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Referring Men to Seek Help: The Influence of Gender Role Conflict and Stigma

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Why do men tend to underutilize mental health services? One reason may be that men are less frequently referred to seek such services. Indeed, male friends and family members may be particularly unlikely to refer men to seek mental health services, as it means going against the traditional male gender role proscription of talking to other men about emotional issues. This study is the first to explore how men's experiences of gender role conflict may be associated with an increased endorsement of stigmatization around mental health concerns and, subsequently, a decreased willingness to refer friends and family members experiencing a mental health concern to seek help. Results based on structural equation modeling with data from 216 male collegians indicated that men who endorsed greater restricted emotionality were less willing to refer friends and family members experiencing a mental health concern to seek treatment. In turn, men who endorsed greater Restricted affectionate behavior between men also endorsed greater stigma, which then led to a decreased willingness to refer friends and family members to seek help.

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Even when distressed, the majority of men do not seek mental health services (Andrews, Issakidis, & Carter, 2001), leaving them vulnerable to experiencing a number of negative mental health concerns such as depression, anxiety, and drug and alcohol abuse (O'Neil, 2008; Wester & Vogel, 2012). One widely cited explanation for this underuse of mental health services is that men may view these services as conflicting with traditional Western male gender roles and thus shun these services so as to avoid appearing weak or unmanly (Pederson & Vogel, 2007; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Western culture demands that men be strong, in control of their emotions and their problems, and able to competently handle life stresses without having to ask for help (O'Neil, 2008; Wester & Vogel, 2012). Hence, they may avoid seeking help even in the face of significant distress (Addis & Mahalik, 2003).

However, another potentially important explanation for men's underuse of mental health services is the influence of traditional gender roles on the willingness of friends and family members to refer the men in their lives to seek treatment. Indeed, a key determinant in the process of making a decision to ultimately seek mental health services is the endorsement of such behavior within one's social network (Angermeyer, Matschinger, & Riedel-Heller, 2001; Cusack, Deane, Wilson, & Ciarrochi, 2004; Pescosolido & Boyer, 1999; Rickwood & Braithwaite, 1994). For example, Dew, Bromet, Schulberg, Parkinson, and Curtis (1991) demonstrated that individuals who sought mental health services were more likely to have had friends or relatives recommend that they seek help than those who had not sought services. Furthermore, Vogel, Wade, Wester, Larson, and Hackler (2007) found that being prompted to seek help by a friend or relative was related to positive expectations about mental health services and that more than 70% of those who sought help from a mental health professional had someone directly suggest that they seek help. In many situations, this reliance on one's social network to assist in making important health-related decisions is adaptive. Yet, this reliance might also place men in a vulnerable position regarding their health, as men may be less likely to seek help when others are less willing to encourage them to do so. This may particularly be the case for men suffering from nonpsychotic or emotional problems such as depression that are incongruent with the traditional male gender role (Addis & Mahalik, 2003; Hammen & Peters, 1978; Rochlen, McKelley, & Pituch, 2006; Wester & Vogel, 2012).

Of particular concern, is that men may be least likely to receive support to seek mental health services by the other men in their social network, given the social proscriptions against men seeking counseling and psychotherapy. Said another way, it is possible that men may not discuss mental health issues and how to seek professional help with their male friends and family members, as it means going against the traditional Western male gender role

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prescription to avoid "nonmasculine" topics in conversations with other men (Wester & Vogel, 2012). This avoidance of "nonmasculine" topics has been explored within specific populations of men such as military servicemen and police officers (e.g., Wester, Arndt, Sedivy, & Arndt, 2010; Wester & Lyubelsky, 2002) and is congruent with the long-standing finding that men's friendships tend to focus more on activities rather than sharing emotions (Caldwell & Peplau, 1982). As such, if some men are less open to referring their male friends and family members, it could further exacerbate men's underuse of mental health services. Indeed, in one study specifically looking at referral rates for those who sought help, 47% of participants reported that mothers encouraged them to seek mental health services, whereas only 5% reported that fathers did (Vogel, Wade, Wester, Larson, & Hackler, 2007). The difference in referral rates found in this one study fits the notion that men's traditional gender roles may be related to their willingness to refer others to seek mental health services. However, despite researchers calls for greater exploration into the relationships among gender, social support networks, and help-seeking behavior (Vogel et al., 2007), this assertion has not been directly tested.

Up until now, the most common referral path for male clients may be through wives, mothers, and/or female friends and partners, yet increasing men's ability to encourage each other to seek services is extremely important. "Men have an enormous capacity to inspire each other or to become encouraged by [the behavior of] their male peers" (Brooks, 1998, p. 118). Increasing men's access to mental health care via an increase in men's willingness to refer other men is essential for the positive mental health men. The psychology of men's literature clearly documents the existence of a vicious cycle, in which increased adherence to the male gender role produces more psychological distress, causing men to withdraw from existing social connections and work harder at "being male" rather than reaching out for help (e.g., Brooks, 1998; Mahalik et al., 1998). This cycle, over time, leads to more isolation as well as increased psychological distress. Understanding how a man's experience of this phenomenon also affects their likelihood of referring others to seek mental health services is a critical step toward destigmatizing the entire act of seeking mental health services for men and empowering men to change this vicious cycle by being a positive resource for change for each other.

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Gender Role Conflict and Willing to Refer Close Others

One construct that is likely to impact the degree to which men are willing to consider referring others to psychological services is gender role conflict (GRC). GGRC (O'Neil, Helms, Gable, David, & Wrightsman, 1986) is a condition in which rigid or overly restrictive male gender roles conflict with incompatible situational demands and lead to negative consequences for men and those around them. GRC has four components: (a) restrictive emotionality (RE); (b) restrictive affectionate behavior between men (RABBM); (c) success, power, and competition (SPC); and (d) conflict between work and family relations (CBWFR; O'Neil et al., 1986). Of these four components, RE, defined as men's tendency to avoid the verbal expression of tender emotions in general (O'Neil, Good, & Holmes, 1995), and RABBM, defined as men's socialized avoidance to limit their expression of warmth and care to other men in their lives (O'Neil et al., 1995), are the most consistent predictors of many of the intra- and interpersonal difficulties related to seeking help. Specifically, RE and RABBM have been linked to emotional difficulties (Wong, Pituch, & Rochlen, 2006; Wong & Rochlen, 2009), decreases in personal self-disclosures (Pederson & Vogel, 2007), interpersonal difficulties (Wester, Pionke, & Vogel, 2005), and a negative view of help seeking (Berger, Levant, McMillan, Kelleher, & Sellers, 2005; Jakupcak, Salters, Gratz, & Roemer, 2003; Rochlen, Land, & Wong, 2004; Tull, Jakupcak, Paulson, & Gratz, 2007; Wong et al., 2006).

These established connections highlight the negative consequences the RE and RABBM aspects of GRC may have for the individual and those around them when male gender roles are at odds with the demands of a given situation. In the case of talking to a friend/family member who is experiencing a mental health concern, men may feel pressure to (a) appear stoic (i.e., RE) and (b) avoid appearing weak to other men (i.e., RABBM) and, therefore, be more likely to pull back from more intimate contact with a male friend to live up to their perceived expectations of the traditional male gender roles. As such, it would be expected that higher endorsement of these facets of GRC would be linked to a decreased willingness to talk to and refer others to seek treatment.

Stigma as a Mediator

The pressure some men may feel to live up to aspects of the male gender role such as RE and RABBM may directly lead to a decreased willingness to refer their friends and family to seek help for a mental health concern. However, past research suggests that the relationship between traditional male gender roles and help-seeking behaviors is mediated by other factors, such as stigma (Pederson & Vogel, 2007). Stigma has consistently been found to be an important predictor of help seeking for men (Hammer, Vogel, & Heimerdinger-Edwards, 2012; Vogel et al., 2011). Furthermore, men who reported greater GRC also reported greater stigma related to mental health issues (Magovcevic & Addis, 2005), and stigma has been shown to mediate the links between GRC and negative attitudes toward and willingness to seeking help (Pederson & Vogel, 2007; Vogel et al., 2011). If stigma is associated with men's reduced likelihood to personally seek help, it is reasonable to anticipate that stigma would also be associated with men's reduced willingness to talk with others about mental health issues and treatment. In addition, men may naturally be less willing to talk about mental health related issues with those whom they have stigmatized. Therefore, it may be that RE and RABBM are connected to stigma, which in turn is connected to less willingness to refer others to seek help.

Current Study

The goal of this investigation is to address previous omissions in the literature by directly examining the links between traditional male gender roles, stigma, and men's willingness to refer a friend or family member experiencing a mental health concern to seek help. If men experiencing GRC are less willing to talk with others about mental health issues or encourage them to seek help, then GRC may be an important barrier not only to men's own help seeking, but also to encouraging significant others, such as friends

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and family members, to talk about and seek help for their mental health concerns. To date, however, no one has tested a theoretical model examining these factors. Therefore, we used structural equation modeling to explore whether GRC (i.e., RE and RABBM) and stigma toward those who have experienced or sought help for mental health concerns are linked to men's willingness to refer a friend or family member to seek help for a mental health concern, in hopes of contributing to our understanding of the reasons for gender disparities in professional help-seeking behavior. Specifically, we hypothesized that greater RE and RABBM would both be associated with less willingness to refer a friend or family member, and that stigma, in turn, would mediate the relationship between both RE and RABBM and willingness (see Figure 1).

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Methods

Participants and Procedures

Before data collection began, university institutional review board approval was obtained. Participation was voluntary and questionnaires were completed anonymously. Participants were 216 male college students enrolled in 100 or 200 level psychology or communication classes at a large Midwestern university. Participants received course credit for their participation. Mean age for the sample was 19.87 ($SD = 2.98$). The majority of participants were first-year students (44%), with the remaining students identifying as second-year students (28%), third-year students (19%), and fourth-year students (9%). Participants self-identified as European American (85%), Asian American (3%), Latino American (3%), multiracial American (3%), African American or Black (2%), and Native American (1%). Three percent of participants identified as international students. The proportion of students from various racial and ethnic identities was representative of this university's undergraduate student population.

Measures

GRC. GRC was measured using the RE and RABBM subscales of the Gender Role Conflict Scale-Short Form (GRCS-SF; Wester, Vogel, O'Neil, & Danforth, 2012). The GCRS-SF is a 16-item version of the 37-item Gender Role Conflict Scale (O'Neil et al., 1986). The GRCS-SF was developed to provide a concise and culturally validated measure of the negative cognitive, emotional, and behavioral consequences associated with male gender role socialization. The two subscales are each assessed with four items chosen on the basis of exploratory and confirmatory factor analyses across diverse samples of men (Wester et al., 2012). The items for each subscale are rated on a 6-point Likert scale, from 1 (*strongly disagree*) to 6 (*strongly agree*) and are summed so that higher scores indicate greater GRC for that subscale. The two subscales have previously demonstrated adequate reliability (.77 for the RE; .78–80 for the RABBM; Wester et al., 2012). The two subscales show small to moderate correlations of .10–.41 with each other as well as correlations with stigma (.15–.26) and depression (.10–.41; Wester et al., 2012). The Cronbach's alpha scores in the current sample were .83 for RE and .82 for RABBM.

Stigma. Stigma was assessed with a modified version of the Perceived Devaluation-Discrimination Scale (PDD, Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). The PDD is the most widely used measure of stigma, having been used in over 45 studies of this concept (see Brohan, Slade, Clement, & Thornicroft, 2010). The PDD scale consists of 12 items, half of which are reverse scored. Following Adewuya and Oguntade (2007), the wording of the items was modified from "Most people . . ." to "I . . . " to reflect the degree of one's own personal acceptance of those who have experienced and/or sought help for mental health concerns, rather than perceptions of the degree of others' acceptance. Sample items include "I would willingly accept a former mental patient as a close friend" and "I believe that a former mental patient is just as trustworthy as the average citizen." For the current investigation, responses were measured on a 5-point scale ranging from 1 (*not at all*) to 5 (*a great deal*). Internal consistency has been reported to be between .72–.88 (Alvidrez, Snowden, Rao, & Boccellari, 2009; Vauth, Kleim, Wirtz, & Corrigan, 2007). The PDD has also demonstrated convergent validity through correlations with other stigma measures ($r = .36–.38$; Vauth et al., 2007). The Cronbach's alpha score for this scale was .88 in the present study.

Referring others. We were unable to find a published measure assessing willingness to encourage others to talk about mental health issues or to seek mental health services. Therefore, to assess this construct, we developed a 7-item measure asking respondents to share how willing they were to talk about mental illness and encourage others to seek psychological help. Example items in-

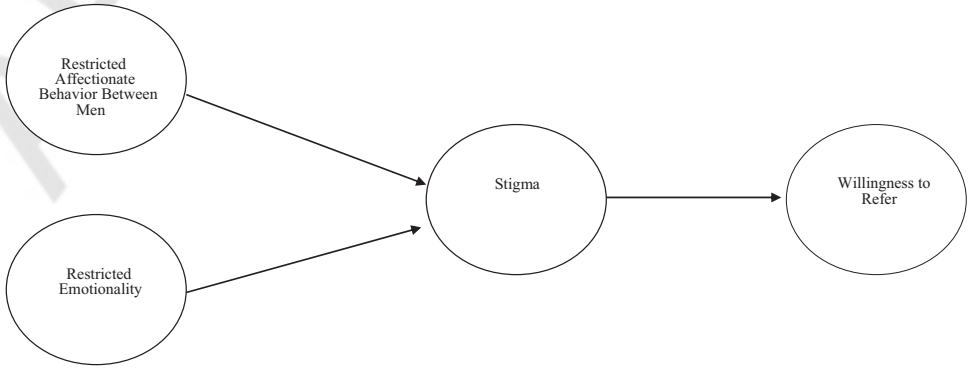

Figure 1. Hypothesized partially mediated model.

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clude "Encourage a friend, family member, or significant other to seek help for their mental illness" and "Encourage a friend, family member, or significant other to talk about their mental illness." We did not specify the issue or severity of the mental health concern they might talk about or encourage others to seek help regarding, choosing instead to write the items to draw an overall response. Respondents rated their willingness from 1 (*definitely unwilling*) to 4 (*definitely willing*). Responses are summed such that higher scores indicate a greater willingness to encourage others to talk about mental health issues and to seek help for these issues. Factor analysis of the seven items using the maximum likelihood method showed a single factor with an eigenvalue of 4.76 accounting for 68.04% of the total variance. All items loaded on this factor above .70, suggesting that there was only one dimension associated with a general willing to refer others to seek psychological help. We named this unidimensional scale the Encouraging Help Seeking Scale (EHSS). The Cronbach's alpha score for this scale was .92 in the present study.

We also adapted a second measure derived from the Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975). Unlike the EHSS, the ISCI lists a series of specific mental health concerns and asks respondents to rate the likelihood they would seek counseling for these issues. Directions were modified to reflect likelihood of talking to a friend or family member about his or her mental health concerns rather than of seeking counseling oneself: "Below is a list of mental health issues people commonly experience. How likely would you be to talk to someone you knew (friend/family member) about his or her concerns if s/he were experiencing these problems?" Seven items from the Psychological and Interpersonal Concerns subscale of the ISCI were listed including relationship difficulties, dating difficulties, depression, loneliness, sleeping difficulties, inferiority feelings, and difficulties with self-understanding. Respondents rated how likely they would be to talk to someone they knew about each issue from 1 (*very unlikely*) to 5 (*very likely*). Responses were summed such that higher scores indicated a greater likelihood of talking with a friend or family member about his or her mental health concerns. Factor analysis of the 7 items using the maximum likelihood method showed a single factor with an eigenvalue of 4.70 that accounted for 67.13% of the total variance. All items loaded on this factor above .71. We named this unidimensional scale the Discussing Other's Concerns Inventory (DOCI). The Cronbach's alpha score for this scale was .92 in the present study.

These two unidimensional measures provided respondents with both general mental health issues as well as specific examples of psychological concerns. To ascertain that the EHSS and DOCI scales were in fact assessing unique constructs, we conducted an additional factor analysis using the maximum likelihood procedure with oblimin rotation on the items from both scales. This analysis produced two factors with eigenvalues of 7.70 and 1.82, accounting for 55% and 13.03% of the variance, respectively. Items from each scale loaded together on one factor and no items loaded across factors (i.e., no items cross-loaded $> .25$). The correlation between factors was .65, suggesting that the EHSS, which asked about general mental health concerns, and DOCI, which asked about specific psychological concerns, assessed related yet orthogonally distinct (i.e., unique) constructs.

Results

The Full Information Maximum Likelihood method in the LISREL 8.8 program was used to examine the measurement and structural models. For each model, the EHSS and DOCI scales were used as the observed indicators of willingness to refer a friend or family member to seek mental health services. In addition, two observed indicators of RE (two scale parcels for the RE subscale of the GRC scale) and RABBM (two scale parcels for the RABBM subscale of the GRC scale), and three observed indicators of stigma (three scale parcels for the PDD scale) were included in the models. Parcels were created, following the recommendation of Russell, Kahn, Spoth, and Altmaier (1998), by separately fitting a one-factor model using exploratory factor analyses with the maximum likelihood method on the items from each scale. To equalize the average loadings of each parcel on its respective factor, we assigned the highest- and lowest-ranking items in pairs to a parcel. We chose to parcel these variables to reduce the number of parameters that would result from using the individual items, thereby improving the estimation of the effects (see Russell et al., 1998).

Because the maximum likelihood procedure assumes normality, we first examined the multivariate normality of the observed variables. The result indicated that the multivariate data were not normal: χ^2 (2, $N = 216$) = 64.81, $p < .001$. Therefore, the scaled chi-square will be reported in subsequent analyses (Satorra & Bentler, 2001). We also report four additional indices to assess the goodness-of-fit of the models: the comparative fit index (CFI; .95 or greater), the incremental fit index (IFI; .95 or greater), the standardized root-mean-square residual (SRMR; .08 or less), and the root mean square error of approximation (RMSEA; .06 or less; Hu & Bentler, 1999).

Measurement Model

Before testing the structural model, we first used confirmatory factor analysis to ensure the data fit the measurement model (see Anderson & Gerbing, 1988). The measurement model showed a good fit to the data, scaled χ^2 (21, $N = 216$) = 31.26, $p = .07$; RMSEA = .05 (90% CI of .00, .08); CFI = .99; IFI = .99, SRMR = .03. The observed variables loadings' on the latent variables were all significant at $p < .001$. Therefore, the latent variables appear to have been adequately measured by their respective indicators.

Structural Model

The hypothesized structural model provided a good fit to the data, scaled χ^2 (21, $N = 216$) = 31.26, $p = .07$; RMSEA = .05 (90% CI of .00, .08); CFI = .99; IFI = .99, SRMR = .03. Together, RE, RABBM, and stigma explained 45% of variance in willingness to refer. Specifically, as can be seen in Figure 2, the results showed that for RABBM there was only an indirect effect (i.e., men who endorse greater RABBM endorsed greater stigma which then led to a decreased willingness to refer). In contrast, RE only had a direct effect (i.e., men who endorse greater RE were less willing to refer). In other words, stigma fully mediated the relationship between RABBM and willingness to refer but did not mediate the relationship between RE and willingness to refer others to seek help.

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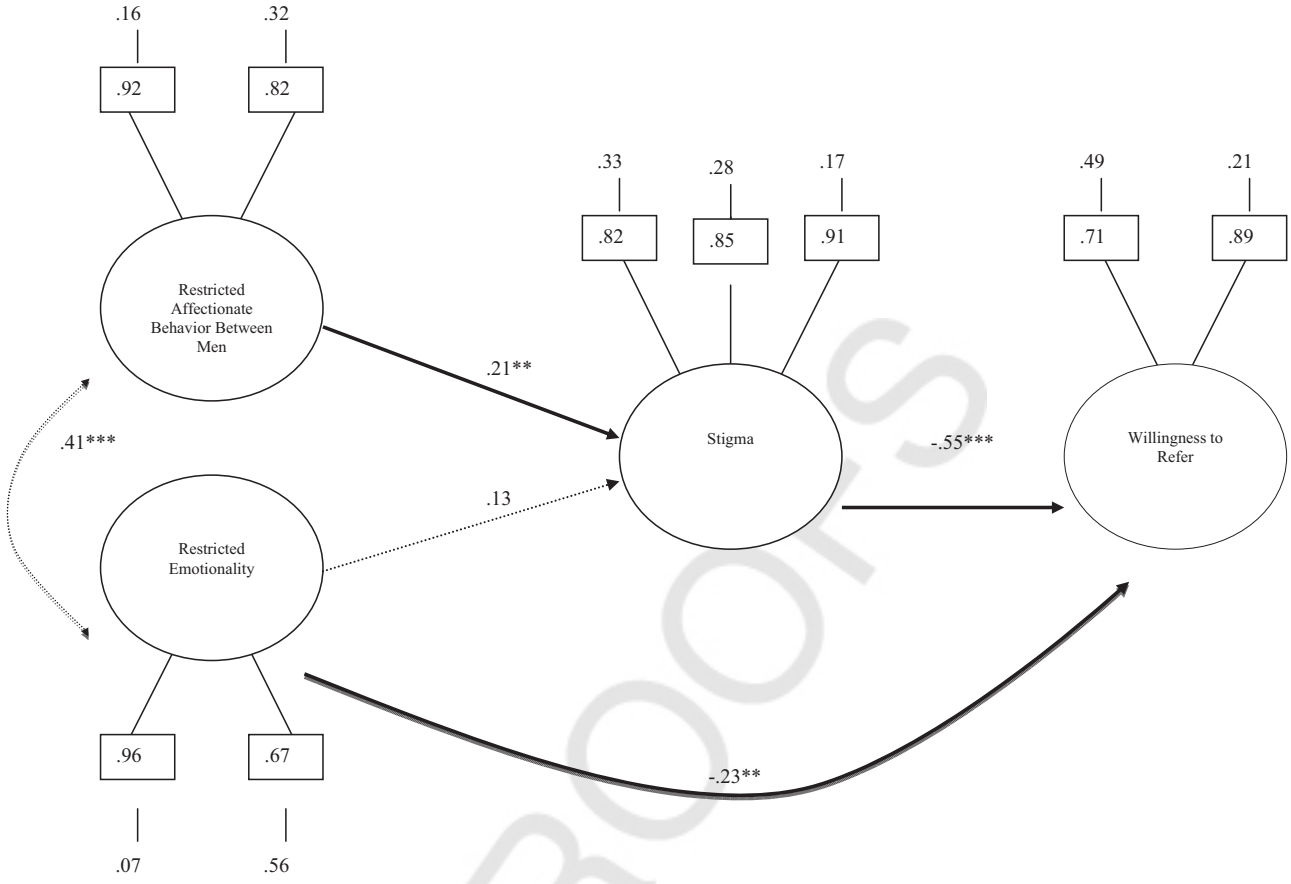

Figure 2. Final mediated model. Scaled χ^2 (N =216, df = 21) = 31.26, p = .07, root mean square error of approximation = .05 (.00, .08), comparative fit index = .99, incremental fit index = .99, standardized root-mean-square residual = .03.

We used the bootstrapping procedure recommended by Shrout and Bolger (2002) to empirically examine the significance of indirect effects in the model. Bootstrapping uses multiple samples drawn by random sampling with replacement from the original sample of participants. The confidence interval for the estimate of the indirect effect is used for the significance level (Efron & Tibshirani, 1993). If the 95% confidence interval does not include zero, it can be concluded there is a significant indirect effect at $p < .05$. To conduct the bootstrap procedure we created 10,000 bootstrap samples from the original dataset (N = 216) and saved 10,000 estimates of the path coefficients in the LISREL program. We calculated the indirect effect of RE on willingness to refer, and the indirect effect of RABBM on willingness to refer. This was done by multiplying the path coefficients from RE to self-stigma with the path coefficient from stigma to willingness to refer, and multiplying the path coefficients from RABBM to stigma with the path coefficient from stigma to willingness to refer. The 95% CI for the indirect path involving RABBM and willingness to refer through stigma did not include zero. Therefore, we concluded this was a significant effect at $p < .05$. The 95% CI for the indirect path involving RE and willingness to refer through stigma did include zero. Therefore, we concluded this indirect effect was not significant. Table 1 shows bootstrap estimates for all of the direct and indirect effects.

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Discussion

Much of the literature on men's help-seeking decisions has focused on the potential male client and the internalized gender role barriers men face in seeking mental health services (Hammer et al., 2012; Pederson & Vogel, 2007; Vogel et al., 2012). However, the current study expanded this focus beyond internal factors to contribute to a better understanding of how traditional male gender roles may also influence external factors (i.e., potential clients' social networks) related to help-seeking decisions. In essence, while previous research has focused on whether or not a man's socialized gender role might prohibit him from being willing to seeking psychological services, in the current study we explored whether that same gender role might also predict how likely a man would be to refer others to seek psychological help. Specifically, the current study tested whether (a) GRC around RE and RABBM was associated with men's willingness to refer others to seek treatment for a mental health concern and (b) men's stigma toward those who have experienced mental health concerns mediated this relationship.

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Overall, the results are consistent with theoretical assertions that traditional male gender roles that encourage men to fix problems without help, deny psychological issues, and withhold emotional expression (e.g., Brooks & Good, 2001; O'Neil, 2008) may dis-

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Table 1
Bootstrap Analysis Results for the Direct and Indirect Effects

Independent variable	Mediator variable	Dependent variable	Standardized effect (β)	Mean effect (B)[a]	*SE* of *M*[a]	95% CI (lower, upper)[a]
RE →		Stigma	.21	0.17	.14	(−0.05, 0.49)
RABBM →		Stigma	.13	0.25	.12	(0.01, 0.50)
RE →		Willingness to refer	−.23	−0.57	.27	(−1.14, −0.10)
RABBM →		Willingness to refer	−.08	−0.17	.24	(−0.65, 0.31)
Stigma →		Willingness to refer	−.55	−1.13	.24	(−1.61, −.66)
RE →	Stigma→	Willingness to refer	.19	−0.19	.17	(−0.58, 0.10)
RABBM →	Stigma→	Willingness to refer	.14	0.67	.07	(0.06, 1.41)

Note. RE = restrictive emotionality; RABBM = restrictive affectionate behavior between men.
[a] These values based on unstandardized path coefficients.

courage men from referring others who may be struggling with mental health concerns and also point out the complex interplay among these constructs. Specifically, the results of the structural model confirmed that greater RABBM was linked with less willingness to refer someone to seek treatment, through the mediated effect of stigma. The thought of sharing emotional experiences with other men likely activates significant normative pressures against such behavior for men endorsing RABBM (Wong & Rochlen, 2005). In addition, it seems that men who endorse greater RABBM likely not only feel pressure to restrict their own emotional behavior with other men, but may also stigmatize other's emotional sharing mental health professionals. As such, consistent with this reasoning, greater endorsement of the GRC facet of RABBM was found to be associated with greater reported stigmatization of those with mental health concerns—individuals who have likely received caring thoughts and feelings from (potentially male) mental health professionals. In turn, greater stigmatization of these individuals was understandably linked with less willingness to talk about mental health-related issues with these devalued individuals. In short, aspects of GRC such as RABBM can lead to stigmatizing reactions toward those who have mental health issues and seek psychological help, and this stigma can lead to a decreased willingness to refer others to seek help for mental health issues.

Results of the structural model also showed that RE was directly associated with less willingness to refer someone to treatment and discuss emotional concerns that might warrant therapy. The direct relationship between RE and willingness to refer makes sense. Certainly, gender role expectations surrounding RE can place men in a difficult situation regarding their willingness to encourage others to talk about mental health issues and refer them to seek help; men higher in RE may be less willing to talk about mental health topics, as the identification and discussion of emotions is often required in such conversations. Beliefs still present in society such "boys do not cry" and "take it like a man" reflect the standards that men should be strong, tough, stoic, and in control of their emotions and that they should avoid behaviors inconsistent with these expectations (Wester & Vogel, 2012). Therefore, men may learn to distance themselves from talking about these issues with others.

Interestingly, unlike RABBM, in the model RE was directly associated with a willingness to talk about mental health issues, yet not linked to the stigmatization of those with mental health concerns. This finding, though initially unexpected, may be understood in terms of how RE reflects intrapersonal conflicts regarding the expressional of emotions, whereas RABBM is more of an interpersonal variable dealing with the expression of feelings to other men. Specifically, RE may be more based on a man's internal reactions to specific situations (i.e., "Is it okay for me to express myself in this situation?"). This contextual managing of their own emotions to fit the demands of the situation (Wong & Rochlen, 2005, 2009) can influence men's personal behavior but may have little relationship to their perceptions of the behavior of others. In other words, a man might struggle with his own RE in certain situations such as talking to others about mental health concerns yet at the same time not stigmatize other's emotional behavior. As such, in regard to RE, the willingness to talk about other's mental health concerns and therapy seems to be solely based on the internal comfort a man feels in discussing these issues. Indeed, researchers have shown that men modify their emotional self-disclosures to others fit with their comfort disclosing about a specific topic (Vogel, Tucker, Wester, & Heesacker, 1999).

The results of the current study add a new dimension to our understanding of the complex and multifaceted ways that societal expectations can impact intentions and behavior. Although extant research has demonstrated the utility of paying attention to the potential role of traditional male gender roles and stigma on potential male clients' willingness to seek help (Vogel et al., 2011), the present results highlight the importance of studying the influence of these factors on potential clients' social network. Because male friends and family members can heavily influence potential clients, it is important that interventions focus on changing restrictive male gender role norms and reducing the stigma related to mental health concerns. Perhaps most importantly, these efforts need to be directed not only at potential male clients, but also at the other men in their lives. Encouraging men to talk about mental health issues with others and be willing to refer friends and family members to therapy may be an essential intervention to help decrease the underuse of mental health services by men and thereby reduce men's vulnerability to dealing with a number of negative mental health concerns in isolation.

Limitations and Conclusions

Despite the importance of the findings, some limitations of the study should be noted. First, the results are based solely on self-report measures. As such, biases in reporting may be present.

The self-report measures used in this research also used phrases such as *mental illness* and *mental patient* which could have activated a perception on the part of respondents regarding more severe forms of psychological distress. Future research might consider using different types of language (i.e., less severe) to determine if the same patterns of prediction hold up. Directly examining potential differences in willingness to refer based on specific types of and degree of severity of psychological distress would also be an important future step. In addition, the study was conducted on a mainly Caucasian sample from a Midwest university. Thus, the results may not be applicable to individuals from diverse backgrounds or to those who are not in college. Another limitation of the study is that although we used structural equation modeling, the procedures still do not prove causal relationships between the variable. Future experimental and longitudinal methods are needed to confirm the current findings. In addition, future studies would benefit from additional assessment of not only how traditional gender roles influence one's social support network to encourage or not encourage the use of mental health services but also the barriers associated with accessing this network. For example, researchers could assess the GRC of both an individual experiencing a mental health concern and the GRC of those close to them (e.g., friends) and examine the unique effects of personal and external GRC-related messages on the likelihood of discussing mental health concerns and the actual use of services. Future researchers may also want to use longitudinal research measuring actual help-seeking behavior after exposure to an intervention to see if it is possible to increase actual discussion about mental health concerns. Despite these limitations, however, the current results provide important information regarding the relationship between GRC, stigma, and willingness to encourage seeking help for mental health issues. The present findings also clearly indicate the need for greater exploration of the relationships among gender roles and the influence of social networks on help-seeking behavior, to be able to better understand and change the underuse of mental health services by men.

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