

Examining men's disclosures, influences, and motivations for seeking therapy

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AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

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Abstract

Numerous studies note that women are more likely than men to seek out therapy. It is suggested that the differences in mental health utilization rates between genders are a function of gender socialization towards general help-seeking behaviors as well as about attitudes towards mental health. Central to understanding men's mental health help-seeking behavior are factors of stigma, social support, motivations for therapy, and basic psychological needs. This study examined the relationship of these factors on men's mental health-seeking behaviors by utilizing the frameworks of social influence theory and self-determination theory. A total of 317 adult males residing within the United States responded to items relating to disclosure, social influence, and motivations for therapy. Men also read and responded to a series of short stories and measures about disclosure, influence, and seeking therapy. A latent profile analysis was first conducted to determine the distinct number of profiles of men on the observed variables of stigma, social support, motivations for therapy, and basic psychological needs. From the latent profile analysis, a total of four distinct profiles emerged: Reluctant, Open, Restrictive, and Considering. Analyses were then conducted to determine the differences between these profiles on psychological openness, intentions to seek therapy, self-compassion, shame, and adherence to traditional masculine norms. The differences between these profiles were also examined using a multinomial logistic regression relating to men's disclosure to seek therapy and the influence of a partner, parent, close friend, religious or spiritual leader, and medical doctor to seek therapy. A final multinomial logistic regression was conducted to analyze the differences amongst these profiles on their reported importance to seek therapy for depression and anxiety, substance use, and suicidality. These findings demonstrate important implications for those working with men in therapy, for public education efforts surrounding men's mental health, and for those in

relationships to men who are experiencing a mental health-related issue. Specifically, recognizing the heterogeneity of men's help-seeking behavior on stigma, social support, motivations for therapy, and basic psychological needs can allow therapists to better work with men in therapy in addition to increasing the knowledge of men's mental health issues to those in relationships with men.

Keywords: help-seeking behavior, men, mental health stigma, self-determination theory, social influence theory, therapy

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Dedications

Several years ago, I stumbled upon an op-ed in a major newspaper that described the complexity and beauty of putting on a theater performance. The author, whose name has escaped me, was essentially making the point that while an audience member sees a handful of people on stage, they should also consider those behind the scenes who have worked countless hours to make the production possible, all of whom the audience member would likely never see or recognize. In that same vein, this dissertation is much of that same idea. While I may be the “actor” on the stage, there are a handful of people whose work over time behind the scenes has contributed to this moment, and as a result, this dissertation is dedicated to them.

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Chapter 1 - Introduction

Previous studies have found that men are less likely than women to seek mental health therapy (Voelker, 2015) although men are as likely as women to suffer from mental health problems. Prior studies have also found that compared to women, men have higher usage of substances (Substance Abuse and Mental Health Services Administration, 2014) and rates of completed suicides (Hedegaard, Curtin, & Warner, 2018). Although women are cited as having higher rates of depression than men (Nolen-Hoeksema, 2001), this does not account for men's underreporting and misdiagnoses due to gendered manifestation of depressive symptoms (Addis, 2008).

Although there appears to be greater acceptance of mental health therapy (e.g., Angermeyer, Matschinger, & Schomerus, 2013), there are still significant barriers to therapy due in part to stigma or negative attitudes and misinformation about mental health (Overton & Medina, 2008) and help-seeking behavior (Mackenzie, Erickson, Deane, & Wright, 2014). The decision to seek therapy is further influenced by whom one confides in when considering therapy (Bos, Kanner, Muris, Janssen, & Meyer, 2009), who can influence the decision to seek therapy (Hampton-Robb, Qualls, & Compton, 2003), and one's motivations for seeking therapy and change (Sheldon, Williams, & Joiner, 2003). When the stigma about mental health lessens, the likelihood of disclosing about one's mental health problems to friends and family increases (Mackenzie, Gekoski, & Knox, 2006). Social networks can inform the decision to seek therapy such that the prompting of a close relationship or knowing someone who had previously sought therapy are both strong predictors of future help-seeking behavior (Vogel et al., 2007).

Germane to understanding men's therapy seeking behavior is their socialization to masculinity, specifically concerning early messages about masculine norms, attitudes, and

behaviors. These messages tend to emphasize attitudes and behaviors of self-reliance, which in turn decreases their proclivity and proficiency of engaging in positive help-seeking behaviors (Englar-Carlson, 2006; Wexler, 2009). In contrast to women, men are more likely to indicate not needing emotional or instrumental support despite evidence suggesting that men's mental health symptoms tend to decrease as they receive emotional support from both family and non-kin relationships (Fiori & Denckla, 2012).

When considering how or when men decide to engage in therapy, it is also important to ascertain their motivation(s) for seeking help. According to Deci and Ryan (2000), individuals strive to augment their well-being through the domains of basic psychological needs (i.e., autonomy, relatedness, and competence), which are then guided by different types of motivations – external (e.g., family-of-origin), identified (e.g., the desire for autonomy and competence), and introjected (e.g., contingent self-worth). Together, motivations and basic psychological needs can inform the process of the disclosure, influence, and decision to seek therapy (Deci & Ryan, 2000; Wilson, Rickwood, Bushnell, Caputi, & Thomas, 2011). For example, shame, an element of introjected motivation, may emerge for men as they perceive themselves incapable of or failing to live up to masculine standards, which may then deter them from seeking therapy (McKenzie et al., 2018). However, men who experience introjected motivations who also have their basic psychological needs of autonomy, competence, and relatedness met may be more open to the influence others and demonstrate the ability to explore various options for their mental health-related issues (Di Domenico, Le, Liu, Ayaz, & Fournier, 2016; Kashdan & Rottenberg, 2010).

To better understand what motivates or inhibits men from seeking therapy is to understand how the combination of social influences and motivations may advance or inhibit the

process of help-seeking behaviors. Utilizing the theoretical frameworks of social influence and self-determination, this study attempts to examine the different profiles of men's mental health seeking behaviors as it relates to their stigma about mental health, social support, motivations for therapy, and basic psychological needs, and how those profiles then inform aspects of disclosure, influence, and importance of seeking therapy.

Chapter 2 - Literature Review

Self-Determination Theory

Self-Determination Theory (SDT) (Deci & Ryan, 1985, 2000, 2008; Ryan & Deci, 2000, 2017) presumes that people are naturally wired to actively seek growth and evolve as they strive to master challenges. To facilitate individual growth, new experiences primarily serve as a means of forming a more defined sense of self. This process of becoming is dependent in large part upon the social support and nurturance received from interpersonal relationships as well as feeling having violation in one's life. SDT hypothesizes that when experiences of autonomy, competence, and relatedness, which comprise an individual's basic psychological needs, are fostered, people function more effectively and experience overall greater well-being (Ryan & Deci, 2017). However, when these needs are thwarted, people experience poorer quality relationships, decreased well-being, and are at risk for greater mental health symptoms (Ryan & Deci, 2017). Autonomy refers to engaging purposefully and volitionally in actions that are congruent with one's current and future self. Competence refers to being effective or having mastered managing one's life within various environments. Relatedness refers to having mutually meaningful interpersonal relationships that are caring and supportive. When an individual's basic psychological needs are being met or satisfied, they feel motivated to persist and perform at their most optimum level, which then inspires resourcefulness and better relationships.

Motivations can be understood on a continuum from intrinsic to extrinsic, and as a combination of internal processes and external behaviors that guide the process of working towards autonomy, competence, and relatedness (Ryan & Deci, 2000). Motivations have everything to do with the "why" behind behavior. Broadly, motivations can be categorized as

autonomous (e.g., self-motivation or intrinsic motivation) or controlled (e.g., external motivation or contingent motivation). The study of motivations has previously been applied to therapy, such that distinctions can be made between *external* (i.e., deriving from an outside entity) or internal (i.e., intrapersonal) motivations for seeking treatment. There also exists variations of internal motivations such as *introjected*, which are internal conflicts of guilt, shame, or anxiety that influence behavior, and *identified*, which is the personal choice to enter into therapy for more intrinsic or value-based reasons (Ryan & Deci, 2000; Urbanoski & Wild, 2012; Wild, Cunningham, & Ryan, 2006). Past research has proven that for substance abuse treatment, an individual's motivations for therapy had important implications for therapy outcomes such that external and introjected motivations were both positively associated with the social pressure to seek help and to quit or taper off substance use (Wild et al., 2006). Wild and colleagues (2006) also found that identified motivations were positively correlated with self-referral, reflecting both autonomy and competence, and negatively associated with coercion to seek therapy.

Motivations have implications for health, close relationships, and well-being (Deci & Ryan, 2008), and are directly linked to help-seeking behaviors. In an experimental study for depression, autonomous motivations for therapy were a better and greater predictor of therapy success than therapeutic alliance (Zuroff et al., 2007). However, in a sample of emerging adults, a greater need for autonomy (i.e., the motivation to work on one's own problems), resulted in reduced intention to seek help from an intimate partner, friend, family, and mental health professional as well as reduced intentions to seek help from anyone for mental health-related concerns (Wilson, Rickwood, Bushnell, Caputi, & Thomas, 2011).

While one's social support network may be a substitute for therapy, in cases of severe mental health-related issues, social networks can motivate and serve as a mechanism to get

people to seek therapy either voluntarily, through pressure, or a combination of both (Thotis, 2011). The literature suggests that men are often coerced into therapy rather than of their own volition, and that such coercion can affect their progress in therapy (Englar-Carlson, 2006; Scher, 1990). For example, when men feel they lack autonomy over their choice to enter into therapy, lack the perceived skills and abilities (i.e., competence) to achieve their goals in therapy or support (i.e., relatedness) to work through their mental health issues, it is possible that they would, in turn, be more inclined to be introjected (shamed) or externally motivated to seek therapy. In particular, external motivation highlights the role of social influence theory, specifically how compliance, identification, and internalization may begin to emerge as a man is coerced or nudged to seek therapy and their subsequent rationales for seeking treatment. As a result, to understand the decision-making process of men's help-seeking, it is essential to understand the relationship among motivations for seeking therapy as well as an individual's striving for autonomy, competence, and relatedness (Pollack, 1990; Ryan, Patrick, Deci, & Williams, 2008). Thus, knowing how men's help-seeking process informs what motivates them to seek therapy can provide new knowledge about how to augment the likelihood that men receive the therapy they need.

Men and the Socialization to Help-Seeking Behaviors

Mahalik, Good, and Englar-Carlson (2003) indicate that as men are socialized to behave and think in certain manners (i.e., traditional masculine norms), they begin to follow scripts that have implications for help-seeking behaviors. Some of these scripts include the 'Strong-and-Silent,' 'Tough-Guy,' 'Winner,' and 'Independent,' all of which have implications for how men view help-seeking, how others may experience them in the help-seeking process, and their potential motivations for engaging in therapy. Additionally, adherence to masculine norms about

help-seeking may constrain a man's ability to effectively utilize coping skills necessary for mental health-related issues (Iwamoto, Liao, & Liu, 2010). However, self-compassion has been found to moderate the relationship between adherence to traditional masculine norms and seeking help (Heath, Brenner, Vogel, Lannin, & Strass, 2017), while also contributing to lower levels of both masculine norm adherence and shame (Reilly, Rochlen, & Awad, 2014).

Addis and colleagues (2010) suggest that broad socio-cultural messages exert an influence on how men view help-seeking and mental health. Vogel and Wester (2003) highlight that an individual's views and attitudes of mental health and mental help-seeking are shaped in part through socialization and social influence. For men, it may more likely be the case that early socio-cultural messages about masculinity and help-seeking behavior have been the strongest, though less acknowledged, of the influences (Bergman, 1995). As men adopt or conform to masculine norms, specifically those of self-reliance, in a rigid manner, they are less likely to utilize mental health services and are at higher risk for mental illness (Wong, Ho, Wang, & Miller, 2017). In one analysis, a greater endorsement of traditional masculinity, specifically those of restrictive emotionality and restrictive affectionate behavior between men, resulted in greater stigma surrounding therapy and a lower likelihood of endorsing that close friends and family members should seek out therapy (Vogel, Wester, Hammer, & Downing-Matibag, 2014).

A more thorough understanding of the variations of men's help-seeking behavior though reveals more nuance as a result of the development and enactment of norms around seeking help that have formed over time. For example, men's aversion to help-seeking and negative attitudes towards therapy may be influenced more by a fear of or unfamiliarity with therapy (Millar, 2003), wanting to maintain a particular image or notion of being a man (Komiya, Good, & Sherrod, 2000), or experiencing pressure to embrace perspectives outside their current

worldview such as being more emotionally expressive or receiving help for mental health-related issues (Englar-Carlson, 2006). These factors have also been corroborated in previous research, such that those with a greater fear of interpersonal intimacy and discomfort being emotionally vulnerable with others are more prone to believe there are fewer benefits and more significant risks of seeking therapy as well as more negative attitudes towards seeking therapy (Shaffer, Vogel, & Wei, 2006).

In a meta-analysis of men's help-seeking in the context of depression, adherence to masculine norms was found to affect the help-seeking process negatively, and men were only willing to engage in therapy after having exhausted other forms of problem-solving or if the depressive symptoms had become too much to manage (Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016). Another meta-analysis uncovered that aspects of guarded vulnerability, a need for independence and control, and embarrassment were all factors in men's rationales for not seeking therapy (Doherty & Kartaloya-O'Doherty, 2010; Yousaf, Grunfeld, & Hunter, 2015). In addition to these factors, Yousaf and colleagues (2015) also noted that men tended to view most physical- and mental health-related symptoms as minor, and instead as something that could be self-managed unless symptoms progressively increased.

Social Influence Theory

Social influence theory (SIT) provides a framework for understanding how attitude and behavior change may occur through the influence of others (Kelman, 1958). The central tenet of SIT is that an individual's attitudes, beliefs, and behaviors can be persuaded by others, or what Kelman deems as an "influencing agent" (p. 54) through processes of compliance, identification, and internalization. Compliance is a means of accepting influence to gain something else in return, whether that gain is tangible (e.g., a promotion, item, or reward) or intangible (e.g.,

esteem, approval, or respect) in addition to avoiding potential negative consequences (e.g., loss of job, status, or relationship). In compliance, an individual might not believe in what they are doing; however, they see it as a means of “keeping the peace” or a necessary salve to maintain the current status quo. Identification can be thought of as a “means to an end.” Specifically, Kelman (1958) notes that in identification, the content or idea is more or less irrelevant, and instead it is a desire to create or maintain a particular relationship, thus resulting in conformity. Contrarily, the idea of internalization of social influence is a function of an individual genuinely believing the attitude or behavior to be essential and is accordingly internalized to the point where the individual notes an intrinsic motivation to change moving forward.

The aspect of power is another critical factor within SIT, such that the perceived or legitimate power constituting the social influence dictates the rationale of an individual’s choice. Kelman (1958) suggests that an influencing agent may utilize means control, which would result in compliance, attractiveness, which would take shape through identification, or credibility, which would manifest in an individual’s internalization. For example, in cases of men’s help-seeking behavior, if a man places a high value on his relationship with his romantic partner, it is likely that his romantic partner will be a more salient influence on his help-seeking behavior than a parent or close friend that may be important, but of less significance than a romantic partner.

Men in committed relationships are more likely to seek out therapy than men who are not in relationships (Blumberg et al., 2014). Others that have been found to influence men to seek therapy include close friends, parents, and medical doctors (Cusack, Deane, Wilson, & Ciarrochi, 2004), while in other instances the African American community has been shown to not only have a strong family influence but also be open to the influence of religious or spiritual leaders (Allen, Davey, & Davey, 2010). Additionally, social relationships can inform an individual’s

attitude and behavior towards mental health through providing support and care, and by providing access to resources and aid (Berkman, Glass, Brissette, & Seeman, 2000).

Social influence and men's help-seeking. Despite the factors that stem from internalized notions of masculinity promoting self-reliance, men nonetheless are influenced by interpersonal relationships (e.g., partner, spouse, parents, close friend) or systems that in some ways govern their day-to-day functions (e.g., work, legal, religious,). A key component of social influence is not only when someone may be prompted to seek therapy, but also if that person has previously known someone who has sought therapy (Vogel et al., 2007). Angermeyer and Matschinger (1999) note that

...attitudes and belief systems prevalent in society have a major impact on help-seeking behaviour, both as transmitted via social networks to the person suffering from mental distress and as reflected in the person's own attitudes, which were formed via socialization (p. 208-209).

For men, their partners play an essential role in their engagement in health-related activities, such that married and cohabitating men are more likely to utilize preventative care measures than men not in romantic relationships (Blumberg, Vahratian, & Blumberg, 2014). Men have also noted that encouragement by someone of the opposite and same sex would increase their likelihood of visiting their primary care physician, though the encouragement of someone of the opposite sex is more effective (Harding & Fox, 2015; Norcross, Ramirez, & Palinkas, 1996). Cusack and colleagues (2004) found that of the men in their study, the majority indicated having been influenced by multiple individuals to seek therapy, with the most prominent influences being an intimate partner and a general physician. Further, a large portion of men indicated that without the prompting of another person they likely would not have sought

therapy. However, upon closer examination, it was not evident the level of importance of these various relationships to men, and how a varying level of importance may have affected the respective relationship's level of influence to seek therapy.

Social influence also plays a role in the aspect of disclosure to seek therapy. A study of Australians found that greater likelihood of disclosure of mental health problems was associated with having previously received some form of therapy and support from family and friends (Reavley, Morgan, & Jorm, 2018). Prior research on the aspect of disclosure to others of a mental health-related illness notes that selective disclosure is a common practice (Pahwa, Fulginiti, Brekke, & Rice, 2017). This is when a select few, mostly family members and friends, are chosen based on with whom one feels comfortable in discussing their mental health issues. Pahwa and colleagues (2017) also note that an individual's social support network plays a vital role in their consideration to disclose their mental health-related concern and that in general, men are less likely than women to engage in the disclosure of their mental illness. Another study examining gender differences in disclosure and mental illness found that men high in attachment avoidance rated disclosure of depression to others more negatively than women and that men who were low in attachment avoidance (Burke, Wang, & Dovidio, 2014). Thus, when considering men's proclivity for seeking therapy, it is important to consider the constitution and importance of those relationships, and how those relationships may inform their disclosure to seek therapy as well as influence them to seek therapy.

Within Group Differences of Men Seeking Therapy

Differences in the mental health utilization rates exist not only across gender groups, but within groups. For men, these differences have been shown to include age (e.g., generational differences about attitudes towards mental health) and racial/ethnic identity (e.g., cultural

attitudes towards mental health and help-seeking behaviors). In a sample of men from the National Health Interview Survey 2010-2013, non-Hispanic Black and Hispanic men ages 18 to 44 were approximately 40% less likely to take medication or seek out therapy for self-reported anxiety or depression than their non-Hispanic White counterparts (Blumberg, Clarke, & Blackwell, 2015). Non-Hispanic Black and Hispanic men ages 18 to 44 were approximately half as less likely as men 45 and over to take medication or talk with a mental health professional (Blumberg, Clarke, & Blackwell, 2015). Also affecting the mental health utilization rates of men of color are other aspects of culture that may inform their views of masculinity, such as institutionalized racism, a lower likelihood of access to health care resources, and the effects of migration and acculturation (Williams, Costa, & Leavell, 2010).

Mental health utilization rates also differ by sexual orientation, as men who identify as a sexual minority utilize therapy at higher rates than heterosexual men (Platt, Wolf, & Scheitle, 2018). Additionally, men with a prior history of military service are at higher risk for diagnosis for both substance use disorders and PTSD (Magen, Ren, Bosch, Marmar, & Seal, 2010) as well as at increased risk for severe psychological distress (Kramarow & Pastor, 2012), yet they are also less likely to seek out mental health services due to issues of stigma (Stecker, Fortney, Hamilton, & Ajzen, 2007).

Clinical Competency and Working with Men in Therapy

Liu (2005) posits that for those attempting to augment their cultural competency, the study of men is a critical component of that effort since the gendered experience of men results in them being less likely to seek therapy and more likely to experience serious mental health-related issues. In some cases, mental health professionals have expressed discomfort when working with men in treatment, and have admitted to holding to stereotypes and biases about

men that have affected their treatment of men (Mahalik, Good, Tager, Levant, & Mackowiak, 2012). To address these issues, the American Psychological Association (APA; 2018) has released a set of guidelines delineating the need for the mental health profession to reconsider how they approach the treatment of men in therapy, specifically drawing attention to the factors that attempt to increase the participation of men in health-related behaviors, the importance of engaging in efforts to educate men about the role of masculinity, and striving to better understand the systems that perpetuate traditional forms of masculinity. Liu (2005) also suggests that to become more competent about working with men means therapists need to recognize their own biases and assumptions about men as well as make a concerted effort to better understand the worldview of men and to consider the diversity of masculinities that exist across different identities.

Purpose of this Study

This study attempts to generate distinct profiles of men to better understand their help seeking behavior for therapy. The study incorporates information on stigma about mental health, social support, motivations to seek therapy, and basic psychological needs, all of which have previously been found to influence help-seeking behaviors. The identified profiles of men are then examined across concepts of masculinity, mental health status, religiosity, attitudes towards and intent to seek therapy, personal characteristics (i.e., psychological openness, self-compassion, shame) to better the attitudes and characteristics of men in these profiles seeking therapy.

RQ1. How many profiles of therapy seeking behavior exist for this sample of men based on their stigma, social support, motivations for therapy, and satisfaction of their basic psychological needs?

RQ2: How do the profiles identified in RQ1 differ across attitudes towards and intent to seek therapy, self-compassion, shame, and adherence to traditional masculine norms?

RQ3: How do the profiles identified in RQ1 differ based on disclosure and influence to seek therapy?

RQ4: How do the profiles in RQ1 differ in seeking therapy for depression and anxiety, substance use, and suicidality?

Chapter 3 - Methods

Participants

Participants consisted of 317 individuals who identified as male, were 18 years old or older, who resided within the United States, and were members of Amazon Mechanical Turk, which is an online community of workers (known as Turkers) that receive payment to complete various tasks. Participants' average age was 36.54 years ($SD = 10.79$; $R = 20$ to 72). Over two-thirds (70.00%) were in some form of a committed or dating relationship with most indicating being in this relationship for approximately 1 to 5 years (41.40%). The majority identified as heterosexual (88.60%), being employed full-time (72.90%), and were White/Caucasian (71.60%). The next largest group identified as being Black or African American (11.70%). Most participants had a bachelor's degree or higher (61.50%), and their income ranged from less than \$20,000 (17.40%) to \$100,000 or more (8.50%). The majority resided in either an urban (36.00%) or suburban (47.60%) area, though some also indicated living in a rural area (16.70%). Approximately two-thirds (64.00%) reported having received mental health treatment at some juncture in their lifetime, and another two-thirds (67.50%) specified knowing at least one family member who had received some form of mental health treatment. Full demographic descriptives are presented in Table 1.

Data Collection

Members of Amazon Mechanical Turk, an online community of workers that receive payment to complete various tasks, were invited to participate in this study. Amazon Mechanical Turk uses an online system to crowdsource a wide range of projects and tasks for completion. One function of the online system is that it allows researchers access to a large pool of participants for academic studies. An analysis of Amazon Mechanical Turk found that it

provided a more demographically diverse sample as compared to traditional participant recruitment methods at universities, and that data collected can in most cases be considered reliable as well as of sufficient quality (Buhrmester, Kwang, & Gosling, 2011). Rouse (2015) noted that some Turkers provide less reliable information than traditional samples; however, when attention check items are included, responses of participants tend to be more reliable.

The study was posted to Amazon Mechanical Turk with a brief description as well as a link to the Qualtrics survey. As participants clicked on the link to the Qualtrics survey they were provided with the study's informed consent. Those not meeting the inclusion criteria were directed to the end of the study and thanked for their consideration. If a participant met the inclusion criteria, completed the study in its entirety, met the minimum number of attention check items, and took more than ten minutes to complete the task, then they received payment of \$3.00.

The sample for this study was determined after a series of steps undertaken to select men Turkers. First, any Turker identifying as a woman or transgender woman, having inconsistencies in reporting their gender identity, and under the age of 18 years old were deleted ($n = 485$). Second, syntax in SPSS (IBM Corporation, 2018) was generated to calculate a participant's attention check score. Based on the recommendation of Rouse (2015), five different attention check items were interspersed throughout the study to ensure the quality of a participant's responses. Participants missing three or more of the attention check items were dropped ($n = 93$ participants). Third, additional syntax in SPSS (IBM Corporation, 2018) was created to calculate participant's study completion time. Participants completing the study in its entirety in less than ten minutes were removed ($n = 11$ participants). Since this study was a part of a larger study, another 25 participants were removed for not adhering to the study requirements regarding the

quality of their responses (i.e., copying and pasting information from websites or blogs into open-ended questions, copying and pasting the prompts into open-ended questions). Three participants identified as transgender. Due to the low number, these participants were also removed from the analysis, which left a total of 324 participants. After running the analyses in *Mplus* and using maximum likelihood estimation with robust standard errors (MLR) for missing data, another seven men were excluded, resulting in a final sample of 317 men.

Measures

Data was collected using a combination of measurement instruments and vignettes. The survey is included in Appendix A.

Social Support

To determine a participant's likelihood of receiving support from their friends and family, three-items from the coping self-efficacy scale (Chesney, Neilands, Chambers, Taylor, & Folkman, 2006) were used. The measure tries to understand an individual's perception of their ability to cope during difficult life circumstances. Previous analysis of the measure has found it to exhibit convergent, divergent, and predictive validity (Chesney et al., 2006). Each item was measured using a scale ranging from 0 to 10, where 0 = *cannot do at all* and 10 = *certain can do*. The three-items were "Get friends to help you with the things you need," "Get emotional support from friends and family," and "Make new friends." The friends and family support subscale has previously reported high reliability ($\alpha = .80$) as well as test-retest reliability. For this study, the reliability coefficient for the scale was .83.

Indifference to Stigma

The indifference to stigma measure was taken from the inventory of attitudes towards seeking mental health services (IASMHS; Mackenzie, Knox, Gekoski, & Macaulay, 2004), and

refers to an individual's concern about significant others finding out they were receiving psychological care. The variable was measured with eight-items. In the instructions, examples of professionals trained in mental health were listed as psychologists, psychiatrists, social workers, and family physicians. Examples of how psychological problems may be referred to were also provided such as mental health concerns, emotional problems, mental troubles, and personal difficulties. Sample items for indifference to stigma included the following: "Important people in my life would think less of me if they were to find out that I was experiencing psychological problems," "I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems," and "Having been mentally ill carries with it a burden of shame."

Participants were asked to rate the degree they agree with each statement using a five-point Likert scale from 1 = *disagree* to 5 = *agree*. For the indifference to stigma scale, items were reversed coded and averaged so that a higher score reflected less stigma and more positive attitudes towards seeking therapy. This scale has been found to have known-groups validity when examining the differences in gender and help-seeking scores as well as discriminant validity between seeking professional psychological help and nonprofessional aid (Mackenzie et al., 2004). The scale's Cronbach's alpha also indicates high reliability of the indifference to stigma substance ($\alpha = .79$; Mackenzie et al., 2004). For this study, the reliability coefficient was .83.

Motivations for Seeking Mental Health Treatment

The treatment entry questionnaire (TEQ; Urbanoski & Wild, 2012; Wild, Cunningham, & Ryan, 2006) is a 12-item scale assessing three motivations (i.e., external, introjected, and identified) for seeking substance use treatment. Each factor was measured by four-items using a

seven-item Likert scale with 1 = *strongly disagree* to 7 = *strongly agree*. Participants were asked to select the degree to which they agreed or disagreed with each statement.

The scale's items were adapted to measure motivations to seek general mental health treatment rather than substance abuse treatment. For example, item one in the original measure stated, "I decided to enter a program because I was interested in getting help," and was amended to read "I would decide to mental health treatment because I would be interested in getting help" to measure identified motivations. Item five stated, "I plan to go through with treatment because I'll be ashamed of myself if I don't," and was altered to "I would plan to go to mental health treatment because I would be ashamed of myself if I didn't get help" to measure introjected motivations. Item six stated, "The reason I am in treatment is because other people have pressured me into being here," which was changed to "The reason I would enter mental health treatment is because others would likely have pressured me into going" to measure external motivations.

Subscale scores were averaged so that higher scores indicated greater levels of external, identified, and introjected motivations for seeking therapy. The original scale was found to have convergent and discriminant validity between treatment motivations and an individual's decision to enter treatment either because of social pressure or as a function of self-referral. Each subscales Cronbach's alpha has previously showed high reliability: external motivations = .89; identified motivations = .84; introjected motivations = .85 (Wild et al., 2006). For this study, the reliability coefficients for the adapted version of the scale were as follows: external motivations = .93; identified motivations = .95; introjected motivations = .86.

Basic Psychological Needs Satisfaction

The basic psychological needs satisfaction scale (BPNS; Deci & Ryan, 2000; Gagne, 2003) is a 21-item measure assessing autonomy (seven-items), competence (six-items), and relatedness (eight-items) as delineated in self-determination theory. Participants were instructed to indicate how true they feel about each statement related to their life in general and respond along a seven-point Likert scale of 1 = *not at all true* to 7 = *very true*. Sample items included, “I feel like I am free to decide for myself how to live my life” for autonomy, “People I know tell me I am good at what I do” for competence, and “I get along with people I come into contact with” for relatedness. Scores were averaged for each subscale with higher scores meaning greater levels of satisfaction of that specific need. This scale was found to have predictive validity with other measures of prosocial engagement and support (Gagne, 2003) in addition to daily well-being (Weinstein & Ryan, 2010). The scale’s Cronbach alpha indicated high reliability: autonomy = .69; competence = .71; relatedness = .86 (Gagne, 2003). For this study, the reliability coefficients for each subscale were as follows: autonomy = .76; competence = .70; relatedness = .82.

Differentiating between Profiles

The profiles of men identified above were differentiated based on the following variables: psychological openness, mental help seeking intentions, gender role-conflict, self-compassion, shame, the disclosure and influence of different types of relationships on their seeking therapy, and the consideration to seek therapy for depression and anxiety, substance use, and suicidality. A combination of measurement instruments (i.e., scales and vignettes) were utilized to examine the distinctions between the profiles of men.

Traditional Masculinity

To assess a participant's adherence to traditional masculine norms, two factors of the gender role conflict scale (GRCS) short form were utilized (Hammer, McDermott, Levant, & McKelvey, 2018; O'Neil, Helms, Gable, David, & Wrightsman, 1986). The scale assesses different dimensions of men's well-being from adherence to traditional or restrictive forms of masculinity (Hammer et al., 2018; O'Neil et al., 1986). Factors of the GRCS have been shown to exhibit convergent validity with increased symptoms of anxiety and depression, along with family distress, social anxiety, mental health stigma, and substance use (Hammer et al., 2018). Prior reliability coefficients for each factor have ranged from .75 to .86 (O'Neil et al., 1986). Additionally, Hammer and colleagues (2018) advise against using a total gender role conflict score for all the items, and instead found it more relevant to utilize the different factor subscales.

The traditional masculine dimensions measured in this study were restrictive emotionality and restrictive affectionate behavior between men. Each factor was measured with four-items assessed with a Likert-scale ranging from 1 = *strongly disagree* to 6 = *strongly agree*, and each factor's items were averaged to generate a mean score. Higher scores reflect a greater adherence to traditional forms of masculinity. Examples items included "I have difficulty expressing my emotional needs to my partner" for restrictive emotionality, and "Affection between other men makes me tense" for restrictive affectionate behavior between men. For this study, the reliability coefficients for each subscale were as follows: restrictive emotionality = .87; restrictive affectionate behavior between men = .89.

Mental Health

Assessment of men's mental health was done using the Depression, Anxiety, Stress Scale (DASS-21; Lovibond & Lovibond, 1995). The DASS-21 is a shortened version of the DASS

with seven-items each for anxiety, depression, and stress measured along a four-point Likert-scale with 0 = *did not apply to me at all (never)* to 3 = *applied to me very much, or most of the time (always)*. Example items include “I found it hard to wind down” for stress, “I was worried about situations in which I might panic and make a fool of myself” for anxiety, and “I felt I wasn’t worth much as a person” for depression.

Each subscale’s items were totaled and then multiplied by two to reflect the clinical scoring for the original DASS. Normal scores for each subscale are the following: depression = 0 to 9, anxiety = 0 to 7, stress = 0 to 14. Clinical cutoff points also exist for mild, moderate, severe, and extremely severe depression, anxiety, and stress. The shortened DASS has been shown to exhibit concurrent validity with other measures of depression, anxiety, and stress (Osman et al., 2012) in addition to construct validity (Brown, Chorpita, Korotitsch, & Barlow, 1997; Henry & Crawford, 2005). According to Osman and colleagues (2012), prior studies examining the DASS-21 have resulted in internal reliability coefficients ranging from .82 to .97 in both clinical and non-clinical samples. For this study, the reliability coefficients for each subscale were as follows: anxiety = .93; depression = .94; stress = .92.

Intention to Seek Therapy

To differentiate between attitudes towards seeking mental health services and intent to seek therapy, the mental help seeking intention scale (MHSIS; Hammer & Spiker, 2018) was used. The MHSIS has shown predictive validity with approximately 70% accuracy of participants seeking therapy within a three-month period (Hammer & Spiker, 2018). The measure consists of three-items assessed with a Likert-scale ranging from 1 = *extremely unlikely/definitely false/strongly disagree* to 7 = *extremely likely/definitely true/strongly agree*. The three-items include the following: “If I had a mental health concern, I would intend to seek

help from a mental health professional,” “If I had a mental health concern, I would try to seek help from a mental health professional,” and “If I had a mental health concern, I would plan to seek help from a mental health professional.” The three-items were averaged with higher scores reflecting greater intentions of seeking help for a mental health-related issue. For this study, the reliability coefficient for the MHSIS was .97.

Psychological Openness

The psychological openness subscale of the inventory of attitudes towards seeking mental health services (IASMHS; Mackenzie et al., 2004) is an eight-item measure of openness to acknowledge the presence of a psychological problem and to consider seeking therapy. In the instructions, examples of professionals trained in mental health were listed as psychologists, psychiatrists, social workers, and family physicians. Examples of how psychological problems may be referred to were also provided such as mental health concerns, emotional problems, mental troubles, and personal difficulties. Sample items for psychological openness included the following: “There are certain problems which should not be discussed outside of one’s immediate family,” “It is probably best not to know *everything* about oneself,” and “There are experiences in my life that I would not discuss with anyone.”

Participants were asked to rate the degree they agree with each statement using a five-point Likert scale from 1 = *disagree* to 5 = *agree*. Each item was reverse coded and averaged so that higher scores reflected greater psychological openness. This scale was found to possess known-groups validity when examining the differences in gender and help-seeking scores as well as discriminant validity between seeking professional psychological help and nonprofessional assistance (Mackenzie et al., 2004). The scale’s Cronbach’s alpha indicates high reliability of the

psychological openness subscale ($\alpha = .76$; Mackenzie et al., 2004). For this study, the reliability coefficient for psychological openness was .84.

Self-Compassion

An abbreviated, 12-item self-compassion scale (Neff, 2003; Raes, Pommier, Neff, & Van Gucht, 2011) was used to measure a single-factor of self-compassion. A five-point Likert-scale was utilized with 1 = *almost never* and 5 = *almost always*. Participants were asked to reflect on how they typically act towards themselves during difficult times. Example items included, “When I fail at something important to me, I become consumed by feelings of inadequacy,” “I try to see my failings as part of the human condition,” and “When something upsets me I try to keep my emotions in balance.”

Mean scores were generated so that higher scores reflected greater levels of self-compassion. The original long-form self-compassion scale was found to possess discriminant validity with self-criticism and a convergent validity with social connectedness in addition to predictive validity of mental health outcomes (Neff, 2003). The Cronbach’s alpha for the short form scale indicates high reliability ($\alpha = .97$) and is highly correlated with the long-form ($r = .97$; Raes et al., 2011). For this study, the reliability coefficient for the self-compassion short-form measure was .83.

Shame

Four-items from the internalized shame scale (ISS; del Rosario & White, 2006; Vikan, Hassel, Rugset, Johansen, & Moen, 2010) were used to assess a specific dimension of shame: vulnerability. A five-point Likert-scale was utilized with 1 = *never* and 5 = *almost always*. Participants were asked to read each statement and select the response indicating the frequency with which they experience that specific item. No specific timeframe was referenced in the

instructions for a respondent to recall experiencing each statement. Each factor's items were averaged with higher scores indicating greater feelings of vulnerability.

Sample items for the vulnerability factor of shame included the following: "At times I feel I will break into a thousand pieces," "I would like to shrink away when I make a mistake," and "I replay painful events over and over in my mind until I am overwhelmed." This scale has been found to have content validity, predictive validity of abandonment and attachment, and construct validity with anxiety and depression (Cook, 1994, 2001; del Rosario & White, 2006). del Rosario and White (2006) labeled this factor fragile and exposed, and found it to have high reliability ($\alpha = .88$). Similarly, Vikan and colleagues (2010) found the vulnerability subscale to also have a high reliability coefficient ($\alpha = .92$). For this study, the reliability coefficient for the vulnerability subscale was .94.

Substance Use

The SAMSHA CAGE-AID (Brown & Rounds, 1995) was used to assess substance use. The measure consists of four-items about an individual's use of alcohol, and their use of illegal drugs or non-prescribed drugs. Brown and Rounds (1995) suggest that a score of one or higher is indicative of potential a substance misuse issue, and that two or more yes responses had a sensitivity of .70 and specificity of .85.

The four-items included, "Have you ever felt that you ought to cut down on your drinking and drug use?"; "Have people annoyed you by criticizing your drinking and drug use?"; "Have you ever felt bad or guilty about your drinking or drug use?"; and "Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?"

Participants were asked to indicate either 0 = *no* or 1 = *yes*. The four-items were summed so that

higher scores reflected a greater likelihood of substance use issues. For this study, the reliability coefficient for the substance use measure was .86.

Social Influence

To determine the social influence and importance of persons in different relationship roles (i.e., partner, parents, close friend, religious or spiritual leader, and medical doctor) on men seeking therapy were ascertained by asking participants the following question: “If you were experiencing difficulties (e.g., personal, relationship, emotional, work), how likely is it that the following people would be able to convince you to seek out therapy from a mental health professional?” Participants responded along a five-point Likert scale from 1 = *extremely unlikely* to 5 = *extremely likely* to rate their partner, parents, close friend, religious/spiritual leader, and medical doctor. An additional component of the influence question related to the importance of these relationships to men. As a result, participants in this study were also asked to rate the importance of these relationships on five-point Likert-scale with 1 = *not important at all* to 5 = *very important*. To calculate a score for the social influence of these different relationships for men to seek therapy, the two items were multiplied together resulting in a score ranging from 1 to 25. A higher score reflects someone for whom a participant would consider an important social influence in their decision to seek therapy.

Disclosure to Others

The disclosure of consideration of seeking therapy was evaluated by asking participants the following: “How likely is it that you might disclose to one of the following individuals that you might be considering therapy with a mental health professional?” Relationships included in the responses include their partner, parents, close friend, religious or spiritual leader, and medical doctor. Responses were given on a five-point Likert scale from 1 = *extremely unlikely* to 5 =

extremely likely. Similar to the social influence question, participants were also asked to rate the importance of these relationships on a five-point Likert-scale with 1 = *not important at all* to 5 = *very important*. To calculate a score for men's disclosure to the individual's in these roles, the two items were multiplied together resulting in a score ranging from 1 to 25. A higher score reflects someone for whom a participant would consider disclosing their intent to seek therapy and believes that this person or relationship is important to them.

Decision to Seek Therapy

Participants reviewed two different vignettes, the last of which was a multiple segment factorial vignette (MSFV). A MSFV is a research method integrating experimental design, probability sampling, and short stories to assess attitudes, beliefs, and perspectives about various topics (Gagong & Coleman, 2006). The first vignette establishes a baseline attitude or belief toward a topic. In subsequent vignettes, different independent variables are introduced to determine what factors may change a participant's attitude or belief about a topic, thus allowing for between-subject differences to be determined. Participants were provided the following instructions before reviewing the vignettes:

Over the next few minutes, you will be reading a few different stories. Afterward, you will be asked to respond to a few questions. In the stories, when you read the phrase "therapy with a mental health professional," think of any type of therapy or counseling service that would (1) be considered "talk therapy," (2) be more than a one-time meeting or session, and (3) be completed with a mental health professional such as a Clinical or Counseling Psychologist, Psychiatrist, Licensed Clinical Social Worker, Licensed Marriage/Couple and Family Therapist, Licensed Professional Counselor, or Pastoral Counselor.

In this study, all participants received the first vignette and were then randomly assigned to one of two versions of the second vignette. The vignettes are as follows:

V1. Decision to seek therapy for anxiety and depression. You have continued to be under a lot of stress, and you have been feeling more depressed and anxious. As a result, you are considering the possibility of seeking out therapy with a mental health professional.

After reading this vignette, participants were asked, “How important is it that you consider therapy with a mental health professional?” with 1 = *not important at all* to 5 = *extremely important*.

V2. Decision to seek therapy for substance misuse or suicidality. More time passes, and the amount of stress you are under is becoming overwhelming. This has resulted in you beginning to spend less time doing the things that you enjoy and more time alone. One thing you have noticed is that you **have begun to drink alcohol and use drugs more frequently / feel the urge to take your life**.

After reading a version of the second vignette, participants were asked, “How important is it that you consider therapy with a mental health professional?” with 1 = *not important at all* to 5 = *extremely important*.

Covariates

The following items were controlled for in the latent profile analysis: age (0 = *all others*; 1 = *18 – 29 years old*), racial and ethnic identity (0 = *White/Caucasian*; 1 = *Non-White*); lifetime mental health treatment (0 = *no*; 1 = *yes*); family mental health treatment (0 = *no*; 1 = *yes*); sexual orientation (0 = *heterosexual*; 1 = *non-heterosexual*); relationship status (0 = *not in a relationship*; 1 = *in a relationship*); education level (0 = *less than a bachelor’s degree*; 1 = *bachelor’s degree or higher*); veteran (0 = *no*; 1 = *yes*); religiosity (continuous; $M = 2.25$, $SD =$

1.42, $R = 1$ to 5); substance use (continuous; $M = 1.21$, $SD = 1.53$, $R = 0$ to 4); anxiety (continuous; $M = 8.30$, $SD = 10.42$, $R = 0$ to 42); depression (continuous; $M = 11.39$, $SD = 12.07$, $R = 0$ to 42); and stress (continuous; $M = 11.74$, $SD = 10.95$, $R = 0$ to 42).

Analytic Plan

Preliminary Analysis

Preliminary analyses examined the amount of missing data, data normality (i.e., skewness and kurtosis), and bivariate correlations using SPSS version 25 (IBM Corporation, 2018). Missing data ranged from none to 40.70% (i.e., Religious/Spiritual Disclosure). Review in SPSS (IBM Corporation, 2018) determined that these data were normally distributed and fell within the acceptable ranges of skewness ($|3|$) and kurtosis ($|10|$) (Kline, 2011). Bivariate correlations were conducted to assess for multicollinearity. There was no evidence of multicollinearity as correlations ranged from $-.47$ (i.e., indifference to stigma and external motivations) to $.84$ (i.e., anxiety and stress). The anxiety, depression, and stress scales were all highly correlated ranging from $.79$ to $.84$; however, prior research has shown that these three subscales, while highly correlated, assess distinct aspects of psychological distress (see Henry & Crawford, 2005).

Main Analysis

Latent profile analysis. In order to generate profiles of men from the observed variables (i.e., indifference to stigma, social support, motivations to seek therapy, and basic psychological needs), a latent profile analysis (LPA) using *Mplus* version 8 (Muthén & Muthén, 1998–2017) was conducted. An LPA, which is specific to continuous variables, assesses for distinct differences amongst cases so that mutually exclusive profiles within a sample can emerge (Oberski, 2016).

Utilizing previously existing LPA procedures (Duncan, Duncan, & Strycker, 2013; Nylund, Asparouhov, & Muthén, 2007), a range of profiles from one to five were examined to uncover the number of mutually exclusive profiles within the sample. The following criteria were utilized to determine the appropriate number of profiles: model convergence; log-likelihood (i.e., a lower number indicates a better fit), Akaiken Information Criterion (AIC), Bayesian Information Criteria (BIC), and sample-size adjusted Bayesian Information Criteria (aBIC; i.e., a lower AIC/BIC/aBIC indicates better model fit; entropy (i.e., .6 or higher for distinct profiles), Lo, Mendell, and Rubin (2001) likelihood ratio statistic (LMR-LRT; i.e., a lower and significant LMR-LRT suggests that the current model was better than the previous model), and Bootstrapped Likelihood Ratio test (BLRT; i.e., a lower and significant BLRT suggests that the current model was better than the previous model). Nyland and colleagues (2007) note that of these criteria, the two best and most consistent indicators of a better fitting profile include the BIC and BLRT. Jung and Wickrama (2008) note, too, that it is critical to consider if a model achieves convergence and exhibits an entropy value of close to 1.00. Thus, of primacy in determining the best profile model the following criteria were evaluated: convergence, BIC, BLRT, and entropy.

Multinomial logistic regression. To answer research questions 2, 3 and 4, differences and similarities between the profiles that appeared from the LPA across demographics of participants, observed variables, and responses to vignettes were determined using for separate multinomial logistic regressions in SPSS (IBM Corporation, 2018). The multinomial logistic regressions consisted of control variables and the following observed variables respectively: (1) psychological openness, mental help seeking intentions, self-compassion, shame, and traditional masculinity; (2) disclosure to partner, parent, close friend, religious or spiritual leader, and

medical doctor; (3) influence of partner, parent, close friend, religious or spiritual leader, and medical doctor; (4) to seek therapy for depression and anxiety; (5) to seek therapy for substance use; and (6) to seek therapy for suicidality.

Chapter 4 - Results

Preliminary Results

Results of the bivariate correlations for the LPA variables and the variables included in the multinomial logistic regressions are presented in Tables 2, 5, 7, and 10.

Bivariate correlations of the Latent Profile Analysis. The correlations results presented in Table 2 were as expected. Indifference to stigma was negatively correlated with anxiety, depression, stress, and substance use, indicating that as stigma about mental health was less problematic, so were the levels of mental health problems. Social support was also negatively linked with anxiety, depression, and stress, showing that more support from family and friends meant lower rates of mental health problems.

While identified motivations were not significantly associated with mental health or substance use, external and introjected motivations were positively associated with anxiety, depression, stress and substance use. These results suggest that motivations derived from external sources and internal shame and guilt, corresponded to higher levels of mental health problems. Autonomy, competence and relatedness were all negatively correlated with anxiety, depression, stress, and substance use, suggesting that the more satisfied men were with their basic psychological needs, the fewer mental health problems they exhibit, thus supporting the propositions of the self-determination theory.

Bivariate correlations of the Multinomial Logistic Regressions. Correlations results presented in Table 5 support the claim that adherence to traditional masculine norms are negatively related to openness to influence and intentions to seek therapy. Adherence to traditional masculine norms also is negatively linked to self-compassion and positively linked to vulnerability, suggesting that adherence to traditional masculine norms is likely to be shown by a

greater fear or lack of emotional expression as compared to an ability to be self-compassionate. As expected, psychological openness, intention to seek therapy and self-compassion are positively related to each other and all three factors are negatively related with vulnerability.

Correlation results presented in Table 7 suggest that having mental health problems and being a veteran are positively related to disclosure to religious/spiritual leaders as well as being influenced by religious leaders to seek therapy. Interestingly, having mental health problems and being veteran are each negatively related to disclosure to one's partner. Being a veteran and having anxiety was positively related to disclosure to a medical provider. High levels of religious beliefs were related to higher likelihood of being influence by a parent, friend, religious/spiritual leader, and medical doctor to seek therapy.

Correlation results presented in Table 10 evidence that being a veteran is negatively related to seeking therapy for substance use and suicidality, suggesting veterans see treatment for more serious mental health issues as less important. A prior experience of therapy appears to be the only factor that was positively related to seeking therapy for suicidality, while having had prior therapy or having family who had prior therapy was positively linked to seeking therapy for substance use. High religious beliefs, being non-White, and being partnered were positively related to seeking therapy for depression and anxiety.

Main Results

RQ1. How many profiles of therapy seeking behavior exist for this sample of men based on their stigma, social support, motivations for therapy, and satisfaction of their basic psychological needs? The series of LPA models and corresponding indicators assessing fit are presented in Table 3, and the LPA is described further in Figure 2. The five-profile model converged, but produced warnings about the results, thus it was not considered in determining

the number of profiles. Only the two-profile model produced a significant LMT-RT, while all the models had a significant BLRT ($p < .001$). The four-profile model had a higher entropy (.89) than did the three-profile model (.87), but the two-profile model showed the highest entropy of the remaining models (.91). However, the four-profile model also produced a lower BIC as well as a lower and significant BLRT than the two-profile model. As a result, the four-profile model was selected to distinguish profiles of men from observed variables -- stigma about mental health, level of social support, motivations to seek therapy, and basic psychological needs. See Table 4 for demographic and help-seeking related characteristics of the four profiles.

Profile one: Reluctant. Profile one consisted of 88 men (27.76%). Overall, this profile was characterized by having more stigmatized views of mental health ($M = 2.49$, $SD = .63$), moderate levels of social support ($M = 7.20$, $SD = 1.78$), higher levels of external ($M = 4.81$, $SD = 1.21$) and introjected ($M = 4.96$, $SD = 1.07$) motivations, and moderate levels of autonomy ($M = 4.17$, $SD = .41$), competence ($M = 4.14$, $SD = .54$), and relatedness ($M = 4.35$, $SD = .44$).

Of all the profiles, these men indicated that their religious beliefs were the most important to them ($M = 3.05$, $SD = 1.33$), while also having the highest level of substance use ($M = 1.70$, $SD = 1.58$). They reported severe anxiety ($M = 18.39$, $SD = 10.78$), moderate depression ($M = 20.14$, $SD = 9.75$), and moderate stress ($M = 20.41$, $SD = 10.01$). Their more negative attitudes towards mental health were also reflected in their lower openness towards seeking therapy ($M = 2.48$, $SD = .70$), hence the label “Reluctant.” This group, however, did report moderate-to-high intentions to seek therapy ($M = 5.33$, $SD = 1.07$). Additionally, the Reluctant profile was characterized by the highest levels of adherence to traditional masculinity of any of the profiles: restrictive emotionality ($M = 3.90$, $SD = 1.05$); restrictive affectionate behavior between men ($M = 3.86$, $SD = 1.10$).

Profile two: Open. Profile two consisted of 72 men (22.71%). Overall, the men of this profile indicated the most positive attitudes towards mental health ($M = 3.98$, $SD = .74$), openness to seeking help ($M = 3.62$, $SD = .90$), and therapy seeking intentions ($M = 5.77$, $SD = 1.70$), hence the label “Open.” They also reported the highest levels of social support ($M = 9.82$, $SD = 1.24$) and self-compassion ($M = 4.09$, $SD = .53$). They were the most likely to report identified motivations as a reason for seeking therapy ($M = 6.14$, $SD = 1.27$), while also indicating moderate-to-high levels of introjected motivations ($M = 3.71$, $SD = 1.69$) and the lowest levels of external motivations ($M = 1.98$, $SD = 1.23$). Across the board, the Open profile exhibited the highest levels of basic psychological needs across all four profiles: autonomy ($M = 6.08$, $SD = .59$), competence ($M = 6.23$, $SD = .63$), and relatedness ($M = 6.34$, $SD = .47$).

The Open profile reported moderate levels of religiosity ($M = 2.97$, $SD = 1.57$); however, as compared to the Reluctant profile, they were characterized by the lowest levels of substance use ($M = .67$, $SD = 1.27$) in addition to normal levels of anxiety ($M = 1.31$, $SD = 3.22$), depression ($M = 1.08$, $SD = 2.42$), and stress ($M = 3.11$, $SD = 4.55$). Compared to the other profiles, they were less likely to endorse the factor of vulnerability ($M = 1.20$, $SD = .47$), and they exhibited low reports of adherence to traditional masculinity: restrictive emotionality ($M = 2.13$, $SD = 1.19$); restrictive affectionate behavior between men ($M = 2.30$, $SD = 1.41$).

Profile three: Restrictive. There were a total of 48 men in profile three (15.14%). Overall, the most striking characteristic of these men were their low levels of social support ($M = 3.78$, $SD = 1.77$), relatedness ($M = 3.63$, $SD = .69$), identified motivations ($M = 4.53$, $SD = 2.06$), introjected motivations ($M = 3.14$, $SD = 1.59$), therapy seeking intentions ($M = 3.95$, $SD = 2.17$), and self-compassion ($M = 2.68$, $SD = .77$), which were the lowest reports across all four profiles. Additionally, they indicated low levels of religiosity ($M = 1.17$, $SD = .48$), moderate-to-high

substance use ($M = 1.54$, $SD = 1.69$), moderate anxiety ($M = 12.13$, $SD = 10.63$), severe depression ($M = 23.21$, $SD = 12.47$), and mild-to-moderate stress ($M = 18.50$, $SD = 11.04$). Similar to the Reluctant profile, these men reported high levels of adherence to traditional masculine norms: restrictive emotionality ($M = 3.81$, $SD = 1.52$); restrictive affectionate behavior between men ($M = 3.20$, $SD = 1.57$). They were open to seeking therapy ($M = 3.22$, $SD = .80$), but less likely than other profiles to report an intent to seek therapy, hence the label “Restrictive.”

Profile four: Considering. Profile four was the largest of the profiles, consisting of 109 men (34.38%). Overall, these men were moderate-to-high in their basic psychological needs: autonomy ($M = 5.19$, $SD = .63$), competence ($M = 4.96$, $SD = .63$), and relatedness ($M = 5.19$, $SD = .60$), which was only lower than the Open profile. These men also exhibited relatively high levels of social support ($M = 7.24$, $SD = 1.64$) in addition to more positive attitudes towards seeking therapy ($M = 3.50$, $SD = .79$). Compared to other profiles, their motivations for therapy were low-to-moderate: external motivations ($M = 2.57$, $SD = 1.35$), identified motivations ($M = 5.10$, $SD = 1.70$), and introjected motivations ($M = 3.25$, $SD = 1.42$).

Similarly, these men were also characterized by moderate levels of religiosity ($M = 1.72$, $SD = 1.05$) and substance use ($M = 1.10$, $SD = 1.42$) in addition to normal levels of mental health: anxiety ($M = 3.10$, $SD = 4.35$), depression ($M = 5.95$, $SD = 7.27$), stress ($M = 7.47$, $SD = 7.33$). They were relatively open to therapy ($M = 3.19$, $SD = .90$), but reported the second-to-lowest levels of therapy seeking intentions ($M = 4.61$, $SD = 1.86$), hence the label “Considering.” Their reports of vulnerability were also relatively low ($M = 1.84$, $SD = .92$), and their level of self-compassion was moderate-to-high ($M = 3.53$, $SD = .56$). Finally, the men in the Considering

profile were low-to-moderate in terms of their masculinity: restrictive emotionality ($M = 2.84$, $SD = 1.06$); restrictive affectionate behavior between men ($M = 2.58$, $SD = 1.34$).

RQ2: How do the profiles identified in RQ1 differ across attitudes towards and intent to seek therapy, self-compassion, shame, and adherence to traditional masculine norms?

A multinomial logistic regression compared the odds of being in one profile over another based-on demographics, mental health and substance use, attitudes towards and intent to seek therapy, self-compassion, shame, and masculinity variables. The Open profile (i.e., profile two) served as the reference group. An odds ratio can be interpreted as follows: a one-unit increase/decrease in the predictor variable, with all other variables being constant, results in an increase/decrease in the odds of an outcome and of being a part of that profile as compared to the reference group. Results are presented in Table 6.

Reluctant vs. Open. The results suggest that with all the other demographic variables being constant, the odds of the Reluctant profile being between the ages of 18 to 29 years old were 8.41 times higher ($b = 2.13$, $p = .001$, $OR = 8.41$, 95% $CI = 2.81, 25.22$) than the Open profile. The Reluctant profile were also more likely in a relationship ($b = 1.99$, $p = .001$, $OR = 7.29$, 95% $CI = 2.63, 20.19$) than were the Open profile. The odds of a man identifying as non-White were greater for the Reluctant profile ($b = 1.93$, $p = .001$, $OR = 6.87$, 95% $CI = 2.54, 18.55$). Surprisingly, the Reluctant profile was more likely to have received therapy in their lifetime ($b = 2.06$, $p = .001$, $OR = 7.82$, 95% $CI = 2.73, 22.42$); however, they were less likely to have known a family member who had received therapy ($b = -1.25$, $p = .01$, $OR = .29$, 95% $CI = .11, .74$). Also, the likelihood of their religious or spiritual beliefs being important to their daily lives were lower ($b = -1.04$, $p = .001$, $OR = .36$, 95% $CI = .23, .54$).

The Reluctant profile was also distinguished from the Open profile by having a greater likelihood of depressive symptoms ($b = .42, p = .001$ OR = 1.52, 95% CI = 1.31, 1.78), less openness to seeking therapy ($b = -2.22, p = .001$, OR = .11, 95% CI = .06, .22), less self-compassion ($b = -3.04, p = .001$, OR = .05, 95% CI = .02, .13), more experiences of shame and vulnerability ($b = 1.64, p = .001$, OR = 5.17, 95% CI = 2.33, 11.45). Finally, the Reluctant profile was more likely to exhibit the traditional masculinity factor of restrictive emotionality ($b = .43, p = .03$, OR = 1.54, 95% CI = 1.04, 2.27) than was the Open profile.

Restrictive vs. Open. The Restrictive profile varied differently than the Open profile on a few demographic items. For example, similar to the Reluctant profile, the Restrictive profile was ten times more likely to be between the ages of 18 and 29 years old ($b = 2.34, p = .001$, OR = 10.35, 95% CI = 3.11, 34.43), and they were five times more likely in a relationship than the Open profile ($b = 1.64, p = .004$, OR = 5.13, 95% CI = 1.67, 15.74). The Restrictive profile was more likely to identify as non-heterosexual ($b = 1.83, p = .04$, OR = 6.20, 95% CI = 1.05, 36.53) as compared to the Open profile. Additionally, the Restrictive profile was less likely to report having received some form of therapy in their lifetime ($b = -1.95, p = .002$, OR = .14, 95% CI = .04, .48), and as was the case for the Reluctant profile, that their religious or spiritual beliefs were less important to them ($b = -3.64, p = .001$, OR = .03, 95% CI = .01, .06).

The Restrictive profile was also distinguished from the Open profile by a higher likelihood of depression ($b = .48, p = .001$, OR = 1.62, 95% CI = 1.39, 1.9) as well as a higher likelihood vulnerability ($b = 1.78, p = .001$, OR = 5.95, 95% CI = 2.55, 13.90). Conversely, the Restrictive profile had a lower odds ratio of having higher therapy seeking intentions ($b = -1.12, p = .001$, OR = .33, 95% CI = .23, .47) and a lower likelihood of self-compassion ($b = -3.09, p = .001$, OR = .05, 95% CI = .02, .13). There were no differences in the odds between the

Restrictive and Open profiles for adherence to traditional masculine norms at the $p < .05$ level; however, closer examination revealed that the Restrictive profile had a greater likelihood of restrictive emotionality that was slightly above the .05 significance level ($b = .45, p = .06, OR = 1.57, 95\% CI = .99, 2.49$) and again slightly above the .10 level for restrictive affectionate behavior between men ($b = .34, p = .12, OR = 1.41, 95\% CI = .92, 2.16$).

Considering vs. Open. Again, the Considering profile differed on several demographic variables as compared to the Open profile. The Considering profile was over eight times more likely to be between the ages of 18 to 29 years old ($b = 2.11, p = .001, OR = 8.27, 95\% CI = 3.26, 20.98$), and were three times less likely to be age 50 or older ($b = -1.19, p = .01, OR = .30, 95\% CI = .12, .75$) than the Open profile. The Considering profile was seven times more likely to be in a committed relationship ($b = 1.99, p = .001, OR = 7.31, 95\% CI = 3.07, 17.41$). The Considering profile was also more likely to have a history of military service ($b = 1.79, p = .003, OR = 5.96, 95\% CI = 1.86, 19.15$) and to identify as non-White ($b = 1.33, p = .002, OR = 3.77, 95\% CI = 1.64, 8.67$). The Considering profile, however, was less likely to indicate knowing a family member who had received therapy ($b = -1.26, p = .001, OR = .28, 95\% CI = .13, .60$), and indicating that their religious or spiritual beliefs were less important to them ($b = -1.58, p = .001, OR = .31, 95\% CI = .14, .30$) than the Open profile.

Surprisingly, the Considering profile was characterized by a lower likelihood of experiencing symptoms of anxiety ($b = -.12, p = .03, OR = .88, 95\% CI = .79, .99$), yet as was the case with the other profiles, the Considering profile was also indicative of a greater likelihood of depressive symptoms ($b = .36, p = .001, OR = 1.43, 95\% CI = 1.24, 1.65$). The Considering profile also demonstrated a lower likelihood of psychological openness ($b = -.81, p = .003, OR = .44, 95\% CI = .26, .76$), therapy seeking intentions ($b = -.55, p = .001, OR = .58,$

95% CI = .44, .76), and self-compassion ($b = -2.09$, $p = .001$, OR = .12, 95% CI = .06, .28).

Similar to the Reluctant and Restrictive profiles, the Considering profile also exhibited a higher likelihood of shame's factor of vulnerability ($b = 1.38$, $p = .001$, OR = 3.98, 95% CI = 1.91, 8.29) as compared to the Open profile. For the Considering profile, there were no differences between the Open profile on adherence to traditional masculine norms.

RQ3: How do the profiles identified in RQ1 differ based on disclosure and influence to seek therapy?

Disclosure to seek therapy. Results are presented in Table 8. For the Reluctant, Restrictive, and Considering profiles, there were no significant differences in disclosure to their partner, parent, close friend, religious or spiritual leader, or medical doctor when compared to the Open profile. However, at the .10 significance level, the Reluctant profile was less likely to indicate they would share their contemplation to seek therapy ($b = -.10$, $p = .05$, OR = .91, 95% CI = .82, 1.00) than was the Open profile.

Influence to seek therapy. Results are presented in Table 9. For the Reluctant, Restrictive, and Considering profiles, there were no significant differences in disclosure to their partner, parent, religious or spiritual leader, or medical doctor when compared to the Open profile. The Restrictive profile, though, was less likely to be influenced by a close friend than was the Open profile ($b = -.13$, $p = .04$, OR = .88, 95% CI = .77, .99). At the .10 significance level, the Restrictive profile was also less likely to be influenced by a parent ($b = -.13$, $p = .07$, OR = .88, 95% CI = .77, 1.01).

RQ4: How do the profiles in RQ1 differ in seeking therapy for depression and anxiety, substance use, and suicidality?

The two vignettes, with the second vignette including a manipulation of the independent variable (i.e., substance use or suicidality), were examined using a multinomial logistic regression to determine the odds of one profile being more or less likely to indicate seeking therapy for the following mental health-related issues: depression and anxiety, substance use, and suicidality.

Depression and anxiety. Results are presented in Figure 3. When compared to the Open profile, the Reluctant ($b = -.49, p = .002, OR = .61, 95\% CI = .45, .84$), Restrictive ($b = -.62, p = .001, OR = .54, 95\% CI = .38, .78$) and Considering ($b = -.48, p = .001, OR = .62, 95\% CI = .48, .79$) groups were less likely to indicate that it would be important for them to seek therapy for depression and anxiety, despite these three groups being more likely to report depressive symptoms.

Substance use. Results are presented in Figure 4. The Reluctant group was almost twice as less likely ($b = -.67, p = .003, OR = .51, 95\% CI = .33, .79$) than the Open profile to indicate that it would be important for them to seek therapy for substance use; however, the Reluctant group was also almost three times likely to indicate using substances ($b = -.99, p = .001, OR = .37, 95\% CI = .20, .69$) than was the Open group.

Suicidality. Results are presented in Figure 5. When compared to the Open group, the Reluctant ($b = -1.19, p = .001, OR = .31, 95\% CI = .15, .61$), Restrictive ($b = -1.37, p = .001, OR = .25, 95\% CI = .12, .53$), and Considering ($b = -1.07, p = .001, OR = .34, 95\% CI = .18, .66$) groups were less likely to believe it to be important to seek therapy for suicidality as compared to the Open profile, despite each of those three profiles being more likely to experience depressive symptoms and to use substances.

Chapter 5 - Discussion

The latent profile analysis applied the theories of social influence and self-determination to better understand the heterogeneity among men across measures of stigma, social support, motivations for therapy (i.e., external, identified, and introjected), and basic psychological needs (i.e., autonomy, competence, and relatedness). The profiles were then examined to better understand men's intentions to seek therapy, psychological openness, self-compassion, shame, adherence to traditional masculine norms, disclosure to and influence by persons close to them, and help-seeking proclivity for depression and anxiety, substance use, and suicidality. The following discussion will examine the Reluctant, Restrictive, Considering and Open profiles that emerged from the latent profile analysis and provide implications for those working with men.

Reluctant

Compared to the Open profile, the Reluctant profile is more likely to be younger, in a committed relationship, be a racial minority, and have a previous experience with therapy. There results are consistent with prior research finding that younger racial minority men experiencing symptoms of depression and anxiety are less likely than their White counterparts to seek therapy (Blumberg et al., 2015). Prior research has also notes that persons of color may be hesitant to engage in therapy due a number of factors such as stigma, a lack of knowledge about the therapy process, a lack of affordability or access, and a mistrust towards the mental health profession (Sanders Thompson, Bazile, & Akbar, 2004). Some have noted, too, that while persons of color may find therapy to be beneficial, they also believe that mental health symptoms are likely to be reduced without treatment (Anglin, Alberti, Link, & Phelan, 2008).

Given the higher likelihood of men of color within the Reluctant profile, racial identity may play a part in the hesitancy to seek therapy, such that societal stereotypes, biases, and

prejudices can potentially portray racial minorities in ways that overlooks their inherent strengths and resiliency, and instead others tend to focus more on the risks, failures, or problems of their racial identity (Appiah-Boateng, Evans, Zambrano, & Brooks, 2014). Despite an earlier experience of therapy, and being just as likely to disclose to and to be influenced by all of the same individuals as the Open profile, the Reluctant profile is less inclined to be psychologically open to seek therapy, which may be the result of a negative experience with therapy, or coercion and undue influence to attend therapy, a common occurrence with racial minority men (Suite, La Bril, Primm, & Harrison-Ross, 2007; Wester, 2008).

When considering therapy, the Reluctant profile is less inclined to find it important to receive help for depression and anxiety, substance use, and suicidality than the Open profile. The Reluctant profile experiences moderate-to-severe mental health issues and high substance use, and while they would disclose to others their intent to seek therapy, their restrictive emotionality and experience of vulnerability may inhibit their ability to seek therapy on their own accord. Their high external motivations indicate, though, that they would seek therapy as a result of the influence of others and less of their own volition, which prior research on motivations would suggest that the Reluctant profile would then be less likely to be successful in treatment (Urbanoski, 2010).

What also distinguishes the Reluctant from the Open profile is their lower self-compassion, greater adherence to traditional forms of masculinity (i.e., restrictive emotionality), and greater experience of vulnerability. The Reluctant profile's greater likelihood of having received therapy in the past appears to be countered by factors related to their low-quality relationships or feeling connected to others (i.e., relatedness), moderate social support, and lower likelihood of knowing a family member who had previously received therapy.

Restrictive

Compared to the Open profile, the Restrictive profile is more likely to be younger and in a committed relationship. These men are less likely to have an earlier experience of therapy and are more likely to identify as non-heterosexual. The Restrictive profile lacks quality interpersonal relationships, which is evidenced by their low relatedness. The Restrictive profile's motivations for therapy reflect what SDT posits as amotivation (Ng et al., 2012). Ryan and Deci (2017) note that amotivation is "...the extent to which they are passive, ineffective, or without purpose with respect to any given set of potential actions" (p. 16). However, they also suggest that underneath this idea of amotivation there are several important factors to consider such as an individual's perceived inability to achieve a goal or be effective (i.e., competence), a lack of interest or relevance in the behavior or action, or resistance to influence (i.e., autonomy or relatedness). Additionally, as their basic psychological needs are less likely to be met, they exhibit moderate-to-severe symptoms of mental health and moderate substance use, which is common for sexual minority men (Osborn et al., 2008). The Restrictive profile was also less likely to consider seeking therapy for depression and anxiety and suicidality than the Open profile, which raises concerns.

What also distinguishes the Restrictive from the Open profile relates to their lower intentions to seek mental health and ability to be self-compassionate in addition to their greater experience of vulnerability. The Reluctant profile's lower likelihood of having received therapy in their lifetime could be attributed to their overall motivations for therapy, specifically their low external and identified motivations, making it difficult for others to influence them into seeking therapy, them not believing in the value of therapy, or them not being able to associate an achievable end-goal with therapy.

Considering

The Considering profile tends to be younger and more likely to be in a committed relationship than the Open profile. These men are also more likely to identify as a veteran and non-White. While similar with the Open profile in terms of their attitudes towards stigma and basic psychological needs, they differed on several factors that have implications for their mental health help-seeking behavior. They do not have knowledge of a family member who had previously sought therapy, but they have strong, supportive relationships as a result of their social support and relatedness. This profile's lack of desire to seek therapy for depression and anxiety may be part due to their minimal level of mental health problems; however, they are also less likely to seek therapy for suicidality.

The help-seeking behaviors of the Considering profile are likely to be thwarted by lower psychological openness, mental help seeking intentions, and self-compassion in addition to higher vulnerability, which could conflict with their disclosure to and ability to be influenced by others to seek therapy. Vulnerability (Vikan, Hassel, Rugset, Johansen, & Moen, 2010) is the experience of "...feeling out of control, being emotionally unstable, and fearful of being exposed (del Rosario & White, 2006, p. 101), which has implications for their motivations for therapy (i.e., introjected motivations) and the effect of social influence (i.e., compliance or identification) on their seeking treatment. In previous studies, self-compassion has been shown to be reflective of less stigma related to help-seeking behaviors as well as lower risks of self-disclosure (Heath et al., 2017), and to be positively associated with having one's basic psychological needs met (Neff, 2003).

Although the Considering profile reported lower self-compassion compared to the Open profile, they were similar on being indifferent to stigma and having their basic psychological

needs met. For veterans, their military training and experience often neglects aspects of vulnerability, disclosure, emotional expression, fear, and failure, thus making them more apprehensive about potentially sharing with others a mental health-related issue (Fenell, 2014).

Open

The Open profile appears to be the group with the greatest likelihood of not letting factors such as stigma, vulnerability, or restrictive emotionality negatively interfere with their decision to seek therapy, or with their disclosure to others and being influenced by others to seek treatment. Having more of their needs met, specifically those related to the quality of relationships and social support, may be what contributes to their increased likelihood to share their intentions to seek therapy in addition to being more open to influence. It is not surprising that the Open profile not only have their basic psychological needs met, but also fewer mental health- and substance use-related issues that reduces the need for therapy. It may be the case then, that the Open profile views therapy as important, but because of the ability to self-manage their mental health-related issues and having the support close others, these men may not see a need to seek therapy. Thoits (2011) posits that increased levels of social support tends to decrease a perceived need or delay of therapy, yet the more serious a mental health issue the greater likelihood someone would seek treatment. Similarly, those with less mental health symptoms are more likely to seek assistance from their friends and family members (Oliver, Pearson, Coe, & Gunnell, 2005).

In contrast to the other profiles, religiosity was an important characteristic of the Open profile. Prior research on religiosity and help-seeking behavior notes that religious or spiritual practices are akin to social networking (Lim & Putnam, 2010) that provide opportunities for social support in various forms (i.e., social interaction, instrumental, and emotional), and that

reduces the likelihood of hopelessness, depression, and suicidality (Hovey, Hurtado, Morales, & Seligman, 2014). Others have found that the relationship between intrinsic religiousness and life satisfaction to be mediated in part by social support (Salsman, Brown, Brechting, & Carlson, 2005). Also, for African Americans, religious-based social support has been shown to mediate the relationship between overall religious attendance and mental health (Assari, 2013). Together these studies and the results suggest that religiosity may be a helpful source of support for men regarding their mental health, and can play an important role in the disclosure and influence to seek therapy process.

Further, the Open profile's mix of identified and introjected motivations for therapy suggests that when seeking therapy, they appear to engage in an internal dialogue about their decision that includes a mixture of a deliberate, intrinsic choice to seek help mixed with feelings of guilt and shame. The presence of guilt or shame is likely to be moderated by their ability to be self-compassionate, thus increasing the likelihood of disclosure, being influenced by others, and ability to seek treatment. SIT addresses the unique aspects of disclosure and influence of men seeking therapy. The Open profile may be indicative of Kelman's (1958) concept of internalizing, where the quality of men's relationship with their social networks influences men's ownership of the decision to disclose and to seek therapy. However, for the other profiles, aspects of compliance or identification may be more expected, especially as men may seek out therapy at the urging of their close friend as a means of gaining respect (i.e., compliance). Or, men may disclose their intention to seek therapy as a way to keep their job or a relationship from ending (i.e., identification).

Another facet of social influence theory is that of power and the role of the influencing agent. For men in the Open profile, their openness to the influence of others and high likelihood

of disclosure to others may reflect a source of credibility that others in these relationships have on their lives such that it is helpful, supportive, and likely non-threatening. Men in the Reluctant, Restrictive, or Considering profiles may view the power or role of influencing agents from their social networks as threatening or coercive, and as what Kelman (1958) deems as means-controlled or attractiveness, or as what SDT suggests may be controlling motivations (Ryan & Deci, 2017) that inhibit a man's autonomy. Consequently, these men's disclosures may be calculated or minimal and the influence of others may be perceived as coercive or threatening. Coercion and undue influence, while at times well-intended on the part of the influencer, may end in what SIT would consider as behavior change that is a consequence of compliance or identifications rather than of internalizing. In such situations, men may not truly benefit from therapy. In fact, men are autonomously motivated to seek therapy tend to enjoy therapy outcomes (Zuroff et al., 2007), whereas the opposite is true when men are externally motivated or coerced into therapy (Urbanoski, 2010; Wild et al., 2006). However, in some cases men are externally motivated to therapy as a result of others or systems (e.g., legal, organizational). This initial nudge may be what is needed to get them in the door to therapy, yet without autonomy supportive relationships and identified motivations then treatment is likely to be unsuccessful (Ryan & Deci, 2017).

Implications

The findings from this study have implications for those working with men such as therapists as well as those working to increase the likelihood of men seeking therapy. A one-sized fits all framework for understanding men seeking therapy neglects the heterogeneity that exists, which can inform the process of seeking therapy as well as the therapeutic process. The profiles identified in this study can be used to better understand what men might need to

effectively engage therapy. For example, by assessing a man's rationale and goals for seeking therapy in addition to the intentions of those goals (Sheldon et al., 2003), clinicians can obtain the information needed to identify if men better fit the Reluctant, Restrictive, Considering or Open profiles. A man may fit the Reluctant profile if his reason for seeking therapy is to appease his partner who requested that he seek treatment (e.g., external motivation, low relatedness) and if he also believes that not seeking therapy would reflect badly on him (e.g., introjected motivation, high vulnerability, low self-compassion).

Further, assessment of these profiles can inform the specific treatment modality utilized by a therapist. Ryan and Deci (2017) suggest that from a SDT perspective, outcome-focused modalities (e.g., behavior therapy, cognitive behavioral therapy, cognitive therapy) could actually be contraindicated for treatment, specifically as these forms of therapy typically incorporate external rewards or reinforcements, and as a result, are less volitional for the client. However, they note that process-focused treatments (e.g., humanistic, motivational interviewing) align with augmenting an individual's autonomy and relatedness by providing greater autonomy-supportive environments as well as by tapping into identified motivations. For example, when working with the Restrictive profile, motivational interviewing (MI; Hettema, Steele, & Miller, 2005), an assessment technique that is a derivative of SDT, could be used to evaluate a man's readiness or resistance to change. MI is used as a screening tool before any formalized treatment process begins, has been found to be beneficial for substance use and depression (Riper et al., 2014). MI attempts to draw out statements of autonomy, present objective information, manage resistance, and delineate between the effects of engaging in treatment versus non-treatment (Sheldon et al., 2003). In particular, MI may be most helpful for the Reluctant and Restrictive

profiles given their lower levels of basic psychological needs, and less needed for the Considering and Open profiles as a result of them having their basic psychological needs met. Overall, SDT advocates that a focus of all therapy should consider how to increase autonomy, enhance relatedness, and augment competence (Ryan & Deci, 2017). All three components could strengthen men's ability to feel secure and seek help on their own accord. Thus, whether a man presents for individual, couple, family, or group therapy, assessment of their help-seeking profile can be a helpful mechanism that would in turn inform future treatment modalities.

In addition to the use of the profiles as a means of assessing for motivations and basic psychological needs, therapists can better understand men's levels of stigma, shame, and adherence to traditional masculine norms may pose challenges for their therapy, and how self-compassion, social support, and psychological openness may play a role in the therapeutic process. When working with men, assessing for adherence to traditional norms of masculinity is an important first step (O'Neil, 2008). Men's adherence to traditional forms of masculinity can be gleaned from how they engage in self-devaluation (e.g., depression, shame, internalized racism), self-restriction, (e.g., stress, alexithymia, negative attitudes towards help-seeking), and self-violation (e.g., substance use, suicidality; O'Neil, 2013). Taking a broader perspective, therapists can utilize knowledge of men's stigma of mental health, adherence to traditional masculine norms, and shame to help destigmatize needing therapy and promote self-compassion in order to prevent men from premature termination of therapy.

Therapists need also note that because the Restrictive profile is more likely to identify as non-heterosexual, the extent to which these men would disclose their desire to seek therapy or mental health issues to others may depend on their level of 'outness' and to whom they are out to (Sanabria, 2014). Also, gay men can be affected by traditional masculine norms such that

adherence to norms surrounding the sharing of emotions and affection may inhibit the quality of their relationships, and that the perceived inability to ‘be a man’ can result in more negative self-views (Sanchez, Greenberg, Liu, & Vilain, 2010). Gay and bisexual men also experience distinct social stressors as a function of their sexual identity that affect their mental health and views of self (Berg, Mimiaga, & Safren, 2008). As a result, it would be important for those working with non-heterosexual men to assess the level of support of their social network (i.e., relatedness) and their adherence to traditional masculine norms.

Considering those comprising men’s social network -- partners, religious/spiritual leaders and medical providers -- could be instrumental in increase men’s likelihood of seeking therapy. Medical doctors have the capability to screen for mental health and substance use during the course of regular visits. Additionally, a growing number of medical communities are embedding mental health professionals within their hospitals and clinics to address patient mental health (McDaniel, Doherty, & Hepworth, 2014). Religious/spiritual leaders can play an influential role in the mental help seeking of their adherents or members (Dempsey, Butler, & Gaither, 2016; Lee, Hanner, Cho, Han, & Kim, 2008; Moreno & Cardemil, 2013). Those who attend church regularly tend to view clergy or pastors as valuable resources of support and advice about mental health; however, men are slightly less likely than women to view clergy as a primary person for mental health and more likely to see them as a tertiary option (Ellison, Vaaler, Flannelly, & Weaver, 2006). In similar positions to medical doctors and religious/spiritual leaders, but not examined in this study, are others that men may engage with more regularly such as barbers or cosmetologists, those working within recreational facilities, bartenders, and other allied health professionals. The APA (2018) has noted that “Psychologists understand and strive to change institutional, cultural, and systemic problems that affect boys and men through advocacy,

prevention, and education” (p. 19). Thus, increasing the knowledge of those that engage with men more regularly about issues pertaining to men’s mental health and their help-seeking behavior can increase the likelihood of these roles serving an important part in men seeking therapy.

There are also implications for those in more direct relationship to men. Men in the Reluctant, Restrictive, and Considering profiles are as likely as the Open profile to confide in others about their consideration to seek therapy. However, what distinguishes these profiles from the Open profile is a lack of self-compassion, more shame and restrictive emotionality, and varying levels of psychological openness, all of which may negatively affect their ability and willingness to disclose to others or their likelihood to acknowledge they are experiencing a mental health issue. Recognizing that these men may want to share about their mental health and desire to seek therapy, but that lack the capacity or language to do so, can lead to increased empathy and compassion for men seeking help. Therapists may want to capitalize on the unique position of partners, close friends, and parents of men who can play an important part in the process of men’s decision to seek therapy. A recent article in *The Atlantic* entitled “Dear Therapist: My Boyfriend’s Depression is Making me Question our Future Together,” (Gottlieb, 2019), paints a picture of how some partners recognize but struggle with how to talk to men about mental health-related issues:

...Recently, his depression has gotten much worse, and because this is the first time he has gotten very depressed since we’ve been physically together, I have no idea what I’m doing. It is like I’m walking on eggshells every time we speak, and if I say the wrong thing, he just shuts down. I can’t push him for information or

try to get him to help me with something around the house. I can barely get a normal conversation. I feel so alone (p. 1).

As a result, therapists can indirectly assess their clients' male family members' well-being when evaluating the family system and invite clients to provide referrals for therapy to these men, while also working to mobilize those within men's social support systems in order to provide men the help they need.

Finally, whereas Liu (2005), Mahalik and colleagues (2003, 2012), and the APA (2018) have advocated that clinicians should make every effort to become more competent surrounding their work with men in therapy, this study also notes that a critical component of that competence includes the understanding and assessment of men's mental help-seeking profiles. A prime example of how this may occur are through the training of clinicians in various mental health programs. In addition to self-of-the-therapist work surrounding a beginning clinician's ideas about men and masculinity, providing training about assessment of the heterogeneity of men's help-seeking profiles would be aligned with extant suggestion of the APA (2018) that mental health professionals make overtures to increase the likelihood that men would engage and benefit from therapy.

Limitations and Future Directions

While there were many strengths to this study, there were also several limitations that have implications for the generalizability of the results. First, the determination of the number of profiles for the LPA is dependent upon the observed and control variables included. A change in the variables used would also change the composition of the profiles and the subsequent results. Similarly, the observed variables were selected for their relevancy to the literature on disclosure,

influence, and motivations as well as to social influence theory and self-determination theory. The choice of a different theory (e.g., gender schema theory, gender role conflict theory, gender socialization and identity theory) would also have affected the choice of observed variables and later results. Future research could continue to explore the heterogeneity amongst men's help-seeking behavior by examining different profiles of men that may take into consideration a more focused look at gender socialization or adherence to traditional views of masculinity.

Second, there was a low number in the total sample of men over the age of 50, men of color, men identifying as non-heterosexual, and men with a history of military service. As researchers continue to explore the heterogeneity of men's help-seeking behavior, it will be important to include a broader diversity of men in study samples to ascertain the within- and between-group differences that may exist for these different demographics, and how in turn that may affect the examined observed variables. As a result of this low number of men in these demographic categories, the inflated odds ratios and confidence intervals for some variables in Table 6 may make the results more difficult to interpret, specifically such that a larger confidence interval tends to indicate a less accurate odds ratio (Szumilas, 2010).

Third, these data were cross-sectional, resulting in a snapshot of men's disclosures, influences, and motivations for therapy at a single point in time. Understanding how men's disclosures, influences, and motivations may change over time because of these various relationship roles would be beneficial for those working systemically to address issues of stigma and men's mental health. Also, while this study was quantitative in focus, understanding the "why" or "how" of men's disclosure, influence, and motivations for seeking therapy would provide more helpful information for those in relationship to men as to better recognize the

process men undergo and the language they may use when, for example, they are externally motivated or when they may lean on the social support of those around them to enter therapy.

Fourth, the treatment entry questionnaire (Urbanoski & Wild, 2012; Wild, Cunningham, & Ryan, 2006) was adapted to more broadly understand motivations for seeking therapy and not just for substance use. While the reliability coefficients were high for each of the three motivation subscales, the adapted measure has not been validated across clinical and non-clinical samples. Also, the three motivations examined (i.e., external, introjected, and identified) exist along a continuum of what Ryan and Deci (2000) describe as nonself-determined to self-determined behavior. Within that spectrum, there are other types of motivations that were not examined with the adapted treatment entry questionnaire such as amotivation, integrated motivation, and intrinsic motivation, which if were included would likely result in a change in the construction of the profiles and the study's results. The client motivations for therapy scale (Pelletier, Tuson, & Haddad, 1997) examine motivations more comprehensively; however, the measure primarily focuses on motivations once an individual is engaged in therapy rather than prior to entering treatment.

Fifth, a single question was asked about religiosity. For future studies, other dimensions of religiosity would be important to explore, such as the differences between intrinsic and extrinsic religiousness (Salsman et al., 2005), how religiosity plays a role in the disclosure, influence, and motivation for therapy process, and the effect of religiosity on mental health stigma for men. Sixth, while the scope of the examined relationships to men considered the importance men place on these individual relationships, the specific gender of the roles was not examined about men's disclosure and influence to seek therapy. The differences in the gender of these various relationships may in turn affect how the men in different profiles may disclose and

respond to influence. For example, mothers may be more likely to receive their son's disclosure and to be able to influence them to seek treatment. Conversely, a close friend of the same gender may be more likely to receive a man's disclosure, but less likely to influence that same man to seek therapy. Thus, future studies should consider the gender differences of these various roles on men's disclosure and influence to seek therapy.

Seventh, the fact that such a high percentage of the sample (64.00%) had experienced some form of mental health treatment may be result of self-selection bias. As this was a study using an online platform to recruit participants, it is likely that the title presented in the informed consent, *Examining Motivations and Influences for Seeking Mental Health Treatment*, resulted in participants that were interested in the topic of mental health, thus the effect of such a large percentage of men with prior experience of mental health. Additionally, it was presumed that a previous experience with mental health and knowing a family member who had experienced mental health treatment would be tied to greater likelihood of seeking therapy. However, no questions were asked about the quality of the therapy experience of these men or their family members, or the attitudes towards mental help seeking of their family members, which would likely also play a role in men's decision to seek therapy. Eighth, the measurement instrument for disclosure and influence was derived from Cusack and colleagues (2004), and extended upon by including a question about the relative importance of that particular individual to a man. This was an attempt to address aspects of disclosure and influence, and future research would be important to examine other ways to consider the interplay of relationship quality, disclosure, and influence as it relates to men's mental help seeking behavior.

Conclusion

From the theoretical frameworks of social influence and self-determination, the implications of these results extend beyond just men, and include those that work with men in therapy as well as those in varying relationship roles to men. While the literature has made the case that men are less likely to seek out mental help, that stigma and gender role socialization have an effect on men's disclosure, and that social support plays an important role in men's disclosure and help-seeking behavior, to-date there has been a paucity of research tying those factors together to better understand the heterogeneity of men's mental help-seeking behavior. This study suggests that a one-sized fits all framework for men seeking therapy neglects the differences amongst men about their unique help-seeking profiles for therapy. A critical component of this study has been an emphasis on those that may work with men in therapy in addition to those that are in various relationship roles to men. Recognizing that men are less likely or hesitant to seek out therapy, it may be more fitting to suggest that it takes the support of others and the necessary motivations for some men to enter into therapy. Therapists should be cognizant of how each of the four profiles may present for treatment, and how each profile's motivations and basic psychological needs can inform selection of a treatment modality that enhances a man's autonomy and augments their relatedness. Similarly, each person within a man's social network must recognize the factors that may inhibit a man like those in the Reluctant, Restrictive, or Considering profiles from entering therapy, and as a result, take a more empathic approach to supporting him through the help-seeking decision process.

Table 1. Descriptive Statistics of Study Variables (N = 317).

	<i>M</i> or %	SD	Range	<i>α</i>
<i>Demographic Variables</i>				
Age: 18-29 years old	27.40%	-	-	-
30-49 years old	58.40%	-	-	-
50 years and older	14.20%	-	-	-
Relationship Status: Widowed	0.30%	-	-	-
Committed	58.70%	-	-	-
Single, never married, not dating	27.80%	-	-	-
Divorced	1.90%	-	-	-
Dating and living separately	6.60%	-	-	-
Cohabiting	4.70%	-	-	-
Sexual Orientation: Heterosexual	88.60%	-	-	-
Gay	3.20%	-	-	-
Bisexual	7.60%	-	-	-
Other	0.60%	-	-	-

Table 1. Continued.

	<i>M</i> or %	<i>SD</i>	<i>Range</i>	<i>α</i>
Education: Less than a bachelor's degree	38.50%	-	-	-
Bachelor's degree	47.60%	-	-	-
Graduate degree or higher	13.90%	-	-	-
Race: Asian American or Asian	5.00%	-	-	-
Native American or Alaska native	2.50%	-	-	-
Black or African American	11.70%	-	-	-
Hispanic or Latino	5.40%	-	-	-
Native Hawaiian or Pacific Islander	0.60%	-	-	-
Middle Eastern or North African	0.30%	-	-	-
White or Caucasian	71.60%	-	-	-
Multiracial	2.80%	-	-	-
Veteran: No	88.60%	-	-	-
Yes	11.40%	-	-	-

Table 1. Continued.

	<i>M or %</i>	<i>SD</i>	<i>Range</i>	<i>α</i>
Lifetime Mental Health Treatment: No	36.00%	-	-	-
Yes	64.00%	-	-	-
Family Mental Health Treatment: No	32.50%	-	-	-
Yes	67.50%	-	-	-
Mental Health: Anxiety	8.30	10.42	0.00 – 42.00	.93
Depression	11.39	12.07	0.00 – 42.00	.94
Stress	11.74	10.95	0.00 – 42.00	.92
Substance Use	1.21	1.53	0.00 – 4.00	.86
Religiosity	2.29	1.42	1.00 – 5.00	-
<i>RQ1 Variables</i>				
Indifference to Stigma	3.25	.93	1.00 – 5.00	.83

Table 1. Continued.

	<i>M</i> or %	<i>SD</i>	Range	<i>α</i>
Social Support	7.29	2.44	0.00 – 10.00	.83
Motivations: External	2.98	1.70	1.00 – 7.00	.93
Identified	5.28	1.61	1.00 – 7.00	.95
Introjected	3.81	1.60	1.00 – 7.00	.86
Basic Psychological Needs: Autonomy	4.92	1.04	1.43 – 7.00	.76
Competence	4.84	1.08	2.00 – 7.00	.70
Relatedness	4.98	2.00	2.00 – 7.00	.82
<i>RQ2 Variables</i>				
Psychological Openness	3.10	.93	1.00 – 5.00	.84
Mental Help Seeking Intentions	4.97	1.80	1.00 – 7.00	.97
Self-Compassion	3.43	.70	1.25 – 5.00	.83
Vulnerability	2.29	1.22	1.00 – 5.00	.94
Traditional Masculinity: Restrictive Emotionality	3.12	1.36	1.00 – 6.00	.87
Restrictive Affectionate Behavior between Men	2.96	1.46	1.00 – 6.00	.89

Table 1. Continued.

	<i>M</i> or %	<i>SD</i>	Range	<i>α</i>
<i>RQ3 Variables</i>				
Disclosure to: Partner	20.44	7.26	1.00 – 25.00	-
Parent	15.77	8.60	1.00 – 25.00	-
Close Friend	14.01	7.74	1.00 – 25.00	-
Religious/Spiritual Leader	9.71	8.65	1.00 – 24.00	-
Medical Doctor	13.63	8.22	1.00 – 25.00	-
Influenced by: Partner	19.47	7.64	1.00 – 25.00	-
Parent	15.86	8.50	1.00 – 25.00	-
Close Friend	14.20	7.84	1.00 – 25.00	-
Religious/Spiritual Leader	9.91	8.43	1.00 – 24.00	-
Medical Doctor	13.16	8.21	1.00 – 25.00	-

Table 1. *Continued.*

	<i>M</i> or %	SD	Range	<i>α</i>
<i>RQ4 Variables</i>				
Seek Therapy for: Depression and Anxiety	3.52	1.31	1.00 – 5.00	-
Substance Use	4.02	1.28	1.00 – 5.00	-
Suicidality	4.07	1.36	1.00 – 5.00	-

Table 2. Correlation of Coefficients of Variables for Latent Profile Analysis, RQ1 (N = 317).

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1. Indifference to Stigma	–																			
2. Support	.21***	–																		
3. External Motivations	-.47***	.05	–																	
4. Identified Motivations	.39***	.27***	.01	–																
5. Introjected Motivations	-.14*	.16**	.52***	.46***	–															
6. Autonomy	.44***	.54***	-.40***	.20***	-.25***	–														
7. Competence	.39***	.58***	-.28***	.16**	-.12*	.70***	–													
8. Relatedness	.46***	.69***	-.23***	.33**	-.02	.72***	.72***	–												
9. Religiosity	-.09	.34***	.29**	.15**	.23***	.06	.13*	.15**	–											
10. Anxiety	-.42***	-.16**	.45***	-.03	.32***	-.52***	-.51***	-.43***	.17**	–										
11. Depression	-.41***	-.39***	.31***	-.05	.22***	-.65***	-.63***	-.57***	.02	.79***	–									
12. Stress	-.44***	-.28***	.41***	-.04	.27***	-.62***	-.53***	-.51***	.13*	.84***	.82***	–								
13. Substance Use	-.19**	-.09	.22***	-.01	.13*	-.18**	-.19**	-.11	.15**	.38***	.34***	.40***	–							
14. Age: 18-29	-.04	.04	.09	.13*	.24***	-.10	-.10	.00	-.02	.15**	.13*	.10	.08	–						
15. Race	-.06	.08	.13*	.07	.11	-.02	.07	.04	.10	.09	.02	.02	-.07	.02	–					
16. Lifetime MHT	.00	-.15*	.03	.14*	.12*	-.22***	-.19**	-.17**	.01	.30***	.32***	.34***	.33***	.06	-.04	–				
17. Family MHT	-.04	.01	.13*	.03	.07	-.14*	-.07	-.04	.10	.21***	.18**	.24***	.18**	.05	.03	.39***	–			
18. Sexual Orienttation	-.14*	-.02	.22**	.08	.17**	-.16**	-.13	-.11*	-.02	.27**	.17**	.26***	.00	.09	.08	.17**	.06	–		
19. Relationship Status	-.06	.18**	.09	.04	.02	.08	.18**	.17*	.16**	.04	-.06	.02	.01	-.17**	.02	.01	.13*	.02	–	
20. Education Level	-.02	.18**	.10	.03	.07	-.02	.05	.11	.11*	.08	-.06	.01	-.09	-.05	.10	.00	.02	-.02	.15**	–
21. Veteran Status	-.23***	.07	.16**	-.13*	.05	-.01	-.03	-.04	.14*	.17**	.11	.11	.08	.00	.02	.06	.10	.03	.10	.12*

Notes: Age 18-29 (All others, 1 = 18-29 years old). Race (0 = White/Caucasian, 1 = Non-White). Lifetime Mental Health Treatment (0 = No, 1 = Yes). Family Mental Health Treatment (0 = No, 1 = Yes). Sexual Orientation (0 = Heterosexual, 1 = Non-Heterosexual). Relationship Status (0 = Not in a relationship, 1 = In a relationship). Education Level (0 = Less than a bachelor’s degree, 1 = A bachelor’s degree or higher). Veteran Status (0 = No, 1 = Yes). $p < .05$

*, $p < .01$ **, $p < .001$ ***.

Table 3. Indicators for Assessing Fit for Number of Latent Profiles, RQ1 (N = 317).

<u>Profiles</u>	<u>Con</u>	<u>LL</u>	<u>AIC</u>	<u>BIC</u>	<u>ABIC</u>	<u>LMR-RT</u>	<u>BLRT</u>	<u>ENT</u>	<u>C1%</u>	<u>C2%</u>	<u>C3%</u>	<u>C4%</u>	<u>C5%</u>
1	Y	-10802.90	21689.80	21848.60	21715.38	-	-	-	1.00	-	-	-	-
2	Y	-3951.31	7978.62	8121.46	8000.94	849.91***	856.91***	.91	.44	.56	-	-	-
3	Y	-3820.64	7761.28	7986.81	7796.50	259.30	261.35***	.87	.26	.32	.42	-	-
4	Y	-386458	7533.16	7841.39	7581.31	269.98	272.12***	.89	.28	.23	.15	.34	-
5	Y	-3592.73	7393.47	7784.39	7454.53	182.26	183.26***	.92	.29	.12	.27	.24	.08

Note: Con = Converge, LL = Log likelihood, AIC = Akaike Information Criterion, BIC = Bayesian Information Criterion, ABIC = Sample-size adjusted BIC, LMR-RT = Lo-Mendell-Rubin Adjusted Likelihood Ratio Test, BLRT = Bootstrapped Likelihood Ratio Test, ENT = Entropy, C1%= Percentage of Sample in Profile 1 and so forth. $p < .05$ *, $p < .01$ **, $p < .001$ ***. Bold indicates number of profiles selected.

Table 4. Demographic Related Characteristics of the Latent Profiles, RQ1 (N = 317).

	P1 – Reluctant	P2 – Open	P3 – Restrictive	P4 – Considering
	(n = 88)	(n = 72)	(n = 48)	(n = 109)
	M (SD) or %	M (SD) or %	M (SD) or %	M (SD) or %
<i>Observed variables:</i>				
Indifference to Stigma (R = 1 – 5)	2.49 (.63)	3.98 (.74)	3.00 (.87)	3.50 (.79)
Social Support (R = 0 – 10)	7.20 (1.78)	9.82 (1.24)	3.78 (1.77)	7.24 (1.64)
External Motivations (R = 1 – 7)	4.81 (1.21)	1.98 (1.23)	2.05 (1.08)	2.57 (1.35)
Identified Motivations (R = 1 – 7)	5.19 (1.13)	6.14 (1.27)	4.53 (2.06)	5.10 (1.70)
Introjected Motivations (R = 1 – 7)	4.96 (1.07)	3.72 (1.69)	3.14 (1.59)	3.25 (1.42)
Autonomy (R = 1 – 7)	4.17 (.41)	6.08 (.59)	3.91 (1.08)	5.19 (.63)
Competence (R = 1 – 7)	4.14 (.54)	6.23 (.63)	3.75 (.82)	4.96 (.63)
Relatedness (R = 1 – 7)	4.35 (.44)	6.34 (.47)	3.63 (.69)	5.19 (.60)
<i>Demographic variables:</i>				
Religiosity (R = 1 – 5)	3.05 (1.33)	2.97 (1.57)	1.17 (.48)	1.73 (1.05)
Substance Use (R = 0 – 4)	1.70 (1.58)	.67 (1.27)	1.54 (1.69)	1.10 (1.42)
Anxiety (R = 0 – 42)	18.39 (10.78)	1.31 (3.22)	12.13 (10.63)	3.10 (4.35)
Depression (R = 0 – 42)	20.14 (9.75)	1.08 (2.42)	23.21 (12.47)	5.95 (7.27)
Stress (R = 0 – 42)	20.41 (10.01)	3.11 (4.55)	18.50 (11.04)	7.47 (7.33)
Age:				
18-29 years old	36.40%	27.80%	27.10%	20.20%
30-49 years old	56.80%	54.20%	60.40%	61.50%
50 years and older	6.80%	18.10%	12.50%	18.30%
Relationship Status:				
Not in a Relationship	27.30%	15.30%	41.70%	36.70%
In a Relationship	72.70%	84.70%	58.30%	63.30%
Racial Identity:				
Racial Minority	34.10%	36.10%	18.80%	22.90%
White/Caucasian	65.90%	63.90%	81.30%	77.10%
Veteran:				
No	80.70%	87.50%	89.60%	95.40%
Yes	19.30%	12.50%	10.40%	4.60%
Sexual Orientation:				
Non-Heterosexual	19.30%	5.60%	8.30%	10.10%
Heterosexual	80.70%	94.40%	91.70%	89.90%
Education Level:				
Less than a Bachelor’s Degree	26.10%	31.90%	60.40%	43.10%
Bachelor’s Degree or Higher	73.90%	68.10%	39.60%	56.90%
Lifetime MHT:				
No	33.00%	52.80%	14.60%	36.70%
Yes	67.00%	47.20%	85.40%	63.30%
Family MHT:				
No	25.00%	40.30%	33.30%	33.00%
Yes	75.00%	59.70%	66.70%	67.00%

Notes: MHT = Mental Health Treatment.

Table 5. Correlations of Coefficients of Factors Related to Help-Seeking Behaviors for Multinomial Logistic Regression, RQ2 (N = 317).

	1	2	3	4	5	6
1. Psychological Openness	—	-	-	-	-	-
2. Mental Help Seeking Intentions	.39***	—	-	-	-	-
3. Self-Compassion	.12*	.09	—	-	-	-
4. Shame: Vulnerability	-.22***	-.05	-.63***	—	-	-
5. Restrictive Emotionality	-.41***	-.13*	-.43***	.57***	—	-
6. Restrictive Affectionate Behavior between Men	-.55***	-.08	-.26***	.36***	.56***	—
7. Religiosity	-.16**	.20***	.15**	-.01	.07	.27***
8. Anxiety	-.26***	.07	-.40***	.67***	.45***	.37***
9. Depression	-.23**	-.02	-.58***	.80***	.51***	.39***
10. Stress	-.22***	.01	-.51***	.73***	.51***	.40***
11. Substance Use	-.09	-.02	-.16**	.33***	.20***	.17**
12. Age: 18-29	.02	.10	-.07	.16**	.14*	-.03
13. Age: 50 and Older	.00	-.03	.09	-.15**	.02	.15**
14. Race	-.08	.16**	.01	.00	.01	.11
15. Lifetime MHT	.06	.19**	-.21**	.30***	.17**	-.04
16. Family MHT	-.06	.04	.00	.12*	.11	.12*
17. Sexual Orientation	-.07	.03	-.13*	.25***	.17**	-.01
18. Relationship Status	-.09	.04	.13*	-.15**	-.05	.07
19. Education Level	.04	.09	.08	-.04	.02	.07
20. Veteran Status	-.19**	-.07	.04	.12*	.14*	-.20**

Notes: Age 18-29 (0 = All others, 1 = 18-29 years old). Age 50 and Older (0 = All others, 1 = 50 years old and older). Race (0 = White/Caucasian, 1 = Non-White). Lifetime Mental Health Treatment (0 = No, 1 = Yes). Family Mental Health Treatment (0 = No, 1 = Yes). Sexual Orientation (0 = Heterosexual, 1 = Non-Heterosexual). Relationship Status (0 = Not in a relationship, 1 = In a relationship). Education Level (0 = Less than a bachelor’s degree, 1 = A bachelor’s degree or higher). Veteran Status (0 = No, 1 = Yes). $p < .05$ *. $p < .01$ **. $p < .001$ ***.

Table 6. Multinomial Logistic Regression Factors Related to Help-Seeking Behaviors, RQ2.

	Profile 1: Reluctant			Profile 3: Restrictive			Profile 4: Considering		
	<i>b</i> (SE)	OR	95% CI	<i>b</i> (SE)	OR	95% CI	<i>b</i> (SE)	OR	95% CI
18-29 years old ^(All others)	2.13 (.56)	8.41***	2.81, 25.22	2.34 (.61)	10.35***	3.11, 34.43	2.11 (.48)	8.27***	3.26, 20.98
50 years old and older ^(All others)	-.41 (.67)	.67	.18, 2.50	-.09 (.76)	.92	.21, 4.05	-1.19 (.46)	.30*	.12, .75
In a Relationship ^(Not in Relationship)	1.99 (.52)	7.29***	2.63, 20.19	1.64 (.57)	5.13**	1.67, 15.74	1.99 (.44)	7.31***	3.07, 17.41
Non-Heterosexual ^(Heterosexual)	-.80 (.75)	.45	.10, 1.95	1.83 (.91)	6.20*	1.05, 36.53	.87 (.59)	2.38	.75, 7.55
Bachelor’s Degree or Higher ^(Less than a Bachelor’s Degree)	-.75 (.44)	.47 [†]	.20, 1.10	.78 (.49)	2.18	.84, 5.69	.14 (.34)	1.15	.59, 2.26
Veteran ^(Not a Veteran)	1.59 (.87)	4.91 [†]	.89, 27.14	-.36 (.83)	.70	.14, 3.55	1.79 (.60)	5.96**	1.86, 19.15
Racial Minority ^(White/Caucasian)	1.93 (.51)	6.87***	2.54, 18.55	.68 (.58)	1.97	.63, 6.15	1.33 (.43)	3.77**	1.64, 8.67
Lifetime MHT ^(No)	2.06 (.54)	7.82***	2.73, 22.42	-1.95 (.62)	.14**	.04, .48	-.39 (.40)	.68	.31, 1.47
Family MHT ^(No)	-1.25 (.48)	.29*	.11, .74	.04 (.55)	1.04	.36, 3.03	-1.26 (.38)	.28**	.13, .60
Religiosity	-1.04 (.22)	.36***	.23, .54	-3.64 (.38)	.03***	.01, .06	-1.58 (.19)	.21***	.14, .30
Substance Use	.12 (.17)	1.13	.82, .157	.03 (.18)	1.03	.72, 1.48	.14 (.14)	1.16	.87, 1.53
Anxiety	.08 (.06)	1.09	.97, 1.22	-.03 (.06)	.97	.86, 1.10	-.12 (.06)	.88*	.79, .99
Depression	.42 (.08)	1.52***	1.31, 1.78	.48 (.08)	1.62***	1.39, 1.89	.36 (.07)	1.43***	1.24, 1.65
Stress	-.05 (.06)	.95	.85, 1.07	-.02 (.06)	.98	.87, 1.10	-.01 (.05)	1.00	.90, 1.11
Psychological Openness	-2.22 (.35)	.11***	.06, .22	-.13 (.39)	.88	.41, 1.89	-.81 (.28)	.44**	.26, .76
Mental Help Seeking Intentions	-.01 (.16)	.99	.72, 1.37	-1.12 (.19)	.33***	.23, .47	-.55 (.14)	.58***	.44, .76
Self-Compassion	-3.04 (.52)	.05***	.02, .13	-3.09 (.53)	.05***	.02, .13	-2.09 (.41)	.12***	.06, .28
Shame: Vulnerability	1.64 (.41)	5.17***	2.33, 11.45	1.78 (.43)	5.95***	2.55, 13.90	1.38 (.37)	3.98***	1.91, 8.92
Restrictive Emotionality	.43 (.20)	1.54*	1.04, 2.27	.45 (.24)	1.57 [†]	.99, 2.49	.22 (.17)	1.25	.89, 1.74
Restrictive Affectionate Behavior between Men	-.31 (.20)	.74	.50, 1.09	.34 (.22)	1.41	.92, 2.16	-.14 (.16)	.87	.64, 1.20
Intercept (SE)		10.92 (2.86)			11.48 (3.10)			10.67 (2.33)	

Note: R² = .83 (Cox and Snell), .89 (Nagelkerke). Model χ^2 (60) = 562.95. SE = Standard Error. OR = Odds Ratio. Reference group is Profile 2: Open. MHT = Mental Health Treatment. Reference group for dichotomous variables in parentheses, otherwise all other variables are continuous. [†]*p* < .10, **p* < .05. ***p* < .01. ****p* < .001.

Table 7. Correlations of Coefficients of Disclosure and Social Influence Variables, RQ3 (N = 317).

	1	2	3	4	5	1a	2a	3a	4a	5a	
1. Partner Disclosure											1a. Partner Influence
2. Parent Disclosure	.50***					.62***					2a. Parent Influence
3. Close Friend Disclosure	.48***	.51***				.54***	.53***				3a. Close Friend Influence
4. Religious/Spiritual Leader Disclosure	.13	.42***	.36***			.25**	.47***	.50***			4a. Religious/Spiritual Leader Influence
5. Medical Doctor Disclosure	.32***	.35***	.41***	.50***		.45***	.57***	.48***	.49***		5a. Medical Doctor Influence
6. Religiosity	-.12	.10	.01	.43***	.08	-.02	.13*	.11*	.47***	.14*	6. Religiosity
7. Anxiety	-.23***	.03	.02	.29***	.14*	-.05	-.01	.06	.24**	.06	7. Anxiety
8. Depression	-.16**	.00	.00	.25***	.08	-.09	-.07	-.01	.18*	-.04	8. Depression
9. Stress	-.19**	-.03	-.02	.23**	.09	-.05	-.06	.01	.17*	.00	9. Stress
10. Substance Use	-.09	.09	.01	.25**	.06	-.03	.03	.07	.21**	.08	10. Substance Use
11. Age: 18-29	-.06	.13*	.02	.07	.01	-.06	.09	.00	.03	-.01	11. Age: 18-29
12. Age: 50 and Older	.08	-.13*	-.11	-.10	-.05	.03	-.05	-.05	-.04	.02	12. Age: 50 and Older
13. Race	.07	.23***	.06	.19*	.30***	.10	.23***	.09	.13	.28***	13. Race
14. Lifetime MHT	.08	.12*	.07	.18*	.21**	.11	.08	.08	.13	.17*	14. Lifetime MHT
15. Family MHT	.03	.11	.01	.20**	.05	.04	.11	.04	.17*	.10	15. Family MHT
16. Sexual Orientation	.01	-.01	.06	.06	.05	.09	-.01	.05	.09	-.01	16. Sexual Orientation
17. Relationship Status	.03	-.10	-.05	-.04	.08	.15*	.05	-.01	.02	.05	17. Relationship Status
18. Education Level	-.09	.00	-.02	.02	.03	.00	.01	.01	-.03	.02	18. Education Level
19. Veteran Status	-.15*	-.07	-.04	.18*	.12*	-.10	-.01	.03	.16*	.10	19. Veteran Status

Notes: Age 18-29 (0 = All others, 1 = 18-29 years old). Age 50 and Older (0 = All others, 1 = 50 years old and older). Race (0 = White/Caucasian, 1 = Non-White). Lifetime Mental Health Treatment (0 = No, 1 = Yes). Family Mental Health Treatment (0 = No, 1 = Yes). Sexual Orientation (0 = Heterosexual, 1 = Non-Heterosexual). Relationship Status (0 = Not in a relationship, 1 = In a relationship). Education Level (0 = Less than a bachelor’s degree, 1 = A bachelor’s degree or higher). Veteran Status (0 = No, 1 = Yes). $p < .05$ *. $p < .01$ **. $p < .001$ ***.

Table 8. Multinomial Logistic Regression for Disclosure to Seek Therapy, RQ3.

	Profile 1: Reluctant			Profile 3: Restrictive			Profile 4: Considering		
	<i>b</i> (SE)	OR	95% CI	<i>b</i> (SE)	OR	95% CI	<i>b</i> (SE)	OR	95% CI
Partner Disclosure	-.10 (.05)	.91 [†]	.82, 1.00	-.08 (.06)	.93	.82, 1.04	-.03 (.04)	.97	.889, 1.06
Parent Disclosure	-.04 (.05)	.97	.88, 1.06	-.08 (.06)	.92	.83, 1.03	-.03 (.04)	.97	.90, 1.05
Close Friend Disclosure	-.03 (.05)	.97	.88, 1.07	.01 (.06)	1.01	.89, 1.15	-.01 (.04)	.99	.92, 1.07
Religious/Spiritual Leader Disclosure	.03 (.04)	1.03	.95, 1.12	.01 (.06)	1.01	.90, 1.14	-.02 (.04)	.98	.91, 1.05
Medical Doctor Disclosure	-.01 (.04)	.99	.91, 1.07	-.07 (.05)	.94	.84, 1.04	-.02 (.04)	.97	.91, 1.03
Religiosity	-.67 (.25)	.51**	.32, .83	-2.27 (.45)	.10***	.04, .25	-1.05 (.21)	.35***	.23, .53
Substance Use	-.11 (.27)	.89	.53, 1.50	.72 (.32)	2.05*	1.11, 3.81	.41 (.21)	1.51 [†]	.99, 2.28
Anxiety	-.02 (.10)	.98	.81, 1.19	-.22 (.11)	.80 [†]	.65, 1.00	-.19 (.09)	.83*	.70, .99
Depression	.59 (.13)	1.80***	1.41, 2.31	.55 (.13)	1.73***	1.34, 2.23	.45 (.12)	1.56***	1.23, 1.99
Stress	.01 (.08)	1.01	.87, 1.17	.15 (.08)	1.17 [†]	.99, 1.38	.09 (.07)	1.09	.95, 1.25
Intercept (SE)		2.08 (1.17)			3.82 (1.34)			3.34 (1.07)	

Note: $R^2 = .71$ (Cox and Snell), $.77$ (Nagelkerke). Model $\chi^2(30) = 204.77$. SE = Standard Error. OR = Odds Ratio. Reference group is Profile 2: Open. [†] $p < .10$, * p

$< .05$. ** $p < .01$. *** $p < .001$.

Table 9. Multinomial Logistic Regression for Social Influence to Seek Therapy, RQ3.

	Profile 1: Reluctant			Profile 3: Restrictive			Profile 4: Considering		
	<i>b</i> (SE)	OR	95% CI	<i>b</i> (SE)	OR	95% CI	<i>b</i> (SE)	OR	95% CI
Partner Influence	-.06 (.07)	.94	.83, 1.07	.08 (.08)	1.08	.93, 1.26	.01 (.06)	1.01	.90, 1.13
Parent Influence	-.02 (.07)	.99	.87, 1.12	-.13 (.07)	.88 [†]	.77, 1.01	-.06 (.06)	.95	.85, 1.06
Close Friend Influence	-.08 (.05)	.92	.83, 1.02	-.13 (.06)	.88*	.77, .99	-.06 (.04)	.94	.86, 1.02
Religious/Spiritual Leader Influence	-.01 (.04)	1.00	.91, 1.09	.09 (.07)	1.10	.97, 1.25	-.05 (.04)	.95	.88, 1.03
Medical Doctor Influence	.02 (.05)	1.02	.93, 1.12	.00 (.06)	1.00	.89, 1.12	.04 (.04)	1.04	.96, 1.13
Religiosity	-.58 (.24)	.56*	.35, .89	-2.68 (.55)	.07***	.02, .20	-.98 (.20)	.37***	.25, .56
Substance Use	-.10 (.26)	.90	.55, 1.50	.65 (.33)	1.92*	1.01, 3.63	.21 (.21)	1.24	.81, 1.88
Anxiety	.10 (.10)	1.11	.91, 1.34	-.09 (.11)	.91	.73, 1.14	-.06 (.10)	.94	.78, 1.14
Depression	.44 (.10)	1.56***	1.29, 1.89	.46 (.10)	1.59***	1.30, 1.94	.34 (.09)	1.40***	1.17, 1.69
Stress	-.02 (.08)	.98	.83, 1.15	.10 (.09)	1.11	.93, 1.32	.02 (.08)	1.02	.88, 1.18
Intercept (SE)		1.60 (1.02)			2.20 (1.38)			3.28 (.92)	

Note: R² = .73 (Cox and Snell), .79 (Nagelkerke). Model $\chi^2(30) = 225.55$. SE = Standard Error. OR = Odds Ratio. Reference group is Profile 2: Open. [†] $p < .10$, * p

< .05. ** $p < .01$. *** $p < .001$.

Table 10. Correlations of Coefficients of Seeking Therapy for Depression and Anxiety, Substance Use, and Suicidality, RQ4

	1	2	3
1. Seek Treatment for Depression and Anxiety			
2. Seek Treatment for Substance Use	.60***		
3. Seek Treatment for Suicidality	.69***		
4. Religiosity	.13*	-.05	.03
5. Anxiety	.09	-.09	-.08
6. Depression	.04	-.10	-.08
7. Stress	.07	-.06	-.09
8. Substance Use	-.02	-.07	-.10
9. Age: 18-29	.07	.10	.13
10. Age: 50 and Older	-.04	-.01	-.10
11. Race	.16**	.02	.11
12. Lifetime MHT	.25***	.18*	.17*
13. Family MHT	.08	.17*	-.01
14. Sexual Orientation	.03	.01	.01
15. Relationship Status	.13*	.11	.11
16. Education Level	.07	-.05	.07
17. Veteran Status	-.10	-.20*	-.16*

Notes: Age 18-29 (0 = All others, 1 = 18-29 years old). Age 50 and Older (0 = All others, 1 = 50 years old and older). Race (0 = White/Caucasian, 1 = Non-White). Lifetime Mental Health Treatment (0 = No, 1 = Yes). Family Mental Health Treatment (0 = No, 1 = Yes). Sexual Orientation (0 = Heterosexual, 1 = Non-Heterosexual). Relationship Status (0 = Not in a relationship, 1 = In a relationship). Education Level (0 = Less than a bachelor’s degree, 1 = A bachelor’s degree or higher). Veteran Status (0 = No, 1 = Yes). $p < .05$ *. $p < .01$ **. $p < .001$ ***.

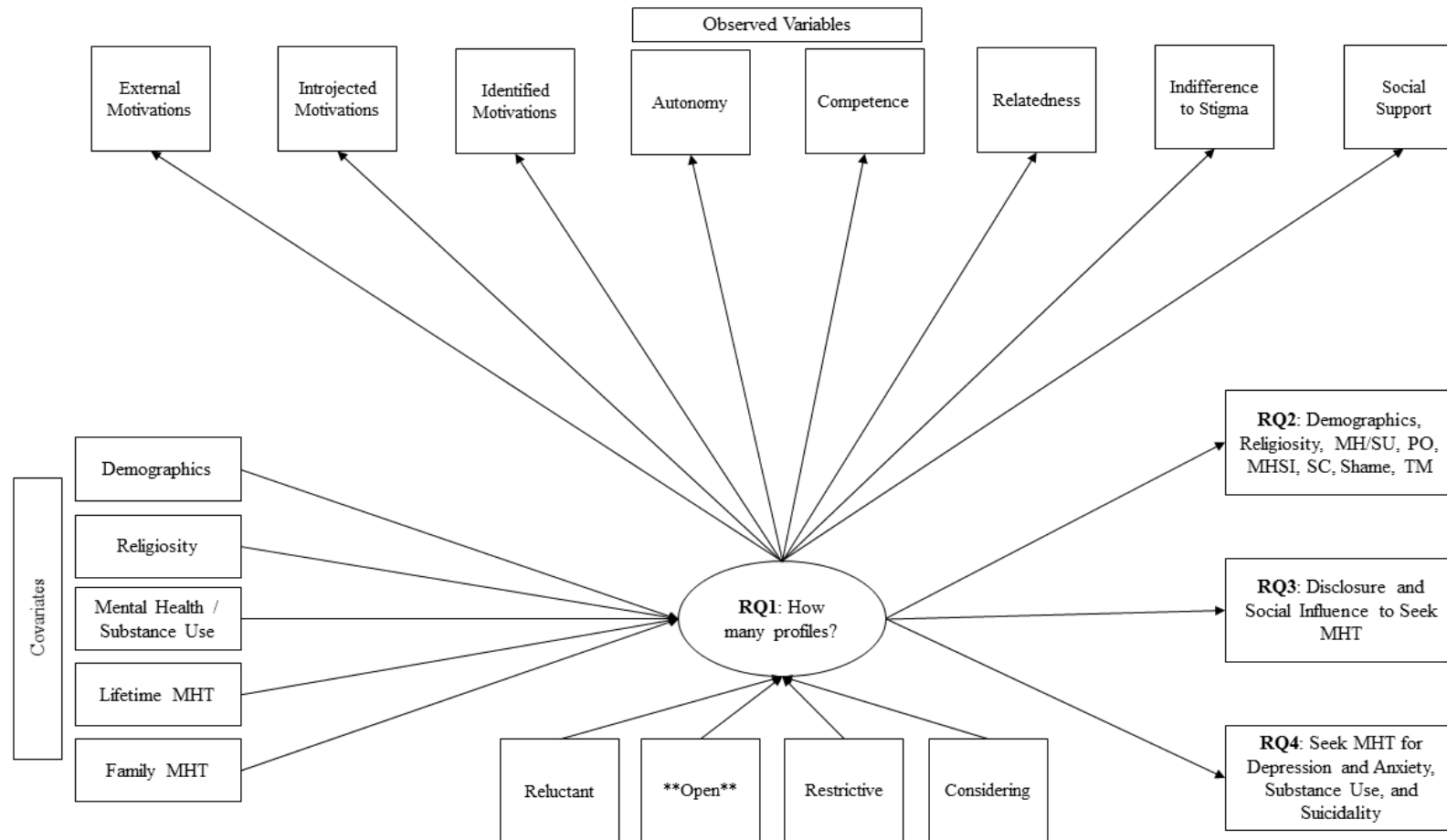


Figure 1. Research Study Diagram.

Note: MHT = Mental Health Treatment. MH = Mental Health. SU = Substance Use. PO = Psychological Openness. MHSI = Mental Help Seeking Intentions. SC = Self-Compassion. TM = Traditional Masculinity.

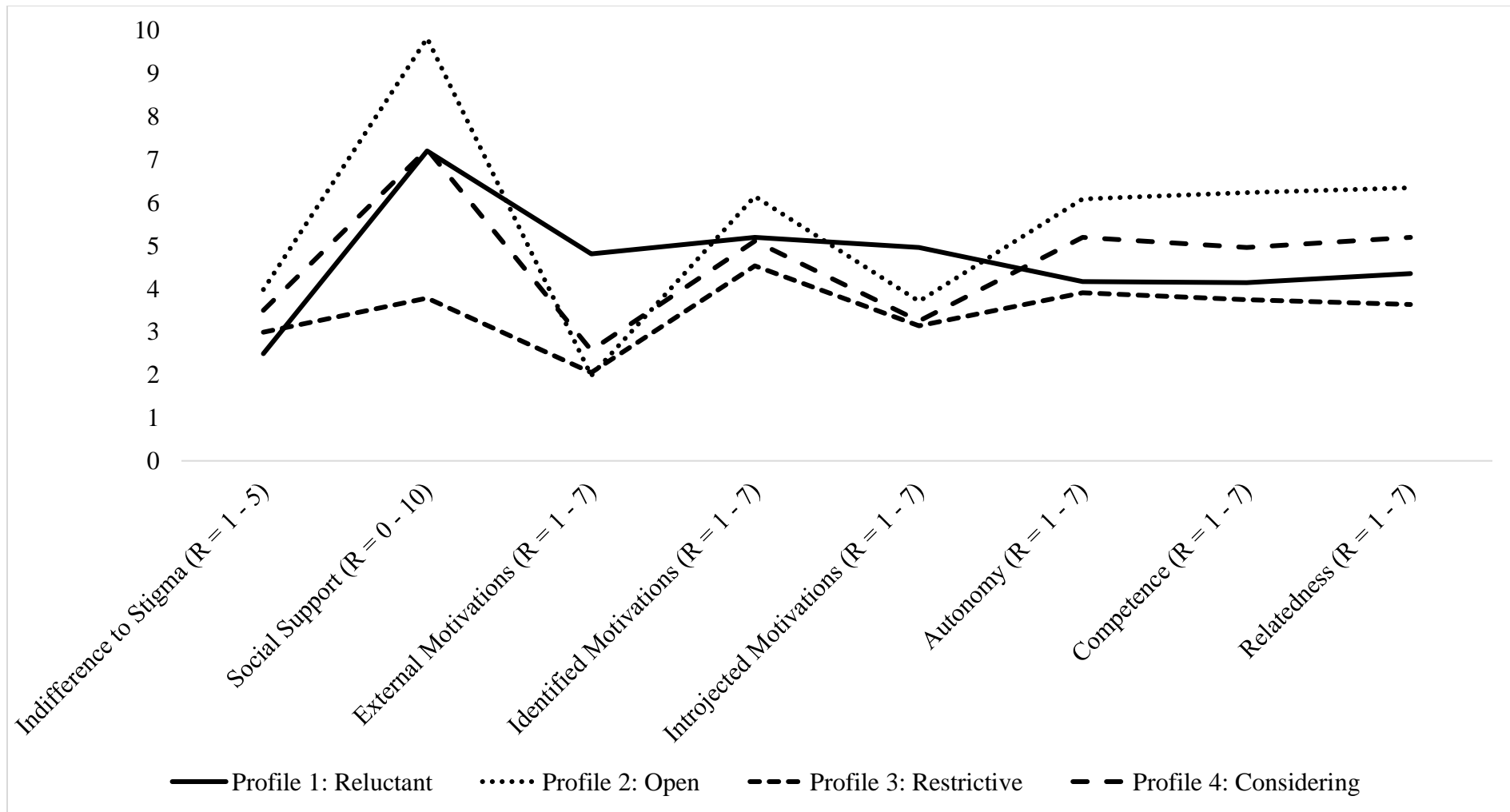


Figure 2. Latent Profile Analysis of Four Profiles.

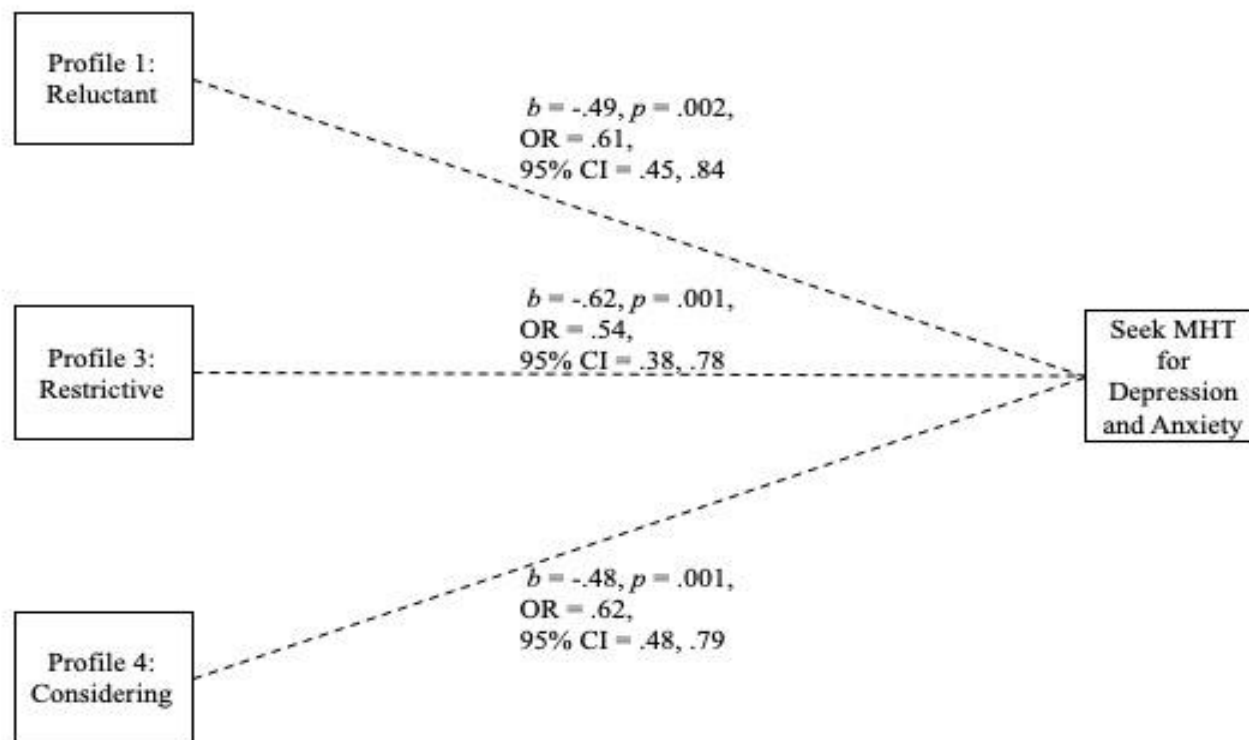


Figure 3. Odds ratio for men's consideration to seek therapy for depression and anxiety.

Note: $R^2 = .73$ (Cox and Snell), $.78$ (Nagelkerke). Model $\chi^2(18) = 407.40$. OR = Odds Ratio. CI = Confidence Interval. MHT = Mental Health Treatment.

Reference group is Profile 2: Open. Controlled for religiosity, substance use, anxiety, depression, and stress. Dotted line indicates significant difference between that profile and the reference group at the $p < .05$ level.

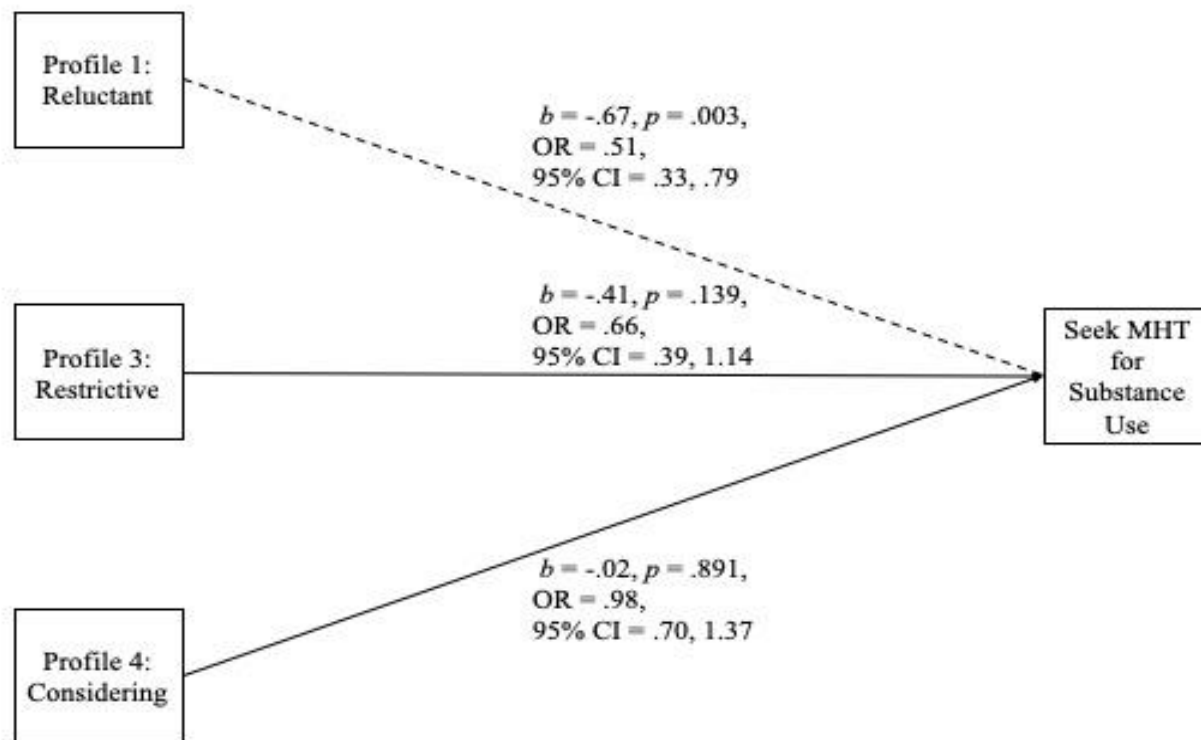


Figure 4. Odds ratio for men's consideration to seek therapy for substance use.

Note: $R^2 = .79$ (Cox and Snell), $.85$ (Nagelkerke). Model $\chi^2(18) = 250.49$. OR = Odds Ratio. CI = Confidence Interval. MHT = Mental Health Treatment.

Reference group is Profile 2: Open. Controlled for religiosity, substance use, anxiety, depression, and stress. Dotted line indicates significant difference between that profile and the reference group at the $p < .05$ level.

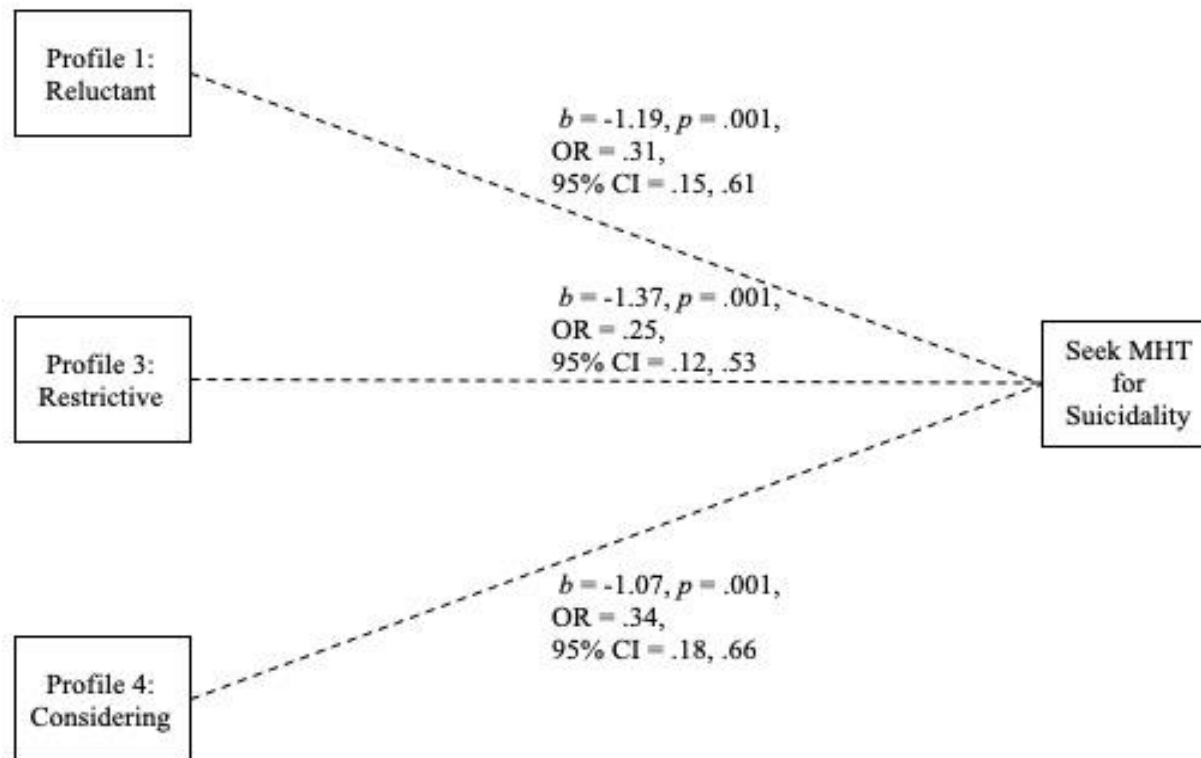


Figure 5. Odds ratio for men's consideration to seek therapy for suicidality.

Note: $R^2 = .68$ (Cox and Snell), $.74$ (Nagelkerke). Model $\chi^2(18) = 180.04$. OR = Odds Ratio. CI = Confidence Interval. MHT = Mental Health Treatment.

Reference group is Profile 2: Open. Controlled for religiosity, substance use, anxiety, depression, and stress. Dotted line indicates significant difference between that profile and the reference group at the $p < .05$ level.

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Appendix A - Additional Documents

Informed Consent

KANSAS STATE UNIVERSITY – INFORMED CONSENT

PROJECT TITLE: Examining Motivations and Influences for Seeking Mental Health Treatment

APPROVAL DATE OF PROJECT: 11/9/2018

EXPIRATION DATE OF PROJECT: 11/9/2019

PRINCIPAL INVESTIGATOR: CO-INVESTIGATOR(S):

Dr. Joyce Baptist (Principal Investigator)

Matthew Hunter Stanfield (Co-Investigator/Graduate Student)

CONTACT AND PHONE FOR ANY PROBLEMS/QUESTIONS:

Dr. Joyce Baptist, jbaptist@ksu.edu, 785-532-6891

Matthew Hunter Stanfield, mhstanfield@ksu.edu, 785-532-6891

IRB CHAIR CONTACT/PHONE INFORMATION:

Rick Scheidt, Chair, Committee on Research Involving Human Subjects, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506, (785) 532-3224.

Cheryl Doerr, Associate Vice President for Research Compliance, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506, (785) 532-3224.

PURPOSE OF THE RESEARCH: The purpose of this research is to study the factors that contribute to an individual's decision-making processes about engaging in mental health treatment.

PROCEDURES OR METHODS TO BE USED: Individuals over the age of 18 will be offered the opportunity to take an online survey about the factors that contribute to their decision-making processes about engaging in mental health treatment.

LENGTH OF STUDY: The survey will take approximately 30-45 minutes to complete.

RISKS ANTICIPATED: Participants may experience mild distress from the inconvenience of participating in this study. At any point in time, participants are allowed to withdraw from the study. Participants are also able to contact study investigators should they have any concerns about their involvement in the study. If a participant experiences any distress or any other unanticipated negative experience from this survey, they can contact Matthew Hunter Stanfield by email (mhstanfield@ksu.edu). At the end of the survey, there is also contact information and links to websites where participants can locate a therapist near them.

BENEFITS ANTICIPATED: This information will be used to better inform mental health treatments and mental health professionals about the preferences of individuals as they seek out mental health services.

EXTENT OF CONFIDENTIALITY: The complete confidentiality of your responses is very important, and steps are taken to keep results confidential. Participants are not asked or required to provide their name or any other identifying information, and as such the information a participant provides is confidential and anonymous.

TERMS OF PARTICIPATION: I understand this project is research, and that my participation is completely voluntary in completing these surveys and I am not required to answer any item I do not feel comfortable with. I also understand that if I decide to participate in this study, I may withdraw my consent at any time, and stop participating at any time without explanation, penalty, or loss of benefits to which I may otherwise be entitled.

I verify that by checking the box below I have read and understood this consent form, am at least 18 years old, and willingly agree to participate in this study under the terms described.

Measure Release of Information Forms

RELEASE FORM FOR THE GENDER ROLE CONFLICT SCALE SHORT FORM (GRCS-SF)

NAME: Hunter Stanfield

ADDRESS: Kansas State University
139 Campus Creek Complex
1405 Campus Creek Road
Manhattan, KS 66506


E-MAIL ADDRESS: MHSTANFIELD@KSU.EDU

PHONE: 785-532-6984 (WORK)

256-710-7114 (CELL)

1. (X) Yes, I plan to use the Gender Role Conflict Scale Short Form in my research.
2. Please briefly describe your research project, if possible, including the nature of your sample and any other scales to be used. **The GRCS-SF will be utilized in my dissertation study that aims to examine men's disclosure, influence, and motivations for mental health treatment through a latent profile analysis, and the comparing the classes using a multinomial logistic regression to determine the odds of being one class over another. The GRCS-SF will be used alongside other measures such as those assessing motivations for mental health treatment, social support, self-compassion, shame, and substance.**
3. How many subjects do you expect will complete the GRCS Short Form? **Between 300-350.**
4. If this research is a supervised undergraduate thesis, masters thesis or **doctoral dissertation**, who is supervising your research? Please give faculty member's name, address, and phone number.
Name: Dr. Joyce Baptist, Associate Professor of Couple and Family Therapy
Address: Kansas State University
139 Campus Creek Complex
1405 Campus Creek Road
Manhattan, KS 66506
Phone: 785-532-6984

I agree to send the results to the study to Dr. Jim O'Neil upon completion of research to be included on the Gender Role Conflict Research Program Web Page and in any future reviews of the literature on men's gender role conflict. This means sending me copies of the thesis, dissertation, convention presentation, and submitted or published journal article that describes the research's rationale, methods, results, and discussion.

Signature  Date 11 Feb 2019

Retain one copy of this release for your records and before the research is implemented return one to:

Dr. James M. O'Neil
Department of Educational Psychology
249 Glenbrook Road, Room, U-2064
University of Connecticut
Storrs, CT 06269-2064
FAX: 860-486-0180
E-MAIL: oneil@uconnvm.uconn.edu
jimoneil1@aol.com

Monday, March 11, 2019 at 2:48:09 PM Central Daylight Time

Subject: Hammer Instrument Permission Form

Date: Tuesday, December 11, 2018 at 4:03:17 PM Central Standard Time

From: Google Forms

To: Hunter Stanfield

Google Forms

Thanks for filling out [Hammer Instrument Permission Form](#)

Here's what we got from you:

EDIT RESPONSE

Hammer Instrument Permission Form

If you wish to use an instrument published by Joseph H. Hammer, PhD, please complete this form. Each new study or application requires a separate permission form.

Please enter your email address below.

Email address *

mhstanfield@ksu.edu

Do you wish to use the instrument(s) for commercial, business, or for-profit applications? *

- ☒ No
☐ Yes

Your Information

Your Name *

Page 1 of 5

Hunter Stanfield

Degree (e.g., MS, PhD, MD) *

M.A., M.D.R., M.S.

Address (Street, City, State, ZIP, Country) *

1701 Hillcrest Drive, Apt. W5, Manhattan, KS 66502, USA

Phone Number *

256-710-7114

Your Educational / Professional Status *

- ☐ Undergraduate Student
- ☒ Graduate or Professional Student
- ☐ Faculty Member
- ☐ Clinician
- ☐ Other:

Supervisor Information

Please provide information about the faculty member who is supervising your research project.

Your Supervisor's Name *

Joyce Baptist

Your Supervisor's Degree (e.g., PhD, MD) *

PhD

Your Supervisor's Address (Street, City, State, ZIP, Country) *

303 Justin Hall 1324 Lovers Lane Manhattan, KS 66506-1403,
USA

Your Supervisor's Phone Number *

785-532-6891

Your Supervisor's Email Address *

jbaptist@ksu.edu

Instruments

Which instrument(s) do you plan to administer? *

- ☐ Help-Seeker Stereotype Scale (HSSS)
- ☒ Mental Help Seeking Attitudes Scale (MHSAS)
- ☒ Mental Help Seeking Intention Scale (MHSIS)
- ☐ Other:

Do you wish to use the instrument(s) for research purposes? *

- ☐ No
- ☒ Yes

Intended Use

What population(s) do you intend to administer the instrument(s) to? *

Men over the age of 18

About how many people do you intend to administer the instrument(s) to? If you're not sure, please give your best guess. *

300

If you plan to adapt/change the instrument(s) in any way, please explain: *

N/A

Please briefly describe how you intend to use the instrument(s), including the purpose of the study and other measures or procedures administered. *

To evaluate men's motivations and influences for seeking mental health treatment.

Dr. Hammer wants to further investigate the psychometric properties of his instruments. This can be done by analyzing large archival data sets created by combining data from various researchers' investigations. Dr. Hammer only desires the data for his instruments, not for other instruments included in the study. At the conclusion of your project, would you be willing to send Dr. Hammer a de-identified dataset (in either Microsoft Excel or SPSS data file format) containing participant responses to Dr. Hammer's instrument items and any available demographic items (e.g., age, gender, race, sexual orientation, clinical status, past experience with therapy)? This is optional, not required. *

- ☒ Yes
- ☐ No

Signature

For this upcoming project that will use Dr. Hammer's instrument(s), I agree to send Dr. Hammer a copy of the thesis, dissertation, convention presentation, and submitted or published journal article (whichever apply) that describes my project's rationale, methods, results, and discussion.

Please sign to indicate your agreement by typing your full name in the box below. *

Matthew Hunter Stanfield

Please date your signature by typing in today's date in the box below. *

12/11/2018

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