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# Gender and Attitudes about Mental Health Help Seeking: Results from National Data

*Douglas Wendt and Kevin Shafer*

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Men often express less emotion than women do, are hesitant to express weakness, and seek professional help much less frequently than do their female counterparts. The lack of help seeking is common across characteristics such as age, race, ethnicity, and nationality. Authors used data from the 2006 General Social Surveys mental health module to suggest that the gender gap in help seeking may be rooted in attitudes regarding help-seeking behaviors generally. Using structural equation modeling, we linked vignette type (depression and schizophrenia) to the endorsement of help seeking from informal and formal sources. Men showed similar support for informal help seeking regardless of the problem but were less likely to endorse formal help for depression. Furthermore, men were no more or less likely than women to endorse help seeking if the individual in the vignette was male or female. Results show some support for the hypothesis that men are less prone than women to display positive help-seeking attitudes, particularly related to common mental health issues. This may help researchers and clinicians better understand the numerous barriers to men's help seeking.

KEY WORDS: *help seeking; masculinity; men's health; mental health*

Mental health problems commonly affect men. Ten percent to 15 percent of men will experience a major depressive episode in their lifetimes (Parker & Brotchie, 2010), and nearly 20 percent will abuse alcohol (World Health Organization, 2007). Of further concern, men sometimes manifest their mental health issues through anger and violence (Mares, Lichtwarck-Aschoff, Burk, van der Vorst, & Engels, 2012). As a result, men's mental health is an important public health issue. Men with mental health issues, compared with those who do not have such issues, are more likely to abuse substances; engage in risky behavior; and have generally negative conduct that can affect themselves, other men, women, children, and their communities (Acevedo, Lowe, Griffin, & Botvin, 2013). In extreme cases, untreated mental health issues can have tragic consequences for men, who are four times more likely to commit suicide than women are (Addis & Mahalik, 2003).

These problems are compounded by the unwillingness of many men to get help for their problems or to acknowledge their weaknesses (Addis & Mahalik, 2003). As a result, men are far less likely than women are to get help—a pattern that holds true across most sociodemographic characteristics (D'Arcy & Schmitz, 1979; Husaini, Moore, & Cain,

1994; Neighbors & Howard, 1987). Another reason men may be hesitant to get help is that they can be skeptical of mental health professionals. Many men think that clinicians are ill equipped to help them, that feelings of depression and anxiety are normative for men and cannot be changed through therapy, that they are misunderstood because of the language they use to express their emotional concerns, and that they are unwanted as clients (Addis, 2011; Rochlen et al., 2010). These are serious roadblocks for unhealthy men, suggesting that clinicians, community organizers, and educators need a better understanding of men's views on help seeking to effectively promote good mental health in men.

Studies examining general attitudes about mental health help seeking are lacking, particularly in nationally representative samples. This is unfortunate because such studies could provide valuable information about the stigmatization of help seeking in men and their patterns of help avoidance. That information could then be used to improve health services and promotion for men. Our article addresses this gap with data from the nationally representative 2006 General Social Surveys (GSS) mental health module. More specifically, we examined how gender influences attitudes about informal and formal help seeking for diagnosable mental health

issues. Furthermore, we considered whether help-seeking endorsement varied by the gender and race of a person with mental illness. In doing so, we seek to demonstrate potential gender differences in help-seeking attitudes and investigate potential variation in these attitudes. In turn, our goal is to reveal the need for a more responsible, gender-specific, and nuanced approach toward clinical and community practice with men.

### HELP-SEEKING BEHAVIOR

Men are typically socialized into a masculine gender role, which requires men to conform to a socially constructed masculine ideal that values independence, emotional silence, self-reliance, and the rejection of personal weakness (Addis & Mahalik, 2003; Furman, 2010). These norms conflict with the idea of getting professional help for one's problems (Addis & Mahalik, 2003; D'Arcy & Schmitz, 1979; Husaini et al., 1994; Neighbors & Howard, 1987). As a result, men are far less likely than women to see physicians, to ask questions of health care professionals, and to be involved in their individual treatment plans (Courtenay, 2000; Galdas, Cheater, & Marshall, 2005). These norms seem to have an even stronger effect on help seeking for mental health issues. Many men say they feel pressured to keep their emotions masked from others. Yet, research has not yet identified if this pressure is real (that is, vocally expressed) or perceived (that is, "I think that my friends will judge me if I do this"; Harding & Fox, 2014). Further compounding the problem, men sometimes deny that they have a mental health issue even when they see a professional, instead deciding that they will not engage in a proscribed management strategy (Rochlen et al., 2010).

Men's help-seeking avoidance can have wide-ranging effects not only on the men who experience mental health problems, but also on the individuals with whom they frequently interact. For example, men's psychological well-being has an impact on women and children, who are often deeply affected by the positive and negative actions of their fathers, brothers, friends, husbands, and lovers (Furman, 2010). Men who need but do not receive psychological help are likely to express their problems in unhealthy ways (through anger, violence, and so on), possibly harming themselves or others. Given these serious consequences and the distrust many men have of mental health providers, it is essential that professionals in research and practice become more attuned to the unique, nuanced, gender-based needs of men.

### HELP-SEEKING ATTITUDES

Individual and societal attitudes about help seeking, particularly among men, can create a significant barrier for men who want or need help (Addis & Mahalik, 2003; Ang, Lim, & Tan, 2004; Mackenzie, Gekoski, & Knox, 2006; Nam et al., 2010). This may help explain the gender gap in help seeking, particularly because prior work suggests that men hold more stigmatized attitudes about mental health help than women do. In fact, not getting help for one's problems may be a socially rewarded choice. For example, Courtenay (2000) argued that other men often perceive individuals who neglect their health and safety as highly masculine. Yet, there is a scarcity of work that specifically focuses on potential gender differences in help-seeking stigmatization. Those studies that have addressed this question show that men stigmatize mental health help seeking more than women do. For example, Chandra and Minkovitz (2006) found that adolescent boys have more negative attitudes about seeing mental health professionals than adolescent girls do; Mackenzie et al. (2006) found similar results in a community sample of Australian adults. Although these articles provide some evidence of a gendered stigmatization of mental health help seeking, there is still little clarity about this question—particularly among U.S. adults.

Although little is known about the relationship between gender and help-seeking stigmatization in the United States, it is clear that the perception of such a stigma has real and substantial consequences on help-seeking behavior. Perceived stigma often leads men with mental health problems to cover up, dispute, or control others' perceptions of them (Addis, 2011). Similarly, men often fear personal shunning and emasculation by friends, family, and acquaintances if they want, need, or go to see a clinician (Rochlen et al., 2010). These issues underscore the need for clinicians and researchers to avoid harmful and damaging stereotypes about men—particularly those men who are willing to see a mental health professional. For example, men who think that help seeking is normative (Brooks, 1998) and beneficial (Hammer, Vogel, & Heimerdinger-Edwards, 2013; Vogel, Wade, & Ascherman, 2009) are far more likely than other men to get help.

### CURRENT STUDY

Help avoidance has real effects on individuals, families, and communities, which raises numerous questions

about whether mental health help-seeking stigma is gendered, how strong this stigma may be, and if the stigma varies across help-seeking venues or mental health problems. Prior studies about help-seeking attitudes fall into two categories. The first group of studies has addressed personal help-seeking attitudes in various hypothetical scenarios (that is, “Would you seek help if . . . ?”), whereas the second group considered attitudes about individuals who get help for mental health problems (that is, “What would you think about a person who . . . ?”). Although these literatures provide valuable information about the factors affecting help-seeking behavior, little is known about gender as a factor in help-seeking attitudes. We addressed this gap by focusing on help-seeking endorsement on the basis of mental health diagnosis and the characteristics of individuals with such a diagnosis (that is, race and gender). We expected that if men truly stigmatize mental health problems and help seeking, they would endorse seeking formal and informal help less often than women did.

## METHOD

### Data

We used data from the 2006 GSS (National Opinion Research Center [NORC], 2015), a biennial survey representing noninstitutionalized U.S. adults. GSS interviews are conducted face-to-face in either English or Spanish. The 2006 GSS included a mental health module that measured respondent attitudes about help seeking, the causes of mental health issues, and personal experiences with the mental health system. We focused specifically on the mental

health vignettes, which provided respondents with information about a hypothetical individual’s mental health and then asked a series of questions about possible causes of the problem and what kind of help (if any) the individual should seek. These questions were posed to a subsample of 927 respondents. We limit our analyses to this group. The demographics of our sample can be found in Table 1.

Respondents were randomly assigned a vignette on depression or schizophrenia. The vignette aligns with DSM-IV criteria. However, the condition is not specifically identified to the respondent. In each vignette, the gender (male or female) and race of the hypothetical individual (black or white) were randomly assigned. The vignette for depression (NORC, 2015) read as follows:

[Person name] is a [race] [gender]. For the last several weeks [person name] has been feeling really down. [He or she] wakes up in the morning with a sad mood and heavy feeling that sticks with [him or her] all day long. [He or she] isn’t enjoying things the way [he or she] normally would. In fact, nothing seems to give [him or her] pleasure. Even when good things happen, they don’t seem to make [person name] happy. The smallest tasks are difficult to accomplish. [He or she] finds it hard to concentrate on anything. [He or She] feels out of energy, out of steam, and cannot do the things [he or she] normally does. And even though [person name] feels tired, when night comes [he or she] can’t go to sleep. [Person name] feels pretty worthless, very discouraged, and guilty. [Person name’s] family has

**Table 1: Descriptive Statistics for the Sample**

Characteristic	Min	Max	Women (n = 491)		Men (n = 436)	
			M	SD	M	SD
Vignette						
Informal help seeking	1	10	8.03	1.78	7.84	1.97
Formal help seeking	1	10	8.59	1.73	8.04	2.09
Male in vignette	0	1	0.50		0.49	
Vignette is depression	0	1	0.53		0.47	
Black in vignette	0	1	0.49		0.50	
Respondent demographics						
Age (in years)	18	89	48.32	17.03	46.56	16.21
White	0	1	0.76		0.77	
Income	0	99	10.85	14.16	16.59	19.28
Education (in years)	3	20	13.34	2.77	13.57	3.27
Religious attendance	0	9	3.76	2.83	3.45	2.82

Notes: Income is an ordinal variable, ranging from 1 = less than \$1,000 in the last year to 25 = \$150,000 or more in the last year. Religious attendance is an ordinal variable, treated as continuous, ranging from 0 = never attend religious services to 8 = attend more than once a week.

noticed that [he or she] has lost appetite and weight. [He or She] has pulled away from them and just doesn't feel like talking. (p. 1935)

The vignette for schizophrenia (NORC, 2015) read as follows:

[Person name] is a [race] [gender]. Up until a year ago, life was pretty OK for [person name]. But then, things started to change. [He or She] thought that people around [him or her] were making disapproving comments, and talking behind [his or her] back. [Person name] was convinced people were spying on [him or her] and they could hear what [he or she] was thinking. [Person name] lost [his or her] drive to participate in [his or her] usual work and family activities and retreated to [his or her] home, eventually spending most of [his or her] time on [his or her] own. [Person name] became so preoccupied with what [he or she] was thinking that [he or she] skipped meals and stopped bathing regularly. At night, when everyone else was sleeping, [he or she] was walking back and forth at home. [Person name] was hearing voices even though nobody else was around. These voices told [him or her] what to do and what to think. [He or she] has been living this way for six months. (p. 1936)

## Variables

**Endogenous Variables.** After respondents were read the vignette, they were asked a series of questions about various places the hypothetical individual could get help for his or her problem. For each potential source of help, respondents were asked to rate how important seeing someone about this problem would be on a scale from 1 = not at all important to 10 = extremely important. Respondents were asked about three informal sources of help—family, friends, and religious leaders—and three formal sources of help—a medical doctor or general practitioner, a psychiatrist or psychologist, or another mental health professional (examples provided to the respondent included a social worker, a couples and family therapist, or a counselor). We wanted to know if we could treat these six variables as two latent variables: one for informal help seeking and one for formal help seeking. As a result, we ran a confirmatory factor analysis (CFA) to confirm this hypothesis. Our results showed that two latent variables existed, and the results of this analysis are available in Figure 1.

**Group Membership.** Because we used a group-comparisons structural equation model (SEM), we identified group membership by the respondent's gender, with 0 = woman and 1 = man.

**Key Exogenous Variables.** We had two key exogenous variables in our analysis. Both are dichotomous measures that identify the hypothetical individual's characteristics in the vignette. The first variable indicated whether the individual in the vignette is male or female (0 = female, 1 = male). We included this variable because help-seeking attitudes may depend on the troubled individual's gender. In other words, it is possible that individuals are more likely to endorse help seeking for women than for men. The second key exogenous variable indicated whether the individual in the vignette has depression or schizophrenia. Here, we considered whether respondents' endorsement of help seeking depends on the presenting problem.

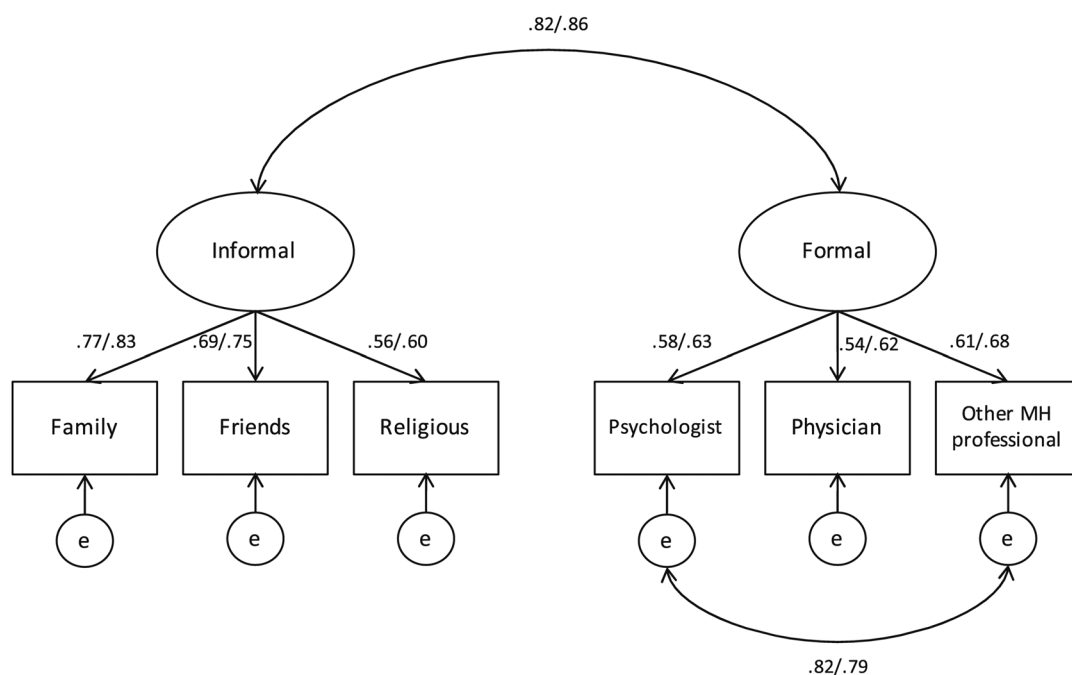
**Exogenous Control Variables.** We controlled for several factors associated with the respondent and the vignette he or she received. The respondent's age was included as a continuous measure, ranging from 18 to 89 years. Income was an ordinal variable, ranging from 1 = less than \$1,000 in the last year to 25 = \$150,000 or more in the last year. Education was a continuous variable for number of years of education and ranged from 1 to 20. Religious attendance was an ordinal variable, which we treated as continuous, ranging from 0 = never attend religious services to 8 = attend more than once a week. Finally, we controlled for whether the individual in the vignette is identified as black or white with a dichotomous measure.

## Data Analysis

Because we were interested in how help-seeking attitudes differ by gender, we analyzed our data with group comparison SEMs, using the method suggested by Acock (2013). First, we ran a CFA on the structural portion of our model to ensure we could combine our observed variables into two latent variables. The CFA showed good model fit [ $\chi^2(103, N = 927) = 121.3, p < .01$ ; root mean square error of approximation (RMSEA) = 0.02; comparative fit index (CFI) = 0.97; standardized root mean square residual (SRMR) = 0.02].

Next, we ran a group comparison model in which all coefficients were allowed to differ by gender. In this unrestricted model, we tested for the group invariance of parameters using Wald tests.

**Figure 1: Confirmatory Factor Analysis for Informal and Formal Help Seeking**



Notes: All standardized coefficients are significant in the model. Results are reported as women/men. MH = mental health.

These tests identified pathways that, if constrained, would significantly worsen model fit. On the basis of the results of this model, we then ran a constrained model, which set all coefficients for men and women to be equal, except for two pathways in the structural model: informal → depression ( $p < .05$ ) and formal → depression ( $p < .001$ ). There were no equality constraints on the variances or covariances in the model. The fit for the constrained model was slightly better than the fit of the unconstrained model (fit statistics of the unconstrained and constrained models can be found in Table 2).

## RESULTS

### CFA

Figure 1 provides the standardized results of the CFA for the latent informal and formal help-seeking constructs. All of the factor loadings are significant at  $p < .001$ , with the informal help-seeking reliability coefficient at 0.71 for women and at 0.74 for men. The corresponding reliability coefficients for formal help seeking are 0.72 and 0.77, respectively. The factor loadings for both informal and formal help seeking are slightly stronger for men than for women. Women's informal help-seeking standardized coefficients

are 0.77, 0.69, and 0.56 for family, friends, and religious leaders, respectively. For men, the corresponding figures are 0.83, 0.75, and 0.60. The standardized coefficients are slightly smaller for formal help seeking. The factor analyses indicated the presence of two latent variables, which we then included in the group-comparison SEMs.

### SEMs

The results of the group-comparison SEM model can be found in Table 2. We began with a discussion of the unconstrained model, as reported in the top half of Table 2. Results for informal help seeking are reported in the left-hand panel and show that only age had a significant association with informal help-seeking attitudes. The standardized coefficients show that a one standard deviation increase in age is associated with .164 and .133 standard deviation decreases in informal help-seeking behaviors for women and men, respectively.

The formal help-seeking statistics, shown in the right-hand panel of Table 2, reveal very interesting results. Namely, women are only slightly and insignificantly less likely to suggest formal help seeking for individuals with depression than for those with

**Table 2: Unconstrained and Constrained Structural Equation Models for Informal and Formal Help Seeking (N = 927)**

Characteristic	Informal		Formal	
	$\beta$	SE	$\beta$	SE
Unconstrained				
Male in vignette				
Women	.035	.054	-.003	.060
Men	.008	.054	-.013	.059
Vignette is depression				
Women	-.046	.054	-.052	.058
Men	-.083	.053	-.266***	.047
Black in vignette				
Women	.007	.054	-.060	.060
Men	.044	.053	.059	.058
Income				
Women	.039	.054	.035	.060
Men	-.094	.053	.036	.060
Religious attendance				
Women	.026	.056	-.079	.061
Men	.082	.055	.063	.060
White respondent				
Women	.070	.056	.003	.063
Men	.037	.053	.007	.058
Age				
Women	-.164***	.044	.110*	.059
Men	-.133***	.036	-.064	.055
Constrained				
Male in vignette				
Women	.025	.041	-.015	.048
Men	.021	.036	-.011	.035
Vignette is depression				
Women	-.067	.041	-.055	.058
Men	-.058	.036	-.266***	.047
Black in vignette				
Women	.025	.041	-.010	.048
Men	.022	.036	-.008	.036
Income				
Women	-.037	.036	.018	.043
Men	-.041	.041	.017	.042
Religious attendance				
Women	.059	.043	-.024	.050
Men	.050	.037	-.017	.037
White respondent				
Women	.056	.043	.001	.050
Men	.048	.037	.001	.037
Age				
Women	-.153**	.044	.043	.051
Men	-.125**	.036	.030	.036

Notes: For the unconstrained structural equation model, the goodness-of-fit statistics were  $\chi^2(88, N=927) = 235.7, p < .001$ ; root mean square error of approximation (RMSEA) = 0.05; comparative fit index (CFI) = 0.95; and standardized root mean square residual (SRMR) = 0.04. For the constrained structural equation model, the goodness-of-fit statistics were  $\chi^2(103, N=927) = 220.1, p < .001$ ; RMSEA = 0.04; CFI = 0.97; and SRMR = 0.04.

\* $p < .05$ , two-tailed. \*\* $p < .01$ , two-tailed. \*\*\* $p < .001$ , two-tailed.

schizophrenia ( $\beta = -.052$ ). However, the effect for men was negative, moderately strong, and significant ( $\beta = -.266, p < .001$ )—representing a substantial departure from women’s attitudes about formal help seeking for depressed individuals. Finally, age was positively associated with formal help seeking for women but not for men.

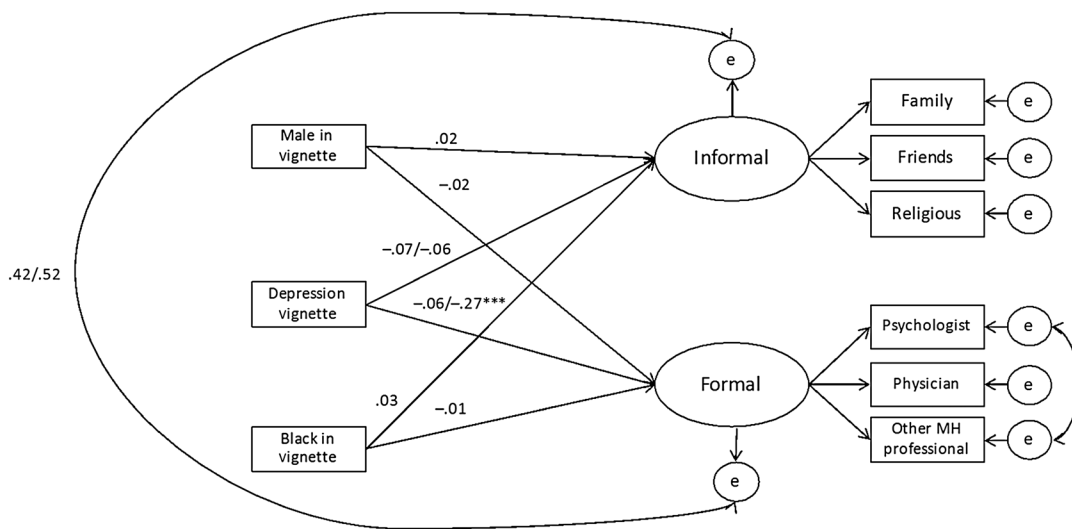
For the sake of simplicity, we provide Figure 2, which highlights the key effects from the constrained model (results are also provided in the lower half of Table 2). Here, we found largely similar results in this model and the unconstrained model. However, we emphasize the moderate negative effect of depression on formal help seeking for men and the nonsignificance of the effect for women. This suggests to us that men are more hesitant than women are to endorse formalized help seeking for depressive symptoms—a point to which we return in our discussion below.

## DISCUSSION AND CONCLUSION

Prior research has shown that compared with women, men are less likely to seek help for mental health problems, tend to eschew getting help for their problems, and are more likely to stigmatize mental health problems (see, for example, Addis & Mahalik, 2003). Prior research has revealed that men’s perception of how others view help seeking influences their own decisions about getting help (Hammer et al., 2013). If we as clinicians, researchers, and mental health advocates want more men to get help for their problems, it is imperative that we gain greater insight into their attitudes about mental health and help seeking. In this light, our goal in this article was to address potential gender differences in the endorsement of help seeking for diagnosable mental health problems. If the attitudes of men and women are largely the same, this would suggest that any social sanctions on men who get help may be much less significant than many men perceive them to be.

This study has three major findings. First, men and women have largely similar attitudes about informal help seeking for mental health problems. One of our most interesting findings was that there was no gender difference in the endorsement of informal help seeking on the basis of the gender of the person in the vignette. In other words, it appears that men and women similarly factor gender into their endorsement of talking to friends, family, and religious leaders. Although we allowed the coefficient from depression to informal help seeking to

**Figure 2: Group Comparisons Structural Equation Model Results**



Notes: Results for unconstrained coefficients are reported as women/men. Results for constrained coefficients are reported as a single number. MH = mental health. \*\*\* $p < .001$ , two-tailed.

vary, we found no gender difference in its endorsement for depression.

Second, men were less likely than women to endorse formal help seeking for individuals who exhibited symptoms of depression. There are three possible explanations for this finding. First, men see schizophrenia as a far more serious problem than depression. Second, and an especially important result, we did not see the same pattern for informal help seeking, as we noted earlier. This suggests that men may see depression as something to be talked about but not a condition so serious as to require formal help. Finally, men often believe that helping professionals are not adept at working them through their emotional problems (Rochlen et al., 2010). Perhaps, then, our finding reflects a widespread belief among men that treatment is less efficacious for depression than it is for “more serious” problems, like schizophrenia.

Finally, we found that the gender of someone with a mental health issue did not play a significant role in help-seeking endorsement. This is an intriguing finding. Prior research suggests that both societal and network pressures influence help-seeking behavior. If a man perceives that other men, whether or not they are part of his social sphere, negatively sanction help seeking, he will not get help. If this reflected actual and not just perceived thinking among men, we would have found that male respondents would

have endorsed help-seeking less for men than for women. Yet, we failed to find this pattern in our data. This suggests a possible disconnect between perceived stigma and actual attitudes about help seeking in men. Unfortunately, our data cannot answer this question. Yet, it is a significant one for future research.

### Limitations

Like any study, our research is limited in its design. First, the data are cross-sectional from a single subsample of the 2006 GSS. Second, it is unclear how well individuals were able to identify the mental health issues in the vignettes. Although the vignettes are based on DSM-IV criteria, it is unknown whether individuals are adept at identifying the problems as serious mental health issues. Third, the vignettes presented to respondents are about hypothetical individuals and fail to consider how respondents would endorse help seeking if their family, friends, or peers had similar problems. It is important to note that prior studies have shown that mental health attitudes sometimes vary by the social proximity of people who need help (Vogel, Wade, & Haake, 2006). Third, it would have been beneficial for the GSS to ask about depression and schizophrenia of all respondents, making within-person comparisons about help-seeking attitudes possible. Future research, when possible, should take such problems into account.



## Clinical Implications

Our study has important clinical and health promotion implications. It underscores the need for researchers, practitioners, and public health advocates to move away from a binary model of help-seeking attitudes in which men see help seeking negatively and women see it positively. We showed that there is remarkable similarity in help-seeking endorsement across gender, with the notable exception of formal help seeking for depression. To help men in positive ways, it is important to keep in mind that men are not universally opposed to help seeking. This knowledge would allow social workers and other helping professionals to productively highlight the seriousness of depression, anxiety, and other common mental health conditions in men. Our results also suggest that promoting informal channels to help may be fruitful for men—although we are unable to formally test this proposition. Men and women had similar attitudes about using informal help-seeking channels, which may provide a pathway toward eliminating some of the stigma associated with counseling and other forms of formal help.

We suggest that mental health advocates, clinicians, and public health officials consider how our findings might be used to shape programs aimed at increasing mental health services utilization among men. Finally, we believe that our results highlight that an open dialogue about mental health, help seeking, and masculinity is needed in communities. Men constantly interact with coworkers, friends, family members, neighbors, and others in various social spheres. As such, they have a significant influence on the people they interact with and their mental health. Our results also reemphasize that men's (un)willingness to seek help is a serious public health concern. We believe our results show that it is important for helping professionals to come together as a group with the goal of improved mental health outcomes in men. **HSW**

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