"Why Won't He Go to the Doctor?": The Psychology of Men's Help Seeking

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Men seek help less often than women and underutilize medical and mental health services. This article explores three bodies of theory and research related to men's help seeking. Gender socialization theories, social constructionist theories, and social psychological theories are considered. Each theoretical paradigm is illustrated through case examples and considered in light of its ability to help health care providers understand men's orientation to health care and help seeking. Strategies to increase men's help seeking are also explored.

Key Words: men's help seeking, health care, strategies to increase men's help-seeking behavior

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A greeting card pictures Moses walking in the desert, looking lost. The caption reads: "Why did Moses spend 40 years wandering in the desert? Because he wouldn't ask for directions." Popular images of men who refuse to ask for help for problems abound in U.S. culture. Sadly, research findings validate the popular idea that men do not seek help often enough. In this article, we review the evidence supporting the conventional wisdom that men infrequently seek help. We use case examples to illustrate three bodies of theory and research that are particularly relevant to understanding the problem and suggest strategies to increase men's help seeking.

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THE CURRENT STATUS OF MEN'S HELP SEEKING

According to the U.S. Department of Health and Human Services (1998), men make fewer contacts with physicians across the lifespan than do women and are twice as likely as women to have gone two years or more since their last contact with a physician (DHHS, 1998). Men suffer higher mortality rates than women (DHHS, 1997; Stillion, 1995; Waldron, 1995) but seek help less often than women for a variety of problems in living including depression, cocaine use, alcohol use, and medical problems (McKay, Rutherford, Cacciola, & Kabaskalian, 1996; Padesky & Hammen, 1981; Thom, 1986; Weissman, & Klerman, 1977; Wills & DePaulo, 1991). In addition, men have suicide rates four to 12 times higher than women, suffer higher levels of substance abuse, and are more likely to suffer chronic conditions and fatal diseases than are women (DHHS, 1997; Kessler, Brown, & Boman, 1981; Robins & Regier, 1991).

Although these findings appear to be robust across age, nationality, and racial/ethnic background (DHHS, 1998; Husaini, Moore, & Cain, 1994; Neighbors & Howard, 1987), it is important to note that underprivileged men are at especially high risk. For example, according to the Department of Health and Human Services (1997), Black men are more likely than White men to die from HIV and diabetes, and they typically receive poorer health care than do White men (Staples, 1995). Similarly, men who do not have citizenship and/or do not speak English are especially disadvantaged regarding health care. Immigrant men may choose not to seek help for a medical problem at all rather than risk being deported. Thus, although men overall suffer higher mortality rates than do women, underprivileged men are especially vulnerable to disease because of their restricted access to resources and services.

Men's low rates of help seeking have only recently come to be considered problematic (Courtenay, 2000). In the past, men's rates of help seeking for problems in living were considered normative; if men sought help less than women, then women were thought to be *over*utilizing services, while men were using services *just the right amount* (Courtenay, 2000). Such interpretations of sex differences in help-seeking behavior served both to position women as weak and hypochondriacal and to construct men as the stronger sex. As Courtenay (2000) points out, these beliefs were maintained in spite of strong evidence that men need more help than they receive.

Despite consistent documentation that men seek help less often than do women, little of the research conducted to date is capable of explaining why this is so. Consequently, there is currently a dearth of interventions, empirically supported or otherwise, for facilitating men's help-seeking behavior. In an effort to develop a framework for understanding men's help seeking that is well grounded in existing theory and research, Addis and Mahalik (2003) integrated work from masculine gender socialization, social constructionist, and social psychological perspectives. For the remainder of the current paper, we consider some of the clinical implications of Addis and Mahalik's framework. We use case examples to illustrate how each perspective can illuminate different aspects of the psychology of men's help seeking. Our hope is that a deeper understanding of men's experience with help seeking will assist health care professionals and other help providers working with men.

MASCULINE GENDER SOCIALIZATION

Gender-role socialization theories hold that social environments, from the level of culture down to individual family and peer relationships, teach men and women to display distinct sex-typed behaviors and attitudes. Joseph Pleck (1981, 1995), one of the pioneers of masculine gender socialization theory, asserts that this teaching is accomplished through the adoption of norms and stereotypes. Norms are prescriptions for how men and women should behave, while stereotypes are generalizations about what men and women are like (Pleck, 1981, 1995). For example, the idea that men *should* be self-reliant is a norm, while the belief that almost all men *are* competitive is a stereotype. We examine two popular areas of focus in masculine gender socialization theories: masculinity ideologies and gender-role conflict (Good, Borst, & Wallace, 1994).

MASCULINITY IDEOLOGIES

> *C. is a 52-year-old plumber. His father died of a heart attack three years ago, and he lost his mother to cancer four months ago. For the last six weeks, C. has felt irritable and gloomy, his energy level has been lower than usual, he has had trouble getting out of bed in the morning, and has been late for work several times as a result. In addition, he has not taken pleasure in things he usually enjoys. His 24-year-old daughter encourages him to see a doctor or therapist about what she believes might be depression, but C. refuses. When his daughter presses him on this, he explains that depression is a disease of the weak, that he needs to be strong, that he should "be a man" and handle this on his own, and that his friends would think less of him for needing to see a therapist. C. resolves to "beat this thing" on his own and refuses to seek professional help for his depression.*

Masculinity ideologies are ideas and concepts that individual men hold about what it means to be a man. The study of masculinity ideologies is concerned with the extent to which men endorse ideologies that emphasize self-reliance, competitiveness, emotional control, power over others, and aggression (Pleck, Sonenstein, & Ku, 1993). For example, a man might believe that men should keep their emotions under control, and that by extension, they should not be emotional when under stress. Alternatively, endorsement of masculine ideologies might involve a man's devotion to self-reliance in the face of hardship, a belief that competition in professional and social domains is crucial for success, a strong preference for resolving conflicts with aggression so as not to appear "girlish," or a desire to demonstrate dominance and power over others in social interactions. Masculinity ideologies can vary between persons and groups and over time (see Kimmel, 1996). However, some masculinity ideologies are thought to be more prevalent than others. In particular, ideologies stemming from White, middle-class, Protestant, and heterosexual subcultures are thought to be most dominant in U.S. culture and are typically referred to as

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traditional masculinity ideologies (Mahalik et al., 2003; Pleck, Sonenstein, & Ku, 1993). In addition, marginalized men are both more likely to subscribe to some traditional masculinity ideologies and to lack access to health services (Courtenay, 2000). Subscription to traditional masculinity ideologies thus adds an ideological barrier to the material barriers marginalized men face in procuring health care services.

While masculinity ideologies contribute to barriers to help seeking, it is important to note that masculinity ideologies may shift depending on the context in which a man finds himself. For example, a man's belief that men should be "sturdy oaks" in a production-oriented work environment may inform his tendency to attempt to control his emotions at work. However, the same man may believe that emotions should be dealt with openly and tenderly within his marriage as that context values intimacy (Addis & Mahalik, 2003). At the same time, subscription to traditional masculinity ideologies may influence men's help-seeking patterns. For example, men with traditional masculinity ideologies may deny or refuse to seek help for pain, illness, or emotional problems in an effort to avoid being perceived as vulnerable or weak (Kaufman, 1994; Mahalik et al., 2003). Thus, adherence to traditional masculinity ideologies may be hazardous to men's mental and physical health. Indeed, endorsement of traditional masculinity ideologies has been correlated with school difficulties, trouble with the law, delinquent activity, alcohol and drug abuse, tobacco use, and violence and sexual aggression (Mahalik et al., 2003; Pleck, Sonenstein, & Ku, 1993).

While masculinity ideologies may prevent men from seeking help, they may also influence men who do choose to seek help. For instance, masculinity ideologies might be invoked in statements like "I should be able to handle this on my own" or "I'd hate for the guys at work/school/on the team to find out I was here." Alternatively, a reticence about feelings or emotionally laden material may be indicative of a masculinity ideology valorizing emotional control.

As the case example above illustrates, masculinity ideologies can be involved in men's decisions about whether or not to seek help for a problem. Within the realm of clinical practice, practitioners might apply knowledge about masculinity ideologies by attempting to gradually shift men's beliefs about what it means to be a man from a preoccupation with stoicism, competition, and aggression to a more flexible outlook in which vulnerability and pain are accepted (Pleck, Sonenstein, & Ku, 1993; Thompson & Pleck, 1986). Of course, effecting significant change in a man's masculinity ideology is probably beyond the scope of much health care practice (e.g., primary care). However, awareness of the presence of masculinity ideologies may lead to subtle positive shifts in provider-patient interactions (Courtenay, 2001). Consider a primary care physician prescribing medication for depression to a man who believes that men should not succumb to emotional problems. If the physician is aware of such an ideology operating, he or she might say, "I've heard a lot of men say that they should be able to handle feeling down or blue on their own. Is that something you've thought about? I think men often forget that one out of five people will experience depression in their lifetime. Many of them are men. Did you know that?" (Courtenay, 2001).

Gender-Role Conflict

> *B. is a 24-year-old investment banker employed at a prominent company. His employer places a high premium on working long hours and on being available whenever he is needed as crises emerge. B. rarely finds time to spend with his girlfriend and sees his family only on major holidays, and even then, he spends only a few hours with them before retreating to do work. He has begun to show some early signs of type-1 diabetes, such as frequent urination, extreme thirst, and feeling as though he doesn't have the same energy level he usually does. B. does not mention his symptoms or the change in his energy level to his coworkers because it is important to him that he appear strong. He fears that if he takes even a couple of hours off to go to a doctor's appointment, his absence would be conspicuous to his coworkers, and he might appear to lack the necessary commitment to excel at his job. B. therefore confides his symptoms only to his girlfriend and family members, but tries to "tough it out" by continuing to work long hours. When his girlfriend asks him if he is scared about his health and wants to talk, B. has trouble even identifying what his feelings are, and their conversation is strained and awkward. He tells her that he doesn't like talking about feelings. His symptoms persist for a couple of weeks, and after several days of vomiting surreptitiously at work, his girlfriend convinces him to go to the emergency room. Once there, he is admitted and diagnosed with type-1 diabetes and diabetic ketoacidosis, a life-threatening condition, which might have been avoided with earlier diagnosis.*

Built on the premise that adhering to particular culturally prescribed masculine gender roles has negative consequences for men, gender-role conflict theory describes the cognitive, affective, and behavioral consequences of masculine gender socialization (O'Neil, Helms, Gable, David, & Wrightsman, 1986). Thus, gender-role conflict overlaps with theory about masculinity ideologies in that both assume masculine gender socialization has negative consequences for men. They differ in that masculinity ideologies are thoughts and ideas about what it means to be a man, whereas gender-role conflict specifies men's experience of masculine gender socialization. Four specific patterns of gender-role conflict have been identified. First, preoccupation with success, power, and competition refers to the extent to which men feel obliged to compete with others in order to acquire interpersonal, financial, or sexual power and to be considered successful at whatever they are doing. Second, restrictive emotionality involves the tendency to avoid emotional expression and to appear strong and stoic in the face of emotionally trying situations. Third, restrictive affectionate behavior between men refers to the extent to which men feel threatened or uncomfortable with the display of loving or erotic behavior between men. Finally, conflict between work and family refers to the extent to which men feel tension about needing to spend time at work at the expense of spending time with family and loved ones.

Gender-role conflict has been found to be negatively correlated with self-esteem, intimacy, and marital satisfaction and positively correlated with anxiety (O'Neil, Good, & Holmes, 1995). In addition, research has shown that men who experience higher levels of gender-role conflict also endorse more negative attitudes toward help seeking (Blazina & Marks, 2001; Blazina & Watkins, 1996; Good, Dell, & Mintz, 1989; Wisch, Mahalik, Hayes, & Nutt, 1995). In particular, Good, Dell, and Mintz (1989) found that high levels of preoccupation with success, power, and competition are related to depression, while high levels of restrictive emotionality are related to negative attitudes toward help seeking. These researchers hypothesize that gender-role conflict creates a "double jeopardy" for men; it both increases their chances of becoming depressed and decreases their likelihood of seeking help (Good & Wood, 1995). In addition, research indicates that men with high levels of gender-role conflict are less attracted to traditional feeling-oriented psychotherapy and more attracted to strategic problem-solving therapies (Robertson & Fitzgerald, 1992; Wisch et al., 1995). Similarly, men with high levels of gender-role conflict are particularly repelled by the idea of participating in men's counseling groups (Blazina & Marks, 2001).

In the case example above, B.'s situation can be seen as an example of the way gender-role conflict can affect some men's responses to health problems. The preoccupation with competitiveness is evident in B.'s hesitancy to take time off from work to attend to his health and in his concern that any absence from work would be received negatively by his coworkers and supervisors. In addition, B.'s experience of restrictive emotionality is illustrated by his difficulty in talking about his emotions. B.'s experience of gender-role conflict seems to have been a barrier to his ability to seek help, which in turn allowed his condition to worsen.

SOCIAL CONSTRUCTIONIST THEORY AND MEN'S HELP SEEKING

> *R. is a 22-year-old Portuguese construction worker who lives with his mother. Almost all of his coworkers are White, and they often call him a mama's boy because of his living situation and his close relationship with his mother. Three weeks ago, R. was on the job repairing a fire escape when he fell two stories and sprained his ankle. The pain was intense, but R. knew that if he complained or asked for time off, his coworkers would view him as weak and continue to taunt him. R. wanted to shed his image as the hen-pecked son and wanted instead to be perceived as a strong man who can "look pain the eye and not blink." As a result, he returned to work and insisted that he did not need time off or medical care.*

Social constructionist theory holds that gender is actively created in social interactions and that the way gender is created depends on what is at stake in particular interactions. Furthermore, what is at stake in an interaction is informed by social structures such as race, class, ethnicity, and sexual orientation. For example, Pyke (1996) explored how social class affects displays of masculinity. She found that among upper middle-class couples, men demonstrated masculinity by working long

hours and by asserting that their career was more important than their spouse's career, which allowed them to take on very little domestic responsibility. By contrast, in working-class couples, men demonstrated masculinity by articulating a more blatant form of patriarchal ideology (e.g., "it's natural for women to be subservient to men") but ended up sharing more domestic responsibility with their wives (Pyke, 1996).

One of the key tenets of social constructionist theory is that gender should not be understood as a trait or personal characteristic, but rather as something that is *done* (West & Zimmerman, 1991). The task or goal of enacting gender, as understood by social constructionist theorists, is to mark oneself as a boy/man or girl/woman in specific situations. According to West and Zimmerman (1991), a person's competence in society rests on his or her ability to demonstrate gender. Because what is at stake in marking oneself as a man or woman, boy or girl, varies from situation to situation, the way in which one behaves or demonstrates gender is also situationally dependent.

With regard to help seeking for a physical or mental health problem, men may deny pain or discomfort in an effort to minimize the problem. Such behavior allows men both to preserve social status in individual social interactions and to maintain gender stereotypes in which men are considered strong, and women weak (Kaufman, 1994). Thus, denying pain and distress can be a way of enacting masculinity. Alternatively, men can steer conversations and interactions in ways that allow them to demonstrate masculinity. For example, in an interaction between two heterosexual college men, one man might attempt to mark his masculinity by talking about his most recent date or by steering the conversation away from emotionally laden subjects that might entail a display of "soft emotions" such as pain, loss, or sorrow. With regard to help seeking, one's desire to be perceived as a man and the way one chooses to mark oneself as a man within a particular context may influence whether a person seeks help.

R.'s demonstration of masculinity in the case example above is apparent in his attempt to change his image from that of an overly dependent son to a stoic worker by ignoring the pain from his injury. Already marginalized from his peers because of his Portugese ethnicity, R.'s denial of the severity of his injury is intended to signal to his coworkers that he is like them and that he is not feminine, particularly in the sense that he can handle pain "like a man."

SOCIAL PSYCHOLOGICAL THEORY AND HELP SEEKING

Social psychology explores common factors that influence why people behave the way they do in social interactions. Addis and Mahalik (2003) identified several social psychological factors that have been shown to be related to help-seeking attitudes and behavior and may be particularly salient for men in varying situations. We consider five social psychological concepts and devote particular attention to the ways each may influence men's help seeking.

larly, for a man who sees virility as central to his self-concept, a problem such as erectile dysfunction might be highly ego-central. When people have problems that are considered to be highly ego-centric, they are less likely to seek help than when they have problems that are not considered ego-central (Nadler, 1990; Wills & DePaulo, 1991). Ego-centrality is not entirely individual; what particular men consider to be ego-central (e.g., the ability to be emotionally cool under pressure, the ability to solve problems on one's own) is informed by societal norms. In the case example above, J. is resistant to seeking help because he values the ability to modulate emotions and sees his Post Traumatic Stress Disorder (PTSD) symptoms as failure to do this.

[margin note: ego-central not -centric?]

CONFORMITY:
How Do the Characteristics of Groups Affect Help Seeking?

> *B. is a 19-year-old college student at a state university. He belongs to a fraternity, and he spends almost all of the time that he is not working or in class at the fraternity house. He has recently started to realize that he has sexual feelings for other men. His fraternity brothers regularly make fun of gay men and use the words "faggot" and "queer" as insults. B. does not know many people outside of his fraternity and holds his fraternity brothers in extremely high regard. He recently saw an announcement for a discussion group about coming out, but when the day of the meeting arrives, he decides not to go because he does not want to risk rejection by his fraternity brothers. Instead, he tries to repress his sexual feelings and begins to fear them.*

Conformity to a group norm is a powerful predictor of behavior (Asch, 1955). In the context of help seeking, men may be disinclined to seek help if they believe they will be stigmatized for doing so (Addis & Mahalik, 2003). Four factors can affect the extent to which a man feels compelled to conform to norms that proscribe help seeking (Addis & Mahalik, 2003). First, research on conformity within groups suggests that if a vast majority of a group express one opinion, it is less likely a member of that group will voice a different opinion or take a different course of action (Gorenflow & Crano, 1989). By extension, if the vast majority of people in a man's life are opposed to men seeking help, it is less likely that the man will seek help when he needs it. Second, if the group influencing a man's choice to seek help is large, the group's opinion will wield more power than if the group consisted of only two or three people (Gerard, Wilhelmy, & Conolley, 1968). Third, if a person considers him or herself to be very much like the members of a group to which he or she belongs, then the group's opinion is more likely to influence the individual's opinion (Morris & Miller, 1975). If, however, a person considers him or herself to be different from the group, it will be easier to disregard the group's opinion. Finally, if a group is of paramount importance to an individual, it is likely to wield a great deal of power over the person's decisions (Morris & Miller, 1975). By contrast, if a group is of more peripheral importance to a person, it is less likely to influence the decision to

seek help for a problem. Thus, if a man greatly admires the people in his life who discourage or speak badly of seeking help, he will be less likely to seek help himself. In the case above, B. would be more likely to seek help if his fraternity members were not uniformly condemning of homosexuality, if the fraternity was smaller, if he *ere?* saw the other members of the group as different from him, or if he did not view the fraternity as important.

REACTANCE:
WILL I BE ABLE TO RETAIN CONTROL OVER MY OWN DECISIONS?

T. is a 72-year-old White man who has recently been diagnosed with high cholesterol. His doctor has advised him to reduce his fat intake by drinking skim milk, drastically reducing the quantity of butter, sour cream, and salad dressing that he uses, and avoiding fried foods. T. likes to be in charge of his own decisions and does not like being told what to do. He feels anxious and out of control, and in an effort to regain a sense of control, he decides to ignore medical advice and "eat what he wants, when he wants." When his wife chides him about this, his autonomy feels even more threatened, so he strengthens his resolve to "live life his own way" and ignore medical advice.

Reactance theory suggests that when people perceive that their autonomy or self-control has been threatened, they will take steps to restore it (Brehm, 1966). The construct of reactance has many implications for help seeking. For example, an invasive physical exam, like a colonoscopy, could be perceived as a threat to a patient's autonomy. Alternatively, having to answer probing questions set forth by a health-care provider or therapist can be perceived as a threat to autonomy. Similarly, requests for behavior changes, such as changes in diet or exercise, may be received as threatening one's autonomy. Reactance can also result from well-intended suggestions to seek help by significant others. In this context, to comply with such a request might be perceived as surrendering control. As a result, the more a significant other encourages a man to seek help, the less inclined he may be to do so. While this may at first seem paradoxical, it makes sense when viewed from a gender socialization paradigm; strong encouragements to seek help or probing questions about a problem might be perceived as threats to self-reliance and self-determination. In the case example above, T. experiences reactance in response to both in doctor's advice and *'his.' not* his wife's requests that he follow his doctor's orders. His efforts to regain autonomy *'in'?* seem to lead him further away from getting needed help and practicing health-promoting behaviors.

RECIPROCITY:
WILL I HAVE A CHANCE TO RETURN THE FAVOR?

C. is a 60-year-old man in early sobriety from alcohol dependence. His family took him to detox, and he has returned home.

Two days after his return home, a friend convinces him to attend an AA meeting. C. is surprised to learn that he can relate to many of the people at the meeting and that many people have struggled with the same issues he is struggling with. C. attends the meeting for a few weeks, and one week a man from the meeting approaches C. to ask him if he would like a sponsor. The man explains that a sponsor is someone to check in with weekly about sobriety and to call in moments of crisis. C. is hesitant at first, but when his prospective sponsor explains that after a year or so, C. will have the chance to serve as a sponsor himself, C. feels much more comfortable accepting the offer. C. accepts the offer and tells his new sponsor that he is glad that he will someday have the chance to "balance the scales."

Reciprocity refers to the idea that help seeking is more likely to occur when there is an opportunity to provide help of some kind in return for help received. Reciprocity allows men to maintain status within an interaction or relationship by avoiding being in a "one-down" position. Put another way, reciprocity allows men to avoid literal or figurative indebtedness for having received help in the past. Seeking help from professionals typically does not involve reciprocity; when one visits a doctor or psychotherapist, there is no opportunity to help the helper. At the same time, seeking help typically involves vulnerability, relinquishing control, expressing feelings, and admitting ignorance, all of which are in opposition to traditional masculinity norms (Brooks, 1998). The fact that there are practically no opportunities for reciprocal vulnerability in most professional help-seeking situations may make it more difficult for men to seek help when they need it. Interestingly, many men are active members of Alcoholics Anonymous (AA), a self-help group in which reciprocity is built into the program of recovery from alcohol abuse. In the case example above, C. was able to receive help from his AA meeting because he knew that he would be able to return the help in the future.

HELPING MEN SEEK HELP

Social psychological, gender socialization, and social constructionist perspectives all help to explain why men underutilize health services and seek help less often than do women. We now explore how these perspectives can elucidate possible ways to increase the frequency with which men seek help.

INCREASING MEN'S MOTIVATION TO SEEK HELP

As discussed earlier, men need more medical and psychological help than they are currently receiving. Thus, one aim for clinicians should be to boost men's motivation to seek help. One well researched tool for facilitating this is motivational interviewing (Miller & Rollnick 2002). Motivational interviewing is built on Prochaska, Norcross, and Diclemente's (1994) model of the stages of readiness for change. The stages of change model holds that as people prepare for change, they move through

various phases, from pre-contemplation, during which they have not even begun to think about change, to contemplation, where they think about change and weigh their options, to action and maintenance, where they initiate and maintain the change. Movitational interviewing attempts to meet patients at their current level of motivation for change and, through non-judgmental discussion about the advantages and disadvantages of a particular course of action, encourage movement toward change. The most obvious difficulty with using motivational interviewing to encourage men to seek help is that many men do not see doctors or health care providers in the first place. Thus, motivational interviewing would probably be most effective if it were implemented in a variety of settings, for example, as part of an employee workshop or in hospital emergency departments as a means of increasing the likelihood that patients will seek follow-up care.

PSYCHOTHERAPEUTIC WORK

Several emerging lines of work in individual and group psychotherapy (e.g., Andronico, 1996; Brooks, 1998; Mahalik, 1999; O'Neil, 1996) are directed toward helping individual men become more aware of masculine gender socialization. The goal of such therapies is to help men become more flexible in relation to masculinity ideologies so that they have a wider array of coping strategies to choose from as they encounter challenges in their lives. Such efforts to change individual men's orientation toward seeking help for problems in living bear resemblance to the women's consciousness raising groups of the early 1970s. Designed to educate men about the male gender role and the ways that adhering to it can be detrimental, such efforts often take the form of workshops or men's groups. One example of such a group is O'Neil's Gender Role Journey workshop (O'Neil, 1996), in which men explore the ways in which masculine gender socialization has negatively impacted their lives and then help each other to consider alternatives to enacting traditional masculine gender roles. Brooks and Silverstein (1995) suggest such groups might be especially appealing to some men because they do not require men to be in the role of patient, while other research (e.g., Blazina & Marks, 2001) suggests that traditional men tend to be repelled by men's counseling groups. Thus, more research is needed to understand how best to implement therapy aimed at promoting flexibility in how men relate to their masculine gender socialization.

CHANGING THE WAY SERVICES ARE PROVIDED

Another strategy for increasing men's help seeking involves changing the manner in which services are provided for men. This can take many forms. For example, Robertson and Fitzgerald (1992) found that traditional men responded more favorably to goal-directed, problem-focused advertisements for psychotherapy than to more emotion-focused exploratory advertisements.

In a related vein, Courtenay (2001) has proposed a six-point plan to improve the way that medical services are provided to men. Therein, Courtenay argues that clinicians should validate men's efforts to seek help and that they should legitimate men's concerns and normalize their experiences whenever possible. Thus, clinicians

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might make comments such as "a lot of men experience this concern but don't get help for it, which makes the problem worse," "you were right to ask about this," or "many men have that concern." In addition, Courtenay suggests that clinicians provide education to male patients about diseases for which men are at risk, especially sexually transmitted diseases, heart disease, and cancer. He emphasizes the importance of giving advice in a clear and direct manner and encourages clinicians to assess whether their male patients have understood their advice. Courtenay also suggests that because men under-report symptoms, clinicians should assume that symptoms are present and ask for confirmation rather than assume that men will report them. With regard to treatment planning, Courtenay encourages clinicians to work collaboratively with male patients to develop a health maintenance plan that is realistic and takes into account the patient's age, cultural background, literacy, intellectual capacity, and current life circumstances.

A clinician working with a man dealing with sexual dysfunction could apply Courtenay's advice by recognizing that sexual dysfunction is a highly ego-central problem and that many men would be loath to seek help for it. The clinician could begin by routinely asking about symptoms of sexual dysfunction, rather than waiting for the patient to report them. In addition, the clinician might be able to gently acknowledge the difficulty in talking about the problem, but subvert the ego-centrality and orientation toward self-reliance by providing information about the pervasiveness of such problems and the strength required to face them head-on. The clinician could then speak directly about a treatment plan and work with the patient to come to an agreement on what would be most comfortable for the patient.

In summary, all clinicians, both mental health practitioners and medical care providers, should be aware that dominant masculinity ideologies emphasize independence, self-reliance, and emotional stoicism. They should also be aware that the masculine gender role might hinder help seeking by creating a perceived threat to a man's "competitive edge." In addition, health-care providers should be savvy about the ways that masculine gender socialization encourages men to engage in high-risk behaviors (Courtenay, 2001; Pleck, Sonenstein, & Ku, 1993).

CONCLUSION

Despite all that is known about the ways in which masculine gender socialization can negatively impact men's help seeking, men's underutilization of services has only recently come to be perceived as problematic. As a result, few attempts have been made to bolster men's help seeking. Broad-based strategies that take masculinity ideologies and gender-role conflict into account are needed to increase men's help seeking. The best strategies are probably those that integrate masculine gender socialization, social constructionist, and social psychological perspectives on help seeking. Implementing these strategies would require education for health-care providers about masculine gender socialization and education for individual men about the importance of help seeking and the detrimental effects of masculine role socialization. In addition, the culture at large would benefit from interventions aimed at normalizing men's help seeking and expression of "soft" emotions such as pain and fear. If men are to seek help in greater numbers than they currently do, efforts must be

made to improve men's motivation to seek help and to provide services in a way that encourages men to use them. Although we have presented pertinent psychological theories about gender and help seeking and have suggested strategies to bolster men's help seeking, little is known about how well such strategies will actually work. Research must focus on testing interventions designed to increase men's help seeking in order to determine which strategies are most effective and for whom.

REFERENCES

Addis, M.E., & Mahalik, J.R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*(1), 5-14.

Andronico, M.P. (1996). *Men in groups: Insights, interventions, and psychoeducational work.* Washington, DC: American Psychological Association.

Asch, S. (1956). Studies of independence and conformity: A minority of one against a unanimous majority. *Psychological Monographs, 70*(9, Whole No. 416).

Blazina, C., & Marks, L.I. (2001). College men's affective reactions to individual therapy, psychoeducational workshops, and men's support group brochures: The influence of gender-role conflict and power dynamics upon help-seeking attitudes. *Psychotherapy 38*(3), 297-305.

Blazina, C., & Watkins, E. (1996). Masculine gender-role conflict: Effects on college men's psychological well-being, chemical substance use, and attitudes toward help-seeking. *Journal of Counseling Psychology, 43*(4), 461-465.

Brehm, J.W. (1966). *A theory of psychological reactance.* New York: Academic Press.

Brooks, G.R. (1998). *A new psychotherapy for traditional men.* San Fransisco: Jossey-Bass.

Brooks, G.R., & Silverstein, L.B. (1995). Understanding the dark side of masculinity: An interactive systems model. In R. Levant & W.S. Pollack (Eds.), *A new psychology of men* (pp. 280-333). New York: Basic Books.

Cialdini, R.B., & Trost, M.R. (1999). Social influence: Social norms, conformity, and compliance. In D. Gilbert, S Fiske, & G. Lindzy (Eds.), *The handbook of social psychology* (Vol. 2, pp. 151-192). Boston: McGraw-Hill.

Courtenay, W.H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science and Medicine, 50,* 1385-1401.

Courtenay, W.H. (2001). Counseling men in medical settings: The six-point HEALTH plan. In G.R. Brooks & G.E. Good (Eds.), *The new handbook of psychotherapy and counseling with men: A comprehensive guide to settings, problems, and treatment approaches* (pp. 59-91). San Francisco: Jossey-Bass.

Department of Health and Human Services. (1997). Report of final mortality statistics, 1995. *Monthly vital statistics report*, 45(11). Hyattsville, MD: Public Health Service.

Department of Health and Human Services. (1998). *Health, United States, with socioeconomic status and health chartbook.* Hyattsville, MD: National Center for Health Statistics.

Gerard, H.B., Wilhelmy, R.A., & Conolley, E.S. (1968). Conformity and group size. *Journal of Personality and Social Psychology, 8*(1, PT. 1), 79-82.

Good, G.E., Borst, T.S., & Wallace, D.L. (1994). Masculinity research: A review and critique. *Applied and Preventive Psychology, 3,* 3-14.

Good, G.E., Dell, D.M., & Mintz, L.B. (1989). Male role and gender role conflict: Relations to help seeking in men. *Journal of Counseling Psychology, 36,* 295-300.

Good, G.E., & Wood, P.K. (1995). Male gender role conflict, depression and help-seeking: Do college men face double jeopardy? *Journal of Counseling and Development, 74,* 70-75.

Gorenflo, D.W., & Crano, W.D. (1989). Judgmental subjectivity/objectivity and locus of choice in social comparison. *Journal of Personality and Social Psychology, 57,* 605-614.

Husaini, B.A., Moore, S.T., & Cain, V.A. (1994). Psychiatric symptoms and help-seeking behavior among the elderly: An analysis of racial and gender differences. *Journal of Gerontological Social Work, 21,* 177-193.

Kaufman, M. (1994). Men, feminism, and men's contradictory experiences of power. In H. Brod & M. Kaufman (Eds.), *Theorizing masculinities* (pp. 142-163). Thousand Oaks, CA: Sage.

Kessler, R.C., Brown, R.L., & Boman, C.L. (1981). Sex differences in psychiatric help-seeking: Evidence from four large scale surveys. *Journal of Health and Social Behavior, 22,* 49-64.

Kimmel, M. (1996). *Manhood in America: A cultural history.* New York: The Free Press.

Mahalik, J.R. (1999). Interpersonal psychotherapy with men who experience gender role conflict. *Professional Psychology: Research and Practice, 30,* 5-13.

Mahalik, J.R., Locke, B., Ludlow, L., Diemer, M., Scott, R.P.J., Gottfried, M., & Freitas, G. (2003). Development of the Conformity to Masculine Norms Inventory. *Psychology of Men and Masculinity, 4,* 3-25.

McKay, J.R., Rutherford, M.J., Cacciola, J.S., & Kabaskalian-McKay, R. (1996). Gender differences in the relapse experiences of cocaine patients. *Journal of Nervous and Mental Disease, 184*(10), 616-622.

Miller, W.R., & Rollnick, S. (2002). *Motovational interviewing: Preparing people for change.* New York: Guilford Press.

Morris, W.N., & Miller, R.S. (1975). Impressions of dissenters and conformers: An attributional analysis. *Sociometry, 38,* 327-339.

Nadler, A. (1990). Help-seeking behavior as a coping resource. In M. Rosenbaum (Ed.), *Learned resourcefulness: On coping skills, self-control, and adaptive behavior* (pp. 127-162). New York: Springer.

Nadler, A., & Maysless, O. (1983). Recipient self-esteem and reactions to help. In J.D. Fisher, A. Nadler, & B.M. DePaulo (Eds.), *New directions in helping* (Vol. 1, pp. 167-188). New York: Academic Press, Inc.

Neighbors, H.W., & Howard, C.S. (1987). Sex differences in professional help seeking among adult Black Americans. *American Journal of Community Psychology, 15*(4), 403-417.

O'Neil, J.M. (1996). The gender role journey workshop: Exploring sexism and gender role conflict in a coeducational setting. In M.P. Adronico (Ed.), *Men in groups: Insights, interventions, psychoeducational work* (pp. 193-218). Washington, DC: American Psychological Association.

O'Neil, J.M., Good, G.E., & Holmes, S. (1995). Fifteen years of theory and research on men's gender role conflict: New paradigms for empirical research. In R.F. Levant & W.S. Pollack (Eds.), *A new psychology of men* (pp. 164-206). New York: Basic Books.

O'Neil, J.M., Helms, B.J., Gable, R.K., David, L., & Wrightsman, L.S. (1986). The gender role conflict scale: College men's fear of femininity. *Sex Roles, 14*, 335-350.

Padesky, C.A., & Hammen, C.L. (1981). Sex differences in depressive symptom expression and help-seeking among college students. *Sex Roles, 7*, 309-320.

Pleck, J.H. (1981). *The myth of masculinity*. Cambridge, MA: MIT Press.

Pleck, J.H. (1995). The gender role strain paradigm: An update. In R. Levant & W.S. Pollack (Eds.), *A new psychology of men* (pp. 11-32). New York: Basic Books.

Pleck, J.H., Sonenstein, F.L., & Ku, L.C. (1993). Masculinity ideology and its correlates. In S. Oskamp & M. Costanzo (Eds.), *Gender issues in social psychology* (pp. 85-110). Newbury Park, CA: Sage.

Prochaska, J., Norcross, J., & DiClemente, C. (1994). *Changing for good: The revolutionary program that explains the stages of change and teaches you how to free yourself from bad habits*. New York: Morrow.

Pyke, K.D. (1996). Class-based masculinities: The interdependence of gender, class and interpersonal power. *Gender & Society, 10*(5), 527-549.

Robertson, J.M., & Fitzgerald, L.F. (1992). Overcoming the masculine mystique: Preferences for alternative forms of assistance among men who avoid counseling. *Journal of Counseling Psychology, 39*(2), 240-246.

Robins, L.N., & Regier, D. (1991). *Psychiatric disorders in America*. New York: Free Press.

Staples, R. (1995). Health among African American males. In D. Sabo & D.F. Gordo (Eds.), *Men's health and illness: Gender, power, and the body* (pp. 121-138). Thousand Oaks: Sage Publications.

Stillion, J.M. (1995). Premature death among males. In D. Sabo & D.F. Gordon (Eds.), *Men's Health and Illness* (pp. 46-67). Thousand Oaks: Sage Publications.

Thom, B. (1986). Sex differences in help-seeking for alcohol problems: 1. The barriers to help-seeking. *British Journal of Addiction, 81*, 777-788.

Thompson, E.H., & Pleck, J.H. (1986). The structure of male role norms. *American Behavioral Scientist, 29*, 531-543.

Waldron, I. (1995). Contributions of changing gender differences in behavior and social roles to changing differences in mortality. In D. Sabo & D.F. Gordon (Eds.), *Men's Health and Illness* (pp. 68-104). Thousand Oaks: Sage Publications.

Weissman, M.M., & Klerman, G.L. (1977). Sex differences and the epidemiology of depression. *Archives of General Psychiatry, 34*, 98-111.

West, C., & Zimmerman, D.H. (1987). Doing gender. *Gender and Society, 1,* 125-151.

Wills, T.A., & DePaulo, B.M. (1991). Interpersonal analysis of the help-seeking process. In C.R. Snyder & D.R. Forsyth (Eds.), *Handbook of social and clinical psychology* (pp. 350-375). Elmsford, NY: Pergamon.

Wisch, A., Mahalik, J.R., Hayes, J.A., & Nutt, L. (1995). The impact of gender role conflict and counseling technique on psychological help seeking in men. *Sex Roles, 33,* 77-89.