideology and gender role conflict. Lastly,

participants who reported a strong adherence to traditional masculinity ideology also tended to report more gender role conflict (See Table 3).

Table 3

Total Correlations Between Measures by Condition

Measure	Courageous ($n = 178$)	Success ($n = 176$)	Neutral ($n = 177$)
1. Likelihood to Call CC – Attitudes Toward Seeking Help	.374**	.293**	.226**
2. Likelihood to Call CC – Traditional Masculinity Ideology	-.160*	-.086	-.077
3. Likelihood to Call CC – Gender Role Conflict	-.170*	-.306**	-.100
4. Attitudes Toward Seeking Help – Traditional Masculinity Ideology	-.399**	-.290**	-.290**
5. Attitudes Toward Seeking Help – Gender Role Conflict	-.347**	-.298**	-.362**
6. Traditional Masculinity Ideology – Gender Role Conflict	.424**	.503**	.526**

Note. **. Correlation is significant at the 0.01 level (2-tailed).
    *. Correlation is significant at the 0.05 level (2-tailed).

<u>Hypothesis 1: Attitudes Toward Seeking Mental Health Services</u>

To test the first hypothesis, I examined whether there were differences in attitudes toward seeking mental health services based on what short story participants read. There were no significant differences in attitudes toward mental health services across

conditions, F (2, 530) = 2.05, p = .129, η^2 = .008, 90% CI [.00, .02]. In other words,

participants who read the courageous or success framed short stories did not report more

positive attitudes toward seeking mental health services compared to participants who

read the neutral short story (See Table 4). Because participants who read the courageous

or success short story did not report more positive attitudes toward seeking help, my first

hypothesis was not supported. Overall, however, participants did report generally positive

attitudes toward seeking help as evidenced by the mean value being greater than the mid-

point of the scale (5-point scale; See Table 4).

<div align="center">Hypothesis 2: Likelihood to Call the Counseling Center</div>

To test the second hypothesis, I examined whether there were differences in

participant's likelihood to call the counseling center based on what short story the

participants read. Across the three conditions, there were no differences in participants'

likelihood to call the counseling center, F (2, 530) = .353, p = .703, η^2 = .001, 90% CI

[.00, .01]. In other words, participants who read the courageous or success framed short

stories did not report a greater likelihood to call the counseling center compared to

participants in the neutral condition (See Table 4). Because participants who read the

courageous or success short story did not report a greater likelihood to call the counseling

center, my second hypothesis was not supported. It is worth noting that participants did

self-report a fairly high likelihood of calling the counseling center across all three

conditions as evidenced by the mean value being greater than the mid-point of the scale

(5-point scale; See Table 4).

Table 4

Dependent Variables by Condition

Variable	Courage (n = 179)	Success (n = 177)	Control (n = 177)
	M (SD)	M (SD)	M (SD)
Attitudes Toward Seeking Help	2.66 (0.49)	2.66 (0.49)	2.57 (0.46)
Likelihood to Call Counseling Center	3.73 (1.11)	3.63 (1.25)	3.65 (1.14)

<u>Hypothesis 3: Gender Role Conflict as a Moderator</u>

To test the third hypothesis, I examined whether gender role conflict moderated the effect of the short story on men's attitudes toward seeking mental health services. The overall model was significant, R^2 = .12, MSE = .21, $F (3, 528)$ = 20.11, $p < .001$, and the analysis showed that gender role conflict was a predictor of attitudes toward seeking mental health services (β = -.21, S.E. = .03, t = -7.32, $p < .001$). Furthermore, the condition did not have a significant effect (β = −.04, S.E. = .02, t = -1.80, p = .073). The moderation was not significant, ΔR^2 = .00, $F (1, 528) < .001$, p = .983 (See Table 5). Participants' level of gender role conflict did not influence the effect of the condition on attitudes toward seeking mental health services, which is in opposition to my third hypothesis.

Table 5

Moderation Effect of Gender Role Conflict on Association between Condition and

Attitudes Toward Seeking Mental Health Services

Variables	Unstandardized β	S.E.	t	p	95% CI
constant	2.63	.02	132.28	<.001	[2.59, 2.67]
Condition	-0.04	.02	-1.80	.07	[-.09, .00]
GRC	-0.21	.03	-7.32	<.001	[-.26, -.15]
Condition x GRC	.00	.04	.02	.983	[-.07, .07]

Hypothesis 4: Masculine Role Norms Inventory as a Moderator

To test the fourth hypothesis, I examined whether adherence to traditional

masculinity ideology moderated the effect of the short story on men's attitudes toward

seeking mental health services. The overall model was significant, $R^2 = .11$, $MSE = .21$, F

$(3, 527) = 17.47$, $p < .001$, and the analysis showed that adherence to traditional

masculinity ideology was a predictor of attitudes toward seeking mental health services

($\beta = -0.16$, S.E. $= .02$, $t = -6.85$, $p < .001$); however, condition did not have a significant

effect ($\beta = -.04$, S.E. $= .02$, $t = -1.47$, p $.142$). Furthermore, the moderation effect was

also not significant, $\Delta R^2 = .003$, $F (1, 527) = 1.30$, $p = .25$ (See Table 6). Therefore,

participants' level of adherence to traditional masculinity norms did not have a significant

effect on the association between the short stories and attitudes towards seeking mental

health services, although the short story did seem to have had the least impact on the

attitudes of men who were highest in adherence to traditional masculinity ideology (See

Figure 1), which is opposite of what I had originally predicted. Therefore, my fourth

hypothesis, that traditional masculinity ideology would moderate the effect of the short

story on attitudes, was not supported.

Table 6

Moderation Effect of Adherence to Traditional Masculinity Ideology on Association

between Attitudes and Condition

Variables	Unstandardized β	S.E.	t	p	95% CI
constant	2.63	.02	131.41	.00	[2.59, 2.67]
Condition	-0.04	.02	-1.47	.14	[-.08, .01]
MRNI	-0.16	.02	-6.85	.00	[-.21, -.11]
Condition x MRNI	.03	.03	1.14	.255	[-.02, .08]

Note. MRNI is Masculine Role Norms Inventory Short Form (i.e., adherence to
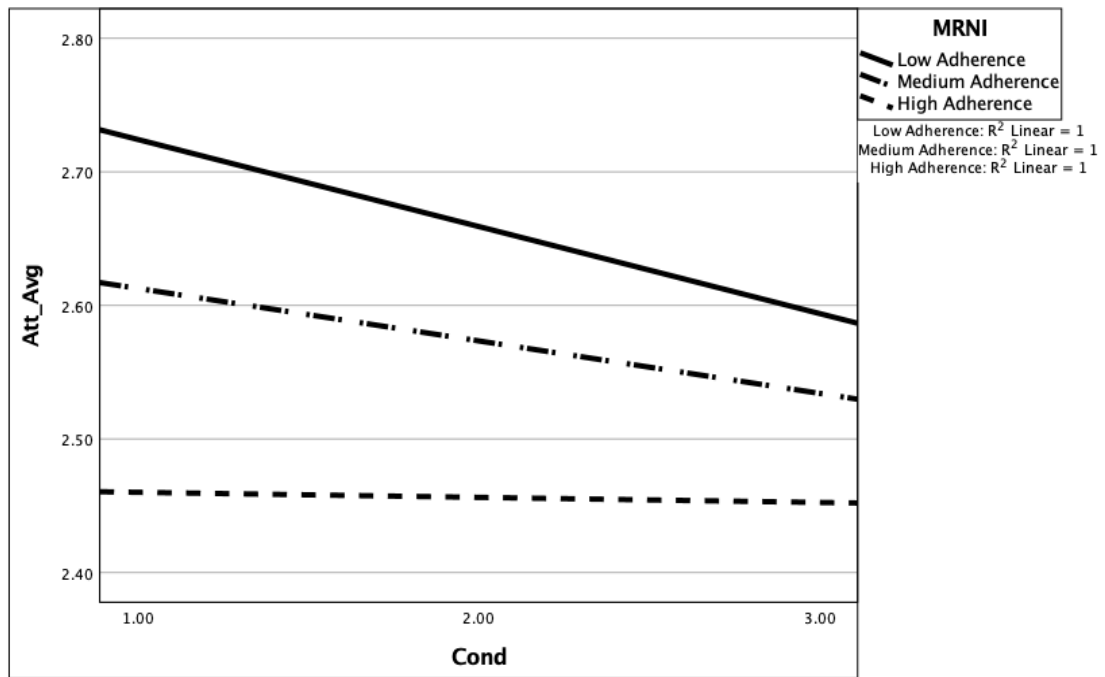
traditional masculinity ideology)

Figure 1

Moderation Effect of Adherence to Traditional Masculinity Ideology on Association between Attitudes and Condition

Note. Condition 1 = Courageous, Condition 2 = Success, Condition 3 = Neutral

DISCUSSION

This experiment examined the effects of using the masculine attributes of courage and success to describe counseling services as a way of improving men's attitudes toward seeking help for their mental health. Participants viewed counseling as more courageous and manly after imagining themselves in a situation where they were experiencing depressive symptoms and a friend suggested that seeking professional counseling was courageous but did not view counseling as more successful or manly when it was described as leading to success. Contrary to hypotheses, reading the courage or success framed short stories did not lead to more positive attitudes toward seeking help or a greater reported likelihood of calling the counseling center in a similar situation. Furthermore, also contrary to hypotheses, neither gender role conflict nor traditional masculinity ideology moderated the effect of the short story on men's attitudes toward seeking help. These results are in contrast to previous research that has suggested that using more masculine symptoms of depression and statistics regarding the prevalence of depression in men resulted in men reporting more positive attitudes toward seeking help (Hammer & Vogel, 2010) and that men, particularly men high in gender role conflict, preferred more alternative "manly" types of services such as workshops and classes (Robertson & Fitzgerald, 1992).

One reason why using these masculine attributes of courage and success to describe counseling may not have impacted attitudes or intentions could be that simply using masculine attributes to describe a single mental health service may not be enough to improve men's attitudes. That is, the manipulation may have been too subtle to change

attitudes, particularly those of men with more traditional or conflicted gender ideologies. Perhaps changing men's attitudes requires changing multiple variables, such as was done in previous research when men preferred a more masculine brochure that featured depression symptoms more prevalent in men (e.g., anger, substance use), a more masculine term for a therapist (e.g., consultant), and prevalence statistics for depression in men (Hammer & Vogel, 2010). It is also possible that creating an actual brochure that advertises a mental health service (Hammer & Vogel, 2010) is a more effective method compared to using attribute framing in a short story where participants were asked to imagine themselves as a male character with depression.

There is also the possibility that the research design and/or unique characteristics of the participants influenced the results. Participants in this study reported generally more positive attitudes than were found in previous research that used the same measure with men in college (Mackenzie et al., 2004; Wahto & Swift, 2016). Similarly, the average response for participants' likelihood to call the counseling center, was "somewhat likely," which also suggests that participants had fairly positive attitudes, even in the control, neutral condition. These findings suggest either that the men in this study provided socially desirable responses or that they were already open to the idea of counseling, which might help explain why describing counseling in "manly" terms did not increase positivity toward counseling. Mental health awareness has progressed over the years, to the point that men may have more positive attitudes toward seeking help than in the past; however, more recent data still show that men are not utilizing mental health services as often as women (National Institute of Mental Health, 2019b). It is also

possible that participants responded differently to the scenario than how they would have responded if they were actually in the situation. The difference in responding to an imagined scenario compared to a real situation could be due in part to social desirability, but it may also be due to a participant's lack of insight regarding how he may react in any given situation.

Men who were higher in traditional masculine ideology or gender role conflict were not more affected by the short stories describing counseling using more manly attributes. These findings are in contrast to a previous study that found men with higher gender role conflict preferred alternative types of services (e.g., classes, workshops; Robertson & Fitzgerald, 1992), so perhaps simply using masculine attributes to describe a single service that men believe is "feminine" (e.g., counseling) is not enough to improve the attitudes of most men, particularly those with high adherence to traditional masculinity ideology and more gender role conflict. As the previous study is almost 30 years old, it is also possible that there has been an increase in mental health awareness that could have led to a cultural shift in attitudes toward seeking mental health services; however, a fairly recent study of college students found that men still have significantly more negative attitudes toward seeking help for their mental health (Çebi & Demir, 2020). Similarly, another recent study found that men on college campuses reported receiving less mental health care compared to the women on campus (Seehuus et al., 2021). Therefore, more recent research suggests that men still experience more negative attitudes toward seeking help and that they utilize fewer mental health services compared to women.

It is also possible that using masculine attributes, particularly courage, to describe counseling services does improve men's attitudes and that traditional masculinity ideology, as well as gender role conflict, do moderate that effect; however, the effect may have been too small to detect with the level of current power (~.80) based on the sample size in this study.

<p style="text-align: center;"><u>Men's Attitudes toward Seeking Mental Health Services</u></p>

Even though my original hypotheses were not supported, exploratory correlational analyses provided further support that masculinity is associated with men's attitudes and that masculinity may still be an important factor in changing men's attitudes toward seeking help. For example, men who reported a stronger adherence to traditional masculinity ideology or more gender role conflict reported more negative attitudes toward seeking help, similar to previous research (Berger et al., 2005; Blazina & Marks, 2001; Wahto & Swift, 2016). They also reported lower likelihoods of utilizing mental health services. These results suggest that the act of seeking help may be in conflict with traditional masculine ideals of self-reliance (David & Brannon, 1976; Levant et al., 2010) and is also consistent with other research showing that men tend to have more self-reported negative attitudes toward seeking help compared to women (Garland & Zigler, 1994; Leong & Zachar, 1999; Nam et al., 2010; Oliver et al., 2005). Furthermore, men with more positive attitudes toward seeking help also reported a greater likelihood to utilize mental health services. The fact that men with more positive attitudes are reportedly more likely to utilize mental health services aligns with past findings that

men's attitudes toward seeking help are positively correlated with men's intentions to seek help (Mackenzie et al., 2004; Seyfi et al., 2013).

<div align="center">Implications</div>

The results showed that men with greater adherence to traditional masculinity ideology and/or more gender role conflict reported more negative attitudes toward seeking help and a lower likelihood to utilize mental health services. These findings suggest that some men's conception of masculinity does conflict with seeking help. Because masculine norms do seem to conflict with seeking help for men, this provides further support to the theory that some men use health behaviors as a way of demonstrating their masculinity (i.e., I do not seek help, because I am tough; Courtenay, 2000). As the theory continues to be supported 20 years post-publication, this result suggests that some traditionally masculine men still experience negative attitudes toward seeking help for their mental health despite progress in mental health awareness (Henderson et al., 2016).

It is clear that men are less likely to seek counseling when they should (National Institute of Mental Health, 2019b), but it is unclear of what the best method to get more men into counseling is. The current findings indicated that the subtle manipulation of using masculine attributes to describe counseling services did not have an effect on men's attitudes, which may suggest that gender-targeted approaches need to be bigger and more obvious. The current findings also show that men high in traditional masculinity ideology tended to be the least affected by the descriptions of counseling. Therefore, traditionally masculine men may have rigid attitudes toward seeking mental health services that are

not easily malleable. Because previous research, including the current study, suggests that men's attitudes toward seeking help are directly related to their intentions to seek help, it seems reasonable to focus on changing men's attitudes (Berger et al., 2005; Wahto & Swift, 2016) using multiple methods and over time. Furthermore, making attitudes more important or personally relevant to a person can lead to greater changes in attitudes (Harton & Latané, 1997).

For example, it may be beneficial for counseling centers, particularly ones located on university campuses, to create specific materials that are targeted at men. The materials should describe mental health services using masculine attributes, such as courage, and include mental health prevalence rates for men, as well as replace "therapist" or "counselor" with alternatives such as "consultant" or "coach". The targeted materials can be intentionally displayed in areas that are predominantly male (e.g., male athletic team lockers, fraternities, hunting stores, sporting venues). It also may be helpful to have some materials or a video that depicts men from the campus or the local community who have benefited from counseling services to make the issue more relevant and thus more important to the men.

<center>Limitations & Future Research</center>

One major limitation of this study is that it measured attitudes toward seeking help, as opposed to actual utilization of mental health services. As a result, it is not possible to make conclusions about whether or not men would utilize counseling after reading the short story, even if they self-reported more positive attitudes toward seeking mental health services. Future research could address this by measuring men's attitudes

toward seeking mental health services, their intentions to seek mental health services, and then conducting a follow-up after a specified amount of time to assess how many men actually utilized a mental health service.

Another limitation of this study is related to the fictional short story. Specifically, it is possible that participants were not able to adequately imagine themselves in the situation described in the short story, which could have resulted in different responses than if the participants were actually feeling the way the individual was described as feeling in the short story. Future research could address this limitation by having participants watch a video of the interaction or having them respond to prompts to ensure that they were paying attention to the scenario. Another possibility would be to conduct a study that tracks whether men with a mental illness start mental health services after being shown different types of advertisements. Because other research that found a significant change in men's attitudes modified several variables in the advertisement, future research should explore modifying various aspects of the description for counseling services, including using a wider range of masculine attributes to describe counseling services (e.g., courage, success, power, strength, self-reliance), as well as using more masculine terminology (e.g., consultant, coach) and statistics related to mental illness in men.

It is also worth noting that there are some limitations due to the sample itself. In particular, the sample was predominantly Non-Hispanic, European American, and heterosexual. It is possible that men of different ethnicities and sexualities may experience masculinity differently, which could impact their attitudes toward seeking

mental health services; however, previous research has found that men of different ethnicities and sexualities still experience negative attitudes toward seeking help (Nam et al., 2010; Simonsen et al., 2000). Another limitation due to the sample could be that the lower response rate was due to men not wanting to complete a questionnaire about their health, which could suggest that the participants who self-selected to complete the questionnaire already had more positive attitudes toward seeking help. In particular, future research could address these sample limitations by intentionally recruiting a more representative and diverse sample of men to complete measures of attitudes toward seeking mental health services and intentions to seek mental health services by using larger incentives or more purposeful samples.

Conclusions

In this study, the use of a single masculine attribute, courage or success, to describe counseling services did not result in men reporting more positive attitudes toward seeking mental health services, in contrast to previous studies that did show effects with stronger manipulations (Hammer & Vogel, 2010) or choices of types of services (Robertson & Fitzgerald, 1992). It is possible that the single, subtle manipulation used in this study was not enough to change men's attitudes, particularly those of men who strongly adhere to traditional masculinity ideology or experience high gender role conflict. Even though this study did not show a positive effect of masculine framing, there was also no evidence of a negative effect of using masculine attributes. Given the results of previous studies and findings in this study suggesting that men who were higher in traditional masculine ideology and gender role conflict held more negative attitudes

toward seeking help for their mental health, clinicians may choose to create advertisements targeted at men and promote their counseling services in areas that are predominated by men (e.g., male athletic locker rooms, fraternities, male dorms) to try to get more men into counseling. As men continue to make up a disproportionately large number of suicides around the world (Hedegaard et al., 2018; Wang et al., 2005), finding low-cost methods to improve men's attitudes toward seeking help is important, even if only for a few men.

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APPENDIX A

COUNSELING SHORT STORIES

<u>Courageous Condition</u>

Instructions: On the next page you are going to be asked to imagine that you are the character in a short story. You will not be allowed to move forward until at least one minute has passed, so please take your time reading the story. It is important that you pay close attention as there will be questions related to the story afterwards.

Imagine the following:

You are a college student and have been feeling really sad all semester for no obvious reason. You have been spending a lot of time laying in your bed watching Netflix, avoiding your friends and family. You are exhausted all the time and have started to wonder why you are even in college at all. You used to like playing video games with your friends, but lately you have no interest in playing games. Instead, you have found yourself drinking more alcohol because at least it keeps you from being stuck inside your head all the time. And sometimes, you even start to think about what it would be like to go to sleep and never wake up again. However, one day your friend approaches you about your recent behavior changes. At first, you really don't feel up to talking about it,

but you eventually decide to talk. After you tell your friend about how you have been

feeling lately, he says the following:

"It sounds like you are really going through a hard time. Maybe you should go see a

counselor. I know that counseling may seem uncomfortable, *but I think counseling is*

courageous. True courage is only possible when you are in a situation that is scary or

uncomfortable and yet you push through the situation. Now, I am sure that dealing with

all those thoughts in your head has got to be hard but there are resources available. *If you*

decide that you are courageous enough for counseling, the counseling center here at the

university is always an option.

Successful Condition

Instructions: On the next page you are going to be asked to imagine that you are the character in a short story. You will not be allowed to move forward until at least one minute has passed, so please take your time reading the story. It is important that you pay close attention as there will be questions related to the story afterwards.

Imagine the following:

You are a college student and have been feeling really sad all semester for no obvious reason. You have been spending a lot of time laying in your bed watching Netflix, avoiding your friends and family. You are exhausted all the time and have started to wonder why you are even in college at all. You used to like playing video games with your friends, but lately you have no interest in playing games. Instead, you have found yourself drinking more alcohol because at least it keeps you from being stuck inside your head all the time. And sometimes, you even start to think about what it would be like to go to sleep and never wake up again. However, one day your friend approaches you about your recent behavior changes. At first, you really don't feel up to talking about it, but you eventually decide to talk. After you tell your friend about how you have been feeling lately, he says the following:

"It sounds like you are really going through a hard time. Maybe you should go see a counselor. I know that counseling may seem uncomfortable, *but I think that in order to*

be successful sometimes we have to accept being uncomfortable. I bet that the most successful people in life are ones that have encountered difficulties along the way. Now I am sure that dealing with all those thoughts in your head has got to be hard, but there are resources available. *If you decide that you want to embrace the discomfort and become more successful,* the counseling center here at the university is always an option."

Traditional (Control) Condition

Instructions: On the next page you are going to be asked to imagine that you are the character in a short story. You will not be allowed to move forward until at least one minutes has passed, so please take your time reading the story. It is important that you pay close attention as there will be questions related to the story afterwards.

Imagine the following:

You are a college student and have been feeling really sad all semester for no obvious reason. You have been spending a lot of time laying in your bed watching Netflix, avoiding your friends and family. You are exhausted all the time and have started to wonder why you are even in college at all. You used to like playing video games with your friends, but lately you have no interest in playing games. Instead, you have found yourself drinking more alcohol because at least it keeps you from being stuck inside your head all the time. And sometimes, you even start to think about what it would be like to go to sleep and never wake up again. However, one day your friend approaches you about your recent behavior changes. At first, you really don't feel up to talking about it, but you eventually decide to talk. After you tell your friend about how you have been feeling lately, he says the following:

"It sounds like you are really going through a hard time. Maybe you should go see a counselor. I know that counseling may seem uncomfortable, *but I think it can help you. There are a lot of people in the world who struggle with stress and emotions and counseling has helped them talk through their feelings*. Now I am sure that dealing with all those thoughts in your head has got to be hard, but there are resources available. *If you decide that this is something you want to do*, the counseling center here at the university is always an option."

APPENDIX B

ATTENTION CHECKS

<u>*Indicates Correct Response</u>

"What was the short story about that you just read?"

- Two friends talking about counseling. *

- Two friends talking about their weekend plans.

- Two friends talking about an upcoming exam.

- Two friends talking about their dating life.

"It's important that you pay attention to this study. Please tick 'Strongly disagree'."

- Strongly disagree *

- Disagree

- Somewhat disagree

- Somewhat agree

- Agree

- Strongly agree

"Going to the spa is difficult for me. Please mark "Somewhat disagree.""

- Strongly disagree

- Disagree

- Somewhat disagree*

- Somewhat agree

- Agree

- Strongly agree

APPENDIX C

LIKELIHOOD TO CALL THE COUNSELING CENTER

Responses range from *Very unlikely* (0), *Somewhat unlikely* (1), *Neutral* (2), *Somewhat likely* (3), *Very likely* (4). The item is not reverse scored. Higher scores indicate a greater likelihood to call the counseling center.

1. "How likely would you be to call the counseling center in the situation that you read about?"

APPENDIX D

MANIPULATION CHECK

Responses range from *Extremely* (1), *Moderately* (2), *Neutral* (3), *Moderately* (3),

Extremely (4). Higher scores indicate that the participant believed the word on the right

of the scale was most descriptive of the short story they read.

"How do you feel counseling was described in the short story that you just read?"

Welcoming (1) -------------------------- (4) Not welcoming

Not for men (1) ------------------------------ (4) For men

Good (1) ---------------------------------- (4) Bad

Weak (1) --------------------------- (4) Courageous

Successful (1) ---------------------------- (4) Not successful

Not manly (1) -------------------------------- (4) Manly

APPENDIX E

INVENTORY OF ATTITUDES TOWARD SEEKING MENTAL HEALTH SERVICES

(MACKENZIE ET AL., 2004)

Higher scores indicate more positive attitudes toward seeking mental health services.

*Item is reverse coded.

Instructions: The next set of questions is going to ask about your thoughts on getting help for mental health problems. Please read the items carefully and answer as honestly as possible.

"The term *professional* refers to individuals, who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term *psychological problems* refer to reasons one might visit a professional. Similar terms include *mental health concerns*, *emotional problems*, *mental troubles*, and *personal difficulties*."

For each item, indicate whether you *disagree* (0), *somewhat disagree* (1), *are undecided* (2), *somewhat agree* (3), or *agree* (4):

1. There are certain problems which should not be discussed outside of one's immediate family.*

2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.

3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.*

4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.*

5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.

6. Having been mentally ill carries with it a burden of shame.*

7. It is probably best not to know *everything* about oneself.*

8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.

9. People should work out their own problems; getting professional help should be a last resort.*

10. If I were to experience psychological problems, I could get professional help if I wanted to.

11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.*

12. Psychological problems, like many things, tend to work out by themselves.*

13. It would be relatively easy for me to find the time to see a professional for psychological problems.

14. There are experiences in my life I would not discuss with anyone.*

15. I would want to get professional help if I were worried or upset for a long period of time.

16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.*

17. Having been diagnosed with a mental disorder is a blot on a person's life.*

18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears *without* resorting to professional help.*

19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.

20. I would feel uneasy going to a professional because of what some people would think.

21. People with strong characters can get over psychological problems by themselves and would have little need for professional help.*

22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up".

24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.*

APPENDIX F

MASCULINE ROLE NORMS INVENTORY – SHORT FORM

(LEVANT ET AL., 2013)

The items are rated on a 7-point Likert scale from 1 "*Strongly disagree*" to 7 "*Strongly agree*". No items are reverse scored. Higher scores indicate greater adherence to traditional masculinity ideology.

*The term "homosexual(s)" is outdated and was replaced with "Gay and lesbian" for the purposes of this thesis.

Instructions: The following questions are going to ask you about **your** thoughts on how **men** should think, act, and feel. Please take your time and answer as honestly as possible.

1. A man should never admit when others hurt his feelings.

2. Men should be detached in emotionally charged situations.

3. Men should not be too quick to tell others that they care about them.

4. Men should have home improvement skills.

5. Men should be able to fix most things around the house.

6. A man should know how to repair his car if it should break down.

7. Homosexuals should never marry.*

8. All homosexual bars should be closed down.*

9. Homosexuals should never kiss in public.*

10. Men should watch football games instead of soap operas.

11. A man should prefer watching action movies to reading romantic novels.

12. Boys should prefer to play with trucks rather than dolls.

13. Men should always like to have sex.

14. A man should not turn down sex.

15. A man should always be ready for sex.

16. The President of the U.S. should always be a man.

17. Men should be the leader in any group.

18. A man should always be the boss.

19. It is important for a man to take risks, even if he might get hurt.

20. When the going gets tough, men should get tough.

21. I think a young man should try to be physically tough, even if he's not big.

APPENDIX G

GENDER ROLE CONFLICT SCALE – SHORT FORM

(WESTER ET AL., 2012)

The items are rated on a 6-point Likert scale from 1 "*strongly disagree*" to 6 "*strongly agree*". No items are reverse scored. Higher scores indicate greater gender role conflict.

Instructions: The following items are going to ask about **your** personal thoughts and behaviors. Please take your time and answer as honestly as you can.

1. Talking about my feelings during sexual relations is difficult for me.

2. I have difficulty expressing my emotional needs to my partner.

3. I have difficulty expressing my tender feelings.

4. I do not like to show my emotions to other people.

5. Winning is a measure of my value and personal worth.

6. I strive to be more successful than others.

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

8. I like to feel superior to other people.

9. Affection with other men makes me tense.

10. Men who touch other men make me uncomfortable.

11. Hugging other men is difficult for me.

12. Being very personal with other men makes me feel uncomfortable.

13. Finding time to relax is difficult for me.

14. My needs to work or study keep me from my family or leisure more than I would

like.

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

etc.).

16. Overwork and stress, caused by a need to achieve on the job or in school,

affects/hurts my life.

APPENDIX H

PATIENT HEALTH QUESTIONNAIRE – 9

(PHQ-9; KROENKE ET AL., 2001)

The items are rated on a scale from 0 to 3 with 0 being not at all and 3 being nearly every day. No items are reverse scored. The answers from 1-9 are then added up. Scores of 5, 10, and 15 represent mild, moderate, and severe levels of depression.

Instructions: The following items are going to ask about depression. For each item, select the number for the answer that best describes how often you have been bothered by the problem in the last 2 weeks.

Over the **last 2 weeks,** how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

    a. 0   1   2   3

2. Feeling down, depressed, or hopeless

    a. 0   1   2   3

3. Trouble falling or staying asleep, or sleeping too much

    a. 0   1   2   3

4. Feeling tired or having little energy

    a. 0   1   2   3

5. Poor appetite or overeating

   a. 0   1   2   3

6. Feeling bad about yourself – or that you are a failure or have let yourself or your

   family down

   a. 0   1   2   3

7. Trouble concentrating on things such as reading the newspaper or watching

   television

   a. 0   1   2   3

8. Moving or speaking so slowly that other people could have noticed? Or the

   opposite – being so fidgety or restless that you have been moving around a lot

   more than usual

   a. 0   1   2   3

9. Thoughts that you would be better off dead or of hurting yourself in some way

   a. 0   1   2   3

10. If you marked off *any* problems, how *difficult* have these problems made it for

    you to do your work, take care of things at home, or get along with other people?

    a. Not difficult at all   Somewhat difficult   Very difficult   Extremely

       difficult

APPENDIX I

DEMOGRAPHIC QUESTIONS

Instructions: The following questions are going to ask you for some basic demographic information (e.g., age, race, sex, gender)

1. What is your age?

   a. 18-100

2. Are you of Hispanic, Latino, or Spanish Origin?

   a. Yes/No

3. How would you describe yourself?

   a. American Indian or Alaska Native

   b. Asian or Asian American

   c. Black or African American

   d. Multiple Races

   e. Native Hawaiian or Other Pacific Islander

   f. Other Race

   g. White or European American

4. How would you describe your gender identity?

   a. Female

   b. Male

   c. Transgender Female

    d.   Transgender Male

    e.   Gender Variant/Non-Conforming

    f.   Not Listed: _____

    g.   Prefer not to answer

5. What biological sex were you assigned at birth?

    a.   Male

    b.   Female

    c.   Intersex

    d.   Not Listed: _____

    e.   Prefer not to answer

6. What is your sexual orientation?

    a.   Asexual

    b.   Bisexual

    c.   Gay or Lesbian

    d.   Heterosexual (Straight)

    e.   Queer

    f.   Pansexual

    g.   Not Listed_____

    h.   Prefer not to say

7. Think of this as a ladder that represents where people stand in the United States. At the **top** of the ladder are the people who are the best off – those who have the most money, the most education and the most respected jobs. At the **bottom** are

the people who are the worst off – who have the least money, least education, and the least respected jobs or no job. The higher up you are on this ladder, the closer you are to the people at the very top; the lower you are, the closer you are to the people at the very bottom.

Where would you put yourself on this ladder?

*Graphic slider that resembles a ladder

8. What year in school are you? (UNI Survey only)

    a. Freshman

    b. Sophomore

    c. Junior

    d. Senior

    e. Graduate Student

    f. Not in school

    g. Other _____

9. Are you currently enrolled in college or university? (*mTurk only*)

    a. Yes

    b. No

10. Are you now, or have you ever, participated in any mental health related services (e.g., therapy, counseling, prescription medications)?

    a. Yes, I have

    b. No, I have not

11. Have you ever received a diagnosis of depression from a mental health

professional (e.g., psychologist, psychiatrist, family doctor)?

    a. Yes, I have

    b. No, I have not

APPENDIX J

ADDITIONAL QUESTIONS

"What do you think the purpose of this study was?"

- _____

"Any comments?"

- _____