Help-Seeking for Depression as a Stigmatized Threat to Masculinity

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To better understand men's reluctance to seek help for mental health issues, we investigated the contributions of depression, stigma, and masculinity on help-seeking likelihood in a sample of depressed men. Two-hundred and fifty-eight men, who screened positive for depression on the PHQ-2, completed measures assessing self-stigma, self-reliance, emotional control, and general help-seeking likelihood via an online Qualtrics survey. Path analysis using MPlus tested one model of moderated mediation and two mediation models among the variables. Results supported a partial mediation model where (a) self-reliance, emotional control, and self-stigma directly related to lower likelihood of help-seeking, (b) self-reliance and emotional control predicted greater self-stigma, (c) depression predicted greater self-reliance and emotional control, (d) self-reliance and emotional control had indirect effects on help-seeking being partially mediated by self-stigma, and (e) depression had significant indirect effects on both help-seeking and stigma, being fully mediated by self-reliance and emotional control. We discuss the need to develop practices and interventions that address self-stigma's contribution to men's help-seeking through the complex relationships between depression and men's self-stigma as mediated by self-reliance and emotional control. Limitations to the study and future research directions are discussed.

> ***Public Significance Statement***
> Depression is costly in both human suffering and the hundreds of billions of dollars it costs the U.S. annually. Although treatment for depression is effective, men are less likely to seek help. The goal of this study was to better understand the complex relationships among masculinity, self-stigma, and depression as they explain help-seeking intentions in men who screened positive for depression. Our findings suggest the importance of psychologists addressing men's gendered reactions to their depression and how those gendered reactions contribute to self-stigma and less likelihood to seek help.

Keywords: depression, masculinity, stigma, help-seeking

Although depression is "eminently treatable" through psychotherapy, medication, or a combination of the two (Hollon, 2016, p. 295), men are less likely to seek help for mental health problems compared to women across races, ethnicities, ages, and other

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sociocultural backgrounds (Addis & Mahalik, 2003). An array of explanations addressing the phenomenon of men's avoidance of help-seeking are offered, often focusing on male gender role socialization. From a gendered perspective, ways in which men are socialized to be masculine—particularly to be self-reliant and in control of their emotions—are viewed as prescriptive roles that are incongruent with acknowledging emotional pain and getting help for it (Addis & Hoffman, 2017; Booth et al., 2019; Wong et al., 2017). There is significant support for this socialization explanation found in many empirical studies that report men's traditional masculinity norms predicting less help-seeking behaviors and more negative attitudes toward help-seeking (see Seidler et al., 2016, for a review).

Other explanations posit that men are more likely to reject help-seeking because they gain privilege and power by rejecting help as a way to assert masculinity (Bunton & Crawshaw, 2002; Courtenay, 2000). For example, the Precarious Manhood model views rejecting help-seeking as connected to enhancing masculine status after experiencing a threat to that status, such as being perceived as weak for experiencing the suffering of depression (Bosson & Vandello, 2011; Vandello & Bosson, 2013). Specific to the issue of help-seeking, the model posits that men's reluctance to seek help for depression is part of managing the threat to their masculine status, given that being depressed or sad is typically viewed as feminine (Cole & Davidson, 2019). Research supports this, as men

experiencing gender-atypical psychological disorders (e.g., depression and anxiety) report feeling more distress as well as a loss of their status as men, compared to gender-typical externalizing disorders (e.g., aggression and substance abuse; Michniewicz et al., 2016). Feeling threat from symptoms that are not viewed as manly, men may be more likely to "tough out" the feelings, rather than seek help because "seeking professional help is itself a socially risky act given that men risk being seen as less manly for such behavior" (Vandello & Bosson, 2013, p. 106).

This experience of depression as a threat to masculinity likely contributes to men's feelings of stigma toward seeking psychological help (Clement et al., 2015; Lindinger-Sternart, 2015). For example, experiencing perceived gender-atypical concerns like depression—and the shame or threat to masculinity it may carry—likely generates men's feelings of stigma, and research confirms that greater levels of stigma predict men seeking less help and having more negative attitudes toward help-seeking (e.g., Galdas et al., 2005). In particular, *self-stigma* is identified as an important predictor of men's help-seeking. Defined as "the reduction of an individual's self-esteem or self-worth caused by the individual self-labeling herself or himself as someone who is socially unacceptable" (Vogel et al., 2006, p. 325), self-stigma is found to predict more negative attitudes toward professional help-seeking (Vally et al., 2018; Vogel et al., 2006, 2007), group counseling (Vogel et al., 2010), intentions to seek help (Wade et al., 2011), and seeking information about mental health and counseling (Lannin et al., 2016). Taken together, these explanations establish that for many men, feeling emotional and psychological pain might be seen as unmanly, threaten their status as men, and lower feelings of self-worth, which may then impede seeking help.

Research by Cole and Ingram (2020) supported that self-stigma and masculinity together were important predictors of help-seeking. In their nonclinical sample of college men engaged in a role induction based upon a vignette about a man with depression, their results indicated that self-stigma predicted more avoidance, less use of informal social supports, and less use of professional help, and masculine gender role conflict predicted more avoidance and less utilization of informal social supports. Although finding a positive relationship between self-stigma and masculine gender role conflict, the authors did not examine the nature of the relationship between self-stigma and conformity to specific masculine norms, which may be an important consideration in understanding the complexity of men's help-seeking and informing practice accordingly.

Mediated and Moderated Relationships

Because there are complex relationships between depression, self-stigma, masculinity, and help-seeking, it is important to understand how they may operate in concert with each other in terms of mediation (e.g., whether the relationship between depression and help-seeking is because both relate to feelings of self-stigma) and moderation (e.g., whether the strength of the relationship between depression and help-seeking may be greater for some men vs. others, magnified by other factors such as self-stigma). For example, Vogel et al. (2011) study of college males reports depression, self-stigma, and conformity to masculine norms each having direct relationships to attitudes toward professional help-seeking, and that self-stigma partially mediates the relationship between depression and attitudes toward help-seeking, as well as between conformity to masculine

norms and attitudes toward help-seeking. The authors also report that this mediated model applies across racial and sexual orientation groups in their study. However, the study utilizes a nondepressed sample of college students, which limits external validity, and also only examines global masculinity, which obscures individual, distinct masculinity norms that provide more specificity in understanding masculinity and help-seeking.

Examining a more complex model of men's help-seeking, Levant et al. (2013) studied a nonclinical sample of men testing both mediation and moderation between masculinity variables (i.e., masculine gender role conflict and ideology), self-stigma, depression, and barriers to help-seeking as predictors of attitudes toward professional help-seeking. In their study, masculine ideology and stigma each had significant direct effects on help-seeking attitudes, while stigma partially mediated masculine ideology's relationship to attitudes and fully mediated the relationship between gender role conflict and attitudes. Although not having direct effects on attitudes toward help-seeking, depression moderated the mediated path from ideology to self-stigma, and between stigma and help-seeking attitudes. Taken together, the results from these studies indicate that these factors do not operate separately from one another, and highlight the importance of understanding the complex relationships between depression, self-stigma, and masculinity in explaining men's help-seeking. As more specificity about the nature of these relationships would enhance applied efforts to facilitate men's help-seeking, we propose the following hypothetical models in pursuit of that clarity.

Hypothesized Models for the Present Study

Self-Reliance and Emotional Control Mediated by Self-Stigma

The findings reviewed above all indicate the importance of both masculinity and self-stigma as they uniquely predict less help-seeking, that they significantly relate to each other, and that stigma typically mediates the relationship between masculinity and help-seeking (i.e., masculinity contributes to greater self-stigma, which then contributes to less help-seeking). However, these studies examined masculinity (i.e., masculinity norms, masculine gender role conflict, and masculine ideology) as a global construct rather than specific aspects of masculine gender role socialization that may be most relevant to men's help-seeking for depression (e.g., being self-reliant, remaining in control of one's emotions; Wong et al., 2017). As McDermott et al. (2018) reported that conformity to the masculine norms of self-reliance and emotional control were the most robust predictors of intentions to seek help, we hypothesize that these specific masculinity norms and self-stigma will directly relate to help-seeking in a sample of adult men who screen positive for depression, that self-reliance and emotional control will predict higher levels of self-stigma, and that self-stigma will mediate the relationship between these two masculinity norms and help-seeking. These mediation paths will be tested in each of our three models which are described below and differentiated by the role that men's depression plays in each. Unlike previous studies that sampled college males or nonclinical adult samples, however, we examine depression's role in help-seeking for men who are experiencing depressive symptoms.

Model 1

Our first model tested Levant et al. (2013) findings, examining whether depression predicted help-seeking and stigma, as well as moderated the relationships between the two masculinity norms and stigma, and between stigma and help-seeking (with higher levels of depression decreasing the strength of the relationship between those variables). Essentially, this first model tested a combination of direct and indirect effects on help-seeking likelihood along with interaction effects between masculine norms, depression, and self-stigma (e.g., whether more severe depressive symptoms interact with higher levels of self-stigma to predict lower levels of help-seeking likelihood).

Model 2

Because a recent meta-analysis of 78 studies examined conformity to masculinity norms and mental health outcomes found masculinity norms were associated with negative mental health outcomes, including depression (Wong et al., 2017), our second model examined whether the self-reliance and emotional control masculinity norms predicted depression and whether depression mediated the relationship between the masculinity norms and help-seeking.

Model 3

As Wong et al.'s findings do not indicate the direction of causality, we tested in the third model whether the sequence of the mediating relationship between depression and masculine norms is the other way around where depression relates to men over-conforming to self-reliance and emotional control when feeling depressed. This conceptualization would be consistent with the Precarious Manhood model (Bosson & Vandello, 2011), which suggests that feelings of depression activate threat that, in turn, leads to greater enactment of self-reliance and emotional control to reestablish manhood. Thus, our third model tested whether depression predicted greater self-reliance and emotional control and whether the two masculinity norms acted as mediators of the relationship between depression and stigma, as well as between depression and help-seeking.

Method

Sample

Four-hundred and thirty-one responses were initially recorded for our online survey. Seventy-two invalid responses were removed from the total sample because the responses were blank, had a duplicate IP address, did not reside in the United States, or were under 18. From the remaining 359 valid responses, participants were screened to determine whether they were currently experiencing distress consistent with symptoms of depression based on their responses to the Patient Health Questionnaire—2 (PHQ-2, see item description below). For this screening, we used a cutoff score of 2 or greater on the PHQ-2, meaning that if participants reported feeling depressed mood or little interest or pleasure in activities for several days over the past 2 weeks, or either symptom more frequently, they would be included in this analysis. Participants who did not report experiencing either of these symptoms at all, or who only experienced one of them for only several days (PHQ-2 scores of 0 and 1) were excluded from this analysis ($n = 101$ screened out for subclinical PHQ-2 scores). This process led to a final analytic sample of 258 men who reported presently experiencing symptoms of depressed mood and anhedonia.

Participants in the final sample ($N = 258$) were mostly white (84.2%; 5.5% Asian or Asian American; 5.2% Hispanic, Latino, or Spanish origin; 3.6% Black or African American; 1.2% Native American, Alaska Native or Native Hawaiian; .3% other racial identity), heterosexual (79.1%; 10.7% bisexual; 8.7% gay), cisgender men (99.2%; .8% transgender; $n = 2$). All participants were between the age of 18 and 73 ($M = 37.04$; $SD = 12.56$), and their education level ranged from having completed high school to obtain a graduate degree, with an average education level of having obtained an associate's or bachelor's degree. Furthermore, participants' income ranged from below the poverty line to upper-middle class, with an average household annual income in the range of $38,000–$60,000.

Measures

Depressive Symptoms

The *Patient Health Questionnaire-2* (PHQ-2; Kroenke et al., 2003) was used to screen for participants' depression-related distress. The PHQ-2 consists of two items, asking participants how often over the past 2 weeks they have been bothered by (a) little interest or pleasure in doing things and (b) feeling down, depressed, or hopeless. Participants choose from the following options: *Not At All*, *Several Days*, *More Than Half the Days*, and *Nearly Every Day*. The PHQ-2 is scored from 0 to 6, with higher scores reflecting more frequent presence of depressed mood and anhedonia. The PHQ-2 has demonstrated sensitivity and specificity in correctly screening patients based on their depression diagnosis, and is strongly associated with other depression screening tools (Kroenke et al., 2003). Furthermore, the PHQ-2 has performed well when compared to clinical interviews (Löwe et al., 2005). We adopted a score of 2 as indicating a positive screen for depression, which is a cutoff score commonly used in empirical studies that screen for depression (see Manea et al., 2016). It is also argued that adopting 2 as a cutoff score is more sensitive in that it detects more participants experiencing a wider range of severity in depressive symptoms (Löwe et al., 2005). For the present study, the alpha for the PHQ-2 was .86.

Self-Stigma

The *Self-Stigma of Seeking Help Scale* (SSOSH; Vogel et al., 2006) was used to measure how much participants feel their self-esteem is being threatened by seeking mental health treatment. The SSOSH scale consists of 10 items, employing a 5-point Likert-type scale ranging from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*), with higher scores reflecting higher levels of self-stigma. Sample items include "I would feel inadequate if I went to a therapist for help," and "My self-esteem would increase if I talked to a therapist" (reverse-scored). The scale's developers report criterion validity for the SSOSH in relation to attitudes toward professional help-seeking and stigma for seeking psychological help, and internal consistency of .89. For the present study, the alpha for the SSOSH was .89.

Conformity to Masculine Norms

Subscales of the *Conformity to Masculine Norms Inventory* (CMNI; Mahalik, Locke, et al., 2003) were used to measure participants' conformity to the masculine social norms of (a) Self-Reliance and (b) Emotional Control. Participants respond to a 4-point Likert scale ranging from 0 (*Strongly Disagree*) to 3 (*Strongly Agree*), with higher scores representing more conformity. The subscale for Self-Reliance consists of six items, such as "I hate asking for help," and Emotional Control consists of 11 items, such as "It is best to keep your emotions hidden." Construct and predictive validity for both CMNI subscales are well established, with higher scores of both Emotional Control and Self-Reliance being linked with comparable measurements of masculinity ideology (Mahalik, Locke, et al., 2003) as well as with outcomes such as stress, depression, suicidal ideation, and lower levels of health-promoting behavior (Gerdes & Levant, 2018; Wong et al., 2017). Furthermore, they have been shown to be consistently valid across groups of racially diverse men (Hsu & Iwamoto, 2014). For this study, the alpha for the Self-Reliance subscale was .83 and the alpha for the Emotional Control subscale was .89.

Help-Seeking Intentions

The *General Help-Seeking Questionnaire* (GHSQ; Wilson et al., 2005) was administered to assess participants' likelihood of seeking help. We chose this brief measure because it aims to assess participants' behavioral *intentions* rather than their attitudes toward seeking help, as well as because it asks about various sources of support in participants' lives. The GHSQ reads: "If you were having a personal/emotional problem, how likely is it that you would seek help from the following people?" Participants respond to this question on a 7-point Likert scale ranging from 1 (*not at all likely*) to 7 (*very likely*) to indicate the likelihood that they would seek help from the following sources: (a) partner, (b) friend, (c) parent, (d) family, (e) mental health professional, (f) helpline (e.g., hotline), (g) doctor/general practitioner, (h) teacher, (i) pastor/priest, (j) youth worker, or (k) that they would not seek help. Test–retest reliability over 3 weeks and internal consistency estimates were reported as .86 and .70, respectively. Divergent and convergent validity were demonstrated when comparing the questionnaire with barriers to seeking help and quality of previous support (Wilson et al., 2005). In this study, the alpha was .73

Procedure

We recruited participants from social media sites through two main strategies. First, we posted an advertisement on Facebook for men living in the United States to take our online survey. Next, we posted the survey to various group pages on the website Reddit in an effort to reach men from different backgrounds (e.g., posting on forums such as Mental Health Support, AskMenOver30, depression, malelifestyle, men, Dads, malementalhealth, TheMensCooperative, MensHealth, Blackfellas, GayMen, and AsianMasculinity). Of our final analytic sample of 258 men, 41 were recruited from Facebook and 186 were recruited from Reddit (with 31 not reporting which site they were recruited from).

Men who agreed to take our 15-min online survey were given informed consent before beginning the survey through Qualtrics.

First, participants completed the demographic questionnaire, the PHQ-2, measures for Self-Stigma, subscales of the CMNI, and Help-Seeking Likelihood. Participants did not receive any compensation for their participation. All procedures were approved by the Boston College Institutional Review Board (Approval #19.198.01e) with investigators obtaining informed consent from participants.

Results

We used Mplus 8.0 (Muthén & Muthén, 1998-2017) to conduct path analyses testing our moderated mediation as well as mediation models. The full information maximum likelihood (FIML) procedure in Mplus was used to impute the .05% of data missing. Means, standard deviations, and intercorrelations of the observed variables are reported in Table 1. We relied on the following fit indices to evaluate each of our path analysis models: Chi-square test of model fit, root mean square error of approximation (RMSEA), comparative fit index (CFI), the Tucker-Lewis index (TLI), and the standardized root mean square residual (SRMR). Following guidelines recommended by Hu and Bentler (1999) as well as Weston and Gore (2006), we used the following cutoff criteria as indicating a good fit to the data: .08 or below for the RMSEA, above .90 for the CFI and TLI, and below .08 for the SRMR. Path analysis was used to test all four models.

Model Results

Model 1

We tested whether emotional control, self-reliance, and self-stigma had direct effects on help-seeking, whether self-stigma mediated the relationship between the two masculinity norms and help-seeking, as well as whether depression directly predicted help-seeking and moderated the relationships between the masculinity norms and stigma, and between stigma and help-seeking. Results testing Model 1 indicated a poor fit to the data on all indices [Chi-square test of model fit (11) = 1592.41, $p < .001$, CFI = .00; TLI = −1.50; RMSEA = .75, 90% CI: .72, .78; SRMR = .43)] with a number of nonsignificant individual path parameters and nonsignificant moderation effects. These results indicated that the moderated mediation model with self-stigma acting as a mediator and depression as a moderator was a poor fit to the data.

Table 1
Means, Standard Deviations, and Intercorrelations Among Variables

Variable	M (SD)	1	2	3	4	5
1. Depression	3.83 (1.60)	—				
2. Self-stigma	25.90 (7.72)	.16**	—			
3. Self-reliance	10.01 (3.50)	.41**	.52**	—		
4. Emotional control	19.83 (6.08)	.33**	.49**	.57**	—	
5. Help-seeking	29.43 (9.12)	−.26**	−.45**	−.48**	−.57**	—

Notes. N = 258. Minimum and maximum values are as follows: Depression (2, 6); Self-Stigma (10, 50); Self-Reliance (0, 18); Emotional Control (0, 33); Help-Seeking (9, 53).
For Depression, only participants scoring between 2 and 6 on the PHQ-2 were included in this study. The measure's full range is (0, 6).
** $p < .01$.

Model 2

We tested whether self-reliance and emotional control positively related to depression and whether depression mediated the relationship between these norms and help-seeking, along with the same mediation effect of stigma on the paths from the masculinity norms predicting help-seeking. Results indicated a moderately good fit to the data on all indices [Chi-square test of model fit (1) = 2.65, $p > .05$, CFI = .994; TLI = .945; RMSEA = .08, 90% CI: .00, .20; SRMR = .017)]. Results indicated that self-reliance, emotional control, and self-stigma all predicted a lower likelihood of help-seeking, self-reliance and emotional control predicted greater stigma, and self-reliance and emotional control predicted more depression in our sample of men who screened positive for depression. Depression scores were not significantly related to help-seeking. The model accounted for 38.4% of the variance in Help-Seeking scores, 32.1% of the variance in Self-Stigma scores, and 18.2% of the variance in PHQ-2 scores (see Figure 1).
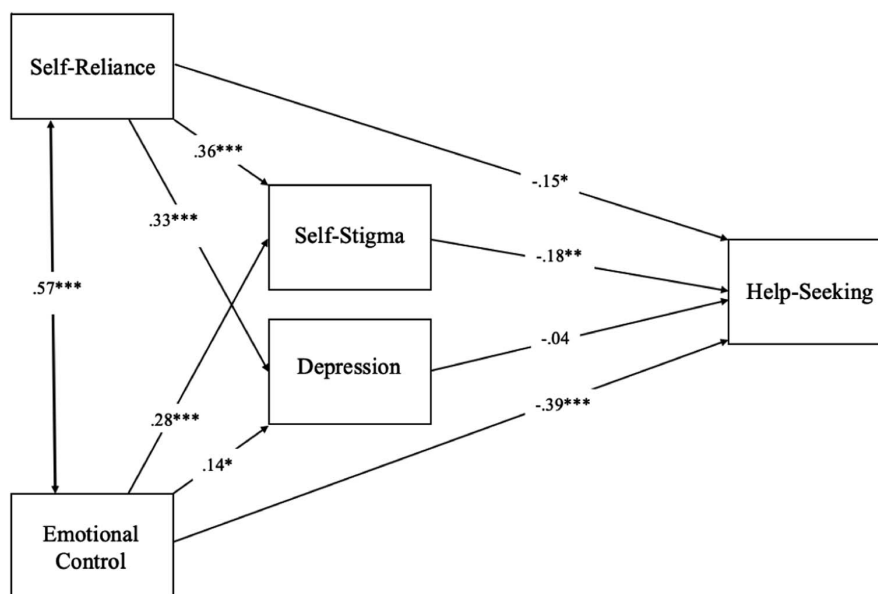
Indirect effects of self-reliance and emotional control on help-seeking as mediated by depression and self-stigma were tested using the bootstrapping procedure outlined by Shrout and Bolger (2002). Specifically, Mplus was instructed to make 1,000 bootstrap samples providing output bias-corrected bootstrap confidence intervals for the indirect effects. Four indirect effects paths were tested, two of which were significant: Self-Reliance and Emotional Control had indirect links to Help-Seeking through Self-Stigma (see Table 2), with greater self-reliance and emotional control indirectly contributing to a lower likelihood of help-seeking. Indirect effects from self-reliance and emotional control through depression in predicting help-seeking were both not significant.

Model 3

For our third model, we tested whether depression positively related to self-reliance and emotional control and whether self-reliance and emotional control mediated the relationships between depression and stigma, and between depression and help-seeking. Model 3 also tested the mediating effect of stigma on paths from masculinity norms predicting help-seeking. Results indicated a strong fit to the data on all indices [Chi-square test of model fit (2) = 3.12, $p > .05$, CFI = .997; TLI = .985; RMSEA = .047, 90% CI: .00, .20; SRMR = .018)], supporting that self-reliance, emotional control, and self-stigma all related to a lower levels of help-seeking, self-reliance and emotional control predicted greater stigma, and depression predicted greater self-reliance and emotional control. The model accounted for 38.4% of the variance in Help-Seeking scores, 32.1% for Self-Stigma scores, 16.9% for Self-Reliance, and 10.8% for Emotional Control (see Figure 2).

Indirect effects of depression on stigma and help-seeking as mediated by self-reliance and emotional control were tested using the bootstrapping procedure described above. Six effects were tested, and all were significant: Depression had indirect links to Help-Seeking via Self-Reliance and Emotional Control; and Depression had indirect links to Self-Stigma via Self-Reliance and Emotional Control; and Self-Reliance and Emotional Control had indirect effects to Help-Seeking via Self-Stigma (see Table 3). Specifically, greater depression indirectly contributed to a lower likelihood of help-seeking, and greater depression indirectly contributed to greater self-stigma; likewise, greater self-reliance and emotional control indirectly contributed to lower likelihood of help-seeking.

Figure 1

Mediation Paths for Model 2. CFI = .994; TLI = .945; RMSEA = .08; SRMR = .017. See Table 2 for Indirect Effects Results

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

Table 2

Indirect Effects Estimates for Model 2

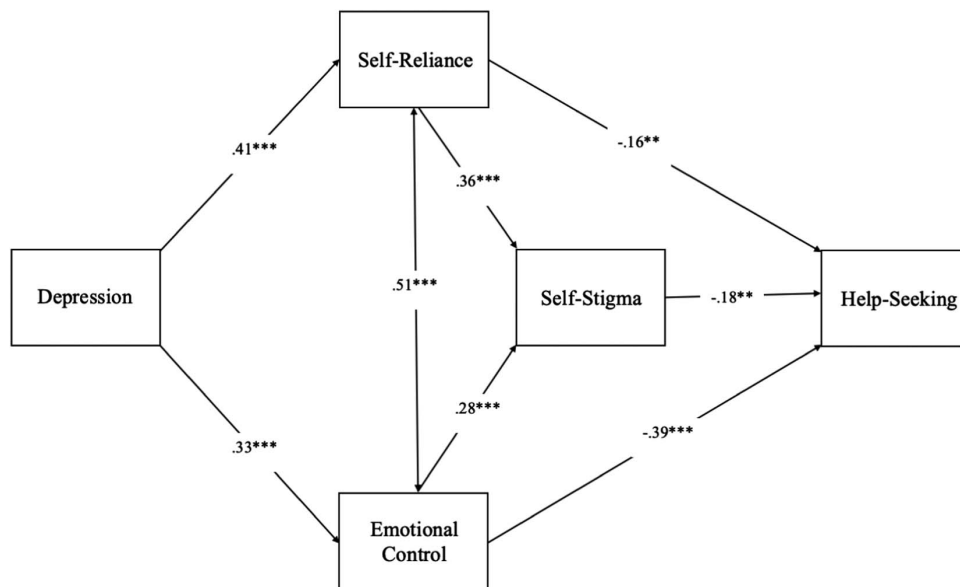| Predictor	Mediator	Outcome	Indirect effect (Standardized)		Bootstrap estimate		Bootstrap 95% CI	
			β	SE	B	SE	LB	UB
Self-reliance	Depression	Help-seeking	−.01	.02	−.03	.05	−.13	.04
Self-reliance	Self-stigma	Help-seeking	−.06**	.02	−.17**	.06	−.29	−.05
Emotion control	Depression	Help-seeking	−.01	.01	−.01	.01	−.04	.02
Emotion control	Self-stigma	Help-seeking	−.05*	.02	−.08*	.03	−.14	−.02

Note. $N = 258$.
* $p < .05$.   ** $p < .01$.

Model Comparison and Selection

Of our three models, the moderated mediation model (Model 1) was a poor fit to the data, leading us to compare the two mediation models (Models 2 and 3) to adopt a final model. In evaluating these models, we followed the recommendations provided by Weston and Gore (2006) for choosing between alternative models. Specifically, we considered an improvement in fit indices, change in explained variance, model parsimony, and parameter significance in evaluating these two mediation models to select our final model.

Many of these criteria were comparable between Model 2 and Model 3 (e.g., the explained variance, model parsimony, and some fit indices requirements). Although both models showed acceptable fit to the data, we recognized noteworthy differences in fit indices between Model 2 and Model 3, particularly: (a) TLI was noticeably higher in Model 3 (TLI = .985) compared to Model 2 (TLI = .945) and (b) RMSEA indicated a markedly stronger fit for Model 3 (RMSEA = .047) than Model 2 (RMSEA =.08). We also considered differences in parameter significance between the two models.

Specifically, depression scores did not directly predict help-seeking likelihood in Model 2, in which depression was modeled as a mediator between masculine norms and help-seeking. Thus, indirect paths through depression in Model 2 were also not significant. In Model 3, however, which positioned depression as a predictor of masculine norms and indirectly predicting help-seeking and self-stigma, all indirect paths were significant. Therefore, we adopted Model 3 as a more accurate representation of the relationships among depression, the two masculinity norms, self-stigma, and likelihood of help-seeking. In summary, the path analysis of Model 3 indicated a partial mediation model which indicated that (a) self-reliance, emotional control, and self-stigma directly related to lower levels of help-seeking, (b) self-reliance and emotional control related to greater self-stigma, (c) depression related to greater self-reliance and emotional control, (d) self-reliance and emotional control had significant indirect links to help-seeking being partially mediated by self-stigma, and (e) depression had significant indirect links to both self-stigma and help-seeking, being fully mediated by

Figure 2

Mediation Paths for Model 3 the Final Adopted Model. CFI = .997; TLI = .985; RMSEA = .047; SRMR = .018. See Table 3 for Indirect Effects Results

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

Table 3
Indirect Effects Estimates for Final Path Model 3

Predictor	Mediator	Outcome	Indirect effect (Standardized)		Bootstrap estimate		Bootstrap 95% CI	
			β	SE	B	SE	LB	UB
Depression	Self-reliance	Self-stigma	.15***	.03	.71***	.15	.44	.99
Depression	Emotional control	Self-stigma	.09***	.03	.45**	.13	.21	.72
Depression	Self-reliance	Help-seeking	−.07*	.03	−.38*	.16	−.71	−.10
Depression	Emotional control	Help-seeking	−.13***	.03	−.74***	.18	−1.14	−.41
Self-reliance	Self-stigma	Help-seeking	−.06**	.02	−.16**	.06	−.28	−.05
Emotion control	Self-stigma	Help-seeking	−.05*	.02	−.07*	.03	−.14	−.02

Note. N = 258.
All indirect effects significant.
* *p* < .05. ** *p* < .01. *** *p* < .001.

self-reliance and emotional control in our sample of men who screened positive for depression.

Discussion

Results from the present study support previous research on the associations between depression, self-stigma, masculinity, and help-seeking. Specifically, our findings support the large number of studies that report masculine social norms as predicting less help-seeking (e.g., Cole & Ingram, 2020) and is generally associated with an array of psychological problems (O'Neil, 2012), as well as highlighting the important role of specific masculine norms, namely self-reliance and emotional control (Addis & Hoffman, 2017; Booth et al., 2019; Mahalik, Locke, et al., 2003; Seidler et al., 2016; Wong et al., 2017). Our findings also support Vogel's research on the importance of self-stigma in understanding men's help-seeking (e.g., Vogel et al., 2011, 2010; Vogel et al., 2006, 2007; Wade et al., 2011) and confirm that depression relates to specific masculinity norms of self-reliance and emotional control (Wong et al., 2017). The findings from this study also extend these literatures by examining these relationships as experienced by adult men who screened positive for depression, rather than in a nonclinical sample.

Beyond supporting previous research on simple relationships between these constructs, our findings support research demonstrating self-stigma to partially mediate the relationship between masculinity norms in predicting men's help-seeking for mental health concerns (Levant et al., 2013; Vogel et al., 2011). This adds to the accumulating evidence that masculinity contributes to less help-seeking both directly, but also by explaining variance in men's self-stigma, and suggests that seeking help for mental health concerns is a stigmatized threat to men's masculinity.

Unlike Levant et al. (2013), we did not find the support that men's depression acted as a moderator between either the masculinity norms' relationships to stigma or stigma's relationship to help-seeking. This may be because they sampled college students or they used a different measure of depression (Radloff, 1977). We did, however, find evidence that depression relates to the masculinity norms of self-reliance and emotional control, and indirectly relates to stigma and help-seeking through those masculinity norms in a sample of men who screen positive for depression. These findings support tenets of the Precarious Manhood model where feelings of depression (e.g., suffering, needing help) may activate a sense of

threat that, in turn, leads to greater enactment of self-reliance and emotional control to reestablish manhood (Bosson & Vandello, 2011; Vandello & Bosson, 2013). They also help illustrate the potential role of depression in activating self-reliance and emotional control masculinity norms, indirectly predicting self-stigma and help-seeking through those norms, and the direct and indirect roles that masculinity plays, along with self-stigma in explaining men's likelihood to seek help. As such, these findings extend a burgeoning literature (e.g., Addis & Mahalik, 2003; Gerdes & Levant, 2018; Mahalik & Dagirmanjian, 2019; Wong et al., 2017) highlighting the problematic health implications of the way boys and men in the U.S. are socialized to view emotions, pain, and the need for help as unmanly.

Implications for Research and Practice

Understanding the influence of self-stigma and the masculine norms of emotional control and self-reliance can aid practitioners, focused on both prevention and remediation, in addressing men's underutilization of mental health services for depression in ways informed by masculine socialization (see Mahalik et al., 2012; Seidler et al., 2019). Specifically, we argue that addressing masculinity-specific stigma represents a useful extension of Seidler et al. (2019) recommendations. Because self-stigma plays such a central role in explaining men's help-seeking, potential factors that magnify or ameliorate that relationship (i.e., moderators) should be examined. Recent promising research found that self-compassion related to more help-seeking (Wasylkiw & Clairo, 2018) and moderated the relationship between masculine gender role stress and stigma (Booth et al., 2019; Heath et al., 2017). Prevention efforts that aimed to promote self-compassion (e.g., being kind to oneself, seeing suffering as human rather than a personal inadequacy; Neff, 2003) may help reduce men's sense of stigma about mental health problems and getting help for them.

Tied most directly to our results, psychologists' prevention efforts to reduce stigma and increase men's help-seeking for mental health issues might focus on messaging that reduces men's feelings of threat to their masculine status in reaction to their depression, and destigmatizes help-seeking by addressing treatment as a way to improve self-reliance and emotional control. Efforts could also be made to reduce men's stigma by helping men view depression and getting help as more normative, rather than shameful. For example,

psychologists can emphasize facts about depression such as that more than 6 million men experience depression each year (American Psychological Association [APA], 2015), and depressed men in the United States get help for depression at higher rates (1 in 4) than the number of men in the U.S. who have a daily exercise routine (1 in 5) (APA, 2015; Woods, 2017). These psychoeducational efforts in treatment could help men see that there are many men feeling depressed and that many depressed men seek help. Similarly, psychoeducation efforts may also help reduce stigma by highlighting information from expert sources such as the American Medical Association who agree that depression is "an illness, not a sign of personal weakness" (Swartz, 2005). Efforts could also be made to better educate the public about the effectiveness of treatments for depression and that the benefits of therapy remain over time (Hollon, 2016).

Specific to clinicians working with depressed men, our findings suggest the importance of clinicians exploring men's gendered reactions to their depression and how those gendered reactions foster self-stigma. Clinicians could do so by exploring men's constructions and feelings around masculine stigma such as "I'm less of a man if I get professional help" or "because I am a man, others will see me as weak if I need help dealing with my feelings." Group therapy for men might be particularly effective as it could help reduce masculine stigma because both depression and help-seeking come to be viewed as more normative when hearing from other men in group work (Rabinowitz, 2019).

Because masculinity norms contribute to men's feelings of stigma, efforts to reframe threats to masculinity could articulate how recognizing depression and getting help for it can help men live up to masculine roles. For example, helping men recognize and find ways to respond to depression can be the first steps toward feeling stronger, having things go better at work, and being there for one's family, all of which are typical societal roles for men. Although reframing help-seeking as congruent with men's gender roles may help facilitate treatment utilization, it may also be important to redefine masculinity to be more validating of men's mental health, as a more strengths-based approach may help to avoid reinforcing stigma (Seidler et al., 2019). We also think developing a gendered framework for referrals to mental health services may be fruitful. Vogel et al. (2014) found masculinity predicted less willingness to refer male friends or family members for psychological services. Professionals along with all others who make up referral systems (e.g., friends, family, clergy, general practitioners, and mental health professionals) could be made aware of the fact that their gendered constructions can promote or inhibit stigma and their own willingness to refer men for services given that we know male psychologists' gender constructions affect their assessments of traditional and nontraditional men (Wisch & Mahalik, 1999).

Limitations

Although we view our sample of men who screened positive for depression as a strength to our study, we also recognize the limitations of our mostly white, mostly heterosexual sample, who tended to have some college education, and all had Internet access. Research shows help-seeking for depression differs as a function of many variables including race, ethnicity, and education (Magaard et al., 2017), as well as sexual orientation and language use (Rutter et al., 2016). Even the relationship between stigma and help-seeking

differs between racial groups with internalized stigma reported to mediate the relationship between public stigma and attitudes toward mental health treatment for white persons but not Black persons (Brown et al., 2010). Thus, the generalization of our findings to other groups of men should be made with caution, as the intersections among race, age, sexual orientation, class, immigration, religion, and other social, political, and personal variables are likely to influence the ways in which men experience depression and help-seeking. The study design also did not address important barriers to help-seeking for depression such as having health insurance that covered psychological treatment or access to psychological service providers due to where one lives in the country. Although path analysis allowed us to examine complex models among the relationships between variables to determine the model that best fit our data (Streiner, 2005), longitudinal research would be important to conduct to understand potential causal and temporal effects among these constructs. In addition to the new directions we discussed above, future research could address these limitations through recruiting men from more diverse backgrounds and examining depression through a lens of intersectionality and marginalization (e.g., the invisibility of Black men's mental health; Franklin, 1999), examining barriers to help-seeking such socioeconomic status and health insurance, and employing longitudinal designs to assess causality and change over time.

Nevertheless, we view our study as extending the previous literature on men's help-seeking by identifying a model that represents a more complex understanding of the relationships among men's depression, self-stigma, and their conformity to self-reliance and emotional control norms as it predicts the likelihood of help-seeking in a clinical sample. We view such an understanding as necessary to help guide both remedial and preventive efforts in the psychological treatment of men with depression.

Conclusion

This study sought to better understand the factors that may inhibit depressed men from receiving treatment by examining the complex relationships among depression, masculinity, self-stigma, and the likelihood of help-seeking. Our findings point to the importance of these variables, and their mediating effects, on men's help-seeking, as well as the promise of stigma-reducing efforts such as normalization, psychoeducation, and reframing the gendered nature of help-seeking. Given the costs of depression in suffering and dollars, psychologists need to directly address the co-occurrence of depression, self-stigma, and masculinity in prevention and clinical interventions with men. In addition to efforts that address stigma and make treatment for depression efficacious and accessible, alleviating the prevalence of men's depression in the United States also depends upon addressing the social and cultural factors that can inform men's beliefs about themselves and shape what is considered acceptable for them when experiencing emotional pain and depression.

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