AN EXAMINATION OF THE RELATIONSHIP BETWEEN EMOTIONAL EXPRESSIVITY AND ATTITUDES TOWARD AND BARRIERS TO SEEKING PSYCHOLOGICAL HELP

A DISSERTATION
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BY
SCOTT G. OLENICK

DISSERTATION ADVISOR: DR. STEFANÍA ÆGISDÓTTIR

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APPROVED BY: 

__________________________________________________________________________ Date 
Stefanía Ægisdóttir, Ph.D., Chair 

__________________________________________________________________________ Date 
Lawrence Gerstein, Ph.D., Cognate Chair 

__________________________________________________________________________ Date 
Sharon Bowman, Ph.D., Floor Representative 

__________________________________________________________________________ Date 
Carolyn Kapinus, Ph.D., University Representative 

__________________________________________________________________________ Date 
Dean of Graduate School 

BALL STATE UNIVERSITY 

MUNCIE, INDIANA 

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# EMOTION AND PSYCHOLOGICAL HELP-SEEKING IN MEN

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ABSTRACT

There is a discrepancy between men and women in regards to utilization of professional psychological services. It has been estimated that two-thirds of all individuals seeking professional psychological services are women. A few reasons that have been suggested to explain this underutilization of services by men is negative attitudes toward seeking psychological services and an inability to express emotion. The current investigation examined the relationship between men’s emotional expression, their attitudes toward expressing emotion, attitudes toward seeking professional psychological services, and their perceived barriers to seeking help. Participants were 228 men from a large, Midwestern university. Their age ranged from 18 to 50 years with a mean age of 23.34 years. Level of education ranged from freshmen undergraduate students to Master’s level graduate students. Eighty six percent identified as Caucasian and 90% identified as straight, and 6.6% identified as gay. To assess the relationship between the variables canonical correlation analysis was performed. Results demonstrated that men’s actual emotional expression and attitudes toward expressing emotion were related to stigma associated with and barriers to seeking professional psychological services. In particular, the more negative attitudes men had toward expressing emotion and the less emotional expressive they were, the greater their stigma beliefs associated with seeking professional psychological services and the more barriers they perceived with seeking said services. Findings from this investigation offer areas for future research, including further investigations of the relationship between attitudes toward expressing emotion and stigma associated with seeking professional psychological services. In addition, clinical
applications are discussed, including methods to decrease stigma associated with seeking professional psychological services and means to address emotional expression with men in therapeutic settings.
CHAPTER I

Introduction

Psychologists are aware of the unequal usage of psychotherapy by men and women. Research has shown that men are less likely than women to seek assistance for problems with daily living, including mental health issues as well as physical problems (Mansfield, Addis, & Courtenay, 2005). Similarly, men have been found to endorse more negative attitudes toward psychological help-seeking than do women and are less likely to seek assistance when needed (Good, Dell, & Mintz, 1989; Ægisdóttir & Gerstein, 2009). Even when cost is held constant, men are less likely than women to use health care services (Neighbors & Howard, 1987; Stockwell, Madhavan, Cohen, Gibson, & Alderman, 1994). It has been estimated that two-thirds of all clients seeking psychological help are women and that one in three women versus one in seven men will seek services from a mental health professional at some point during their lifetime (Good et al.). Addis and Mahalik (2003) concluded that a growing body of empirical evidence confirms the notion that “men are reluctant to seek help from health professionals” (p. 5) and hold less favorable attitudes toward professional psychological services than do women (Ægisdóttir & Gerstein, 2009). These findings appeared true for men throughout the lifespan, from childhood to old age (Carpenter & Addis, 2000), as men are discouraged at an early age by parents, peers, and the media from requesting assistance...
for personal and emotional issues. This lack of psychological help-seeking is evident in mental health settings where there is a disproportionate usage of psychotherapy by men and women for psychological issues, including depression, anxiety disorders, substance abuse disorders, and relationship problems. Furthermore, it has been stated that those men who do enter therapy are “disproportionately represented among many problem populations” (Levant, 1996, p. 259), including substance abusers, perpetrators of family and interpersonal violence, parents estranged from their children, sex addicts and sex offenders, victims of homicide, and suicide. Kelly and Hall (1992) agreed, stating that, “when men’s issues are addressed in the counseling literature, it is too often in the context of treatment of the relatively few men who batter, abuse, and victimize others” (p. 255). When seen in clinics or treatment centers, these men are labeled as “reluctant” or “treatment resistant” and often are treated as batterers or law-breakers. Consequently, the therapeutic approach employed by the counselor or counseling psychologist may not consider the full extent of the man’s individual experience, as the focus may be on treating the “offense,” rather than the person.

Anecdotally, men are considered “less emotional” than their female counterparts and are more inclined to refrain from expressing themselves emotionally. Additionally, these beliefs may lead therapists toward a confirmation bias in which they look for evidence to verify that men, indeed, are not emotionally expressive and ignore instances in which men do experience and express emotions. These same assertions that regard men as being less emotionally expressive than women have been suggested to play a major factor in men’s underutilization of psychological services. However, no studies have examined the role that attitudes toward emotional expression play in men’s decision
to seek or not seek professional psychological treatment. In addition, little research exists which examines how emotions act as a barrier to seeking professional psychological assistance. With that said, a few questions remain; namely, does emotion act as a barrier preventing men from seeking services for mental health concerns? And, how does men’s attitudes toward expressing emotion and their actual experience of emotion affect whether or not they will seek professional services for psychological concerns? The aim of the following study was to answer these questions. Specifically, this study examined the role that men’s emotional expression and attitudes toward emotional expression contribute to their attitudes toward seeking professional psychological services. In addition, this investigation examined how men’s attitudes toward expressing emotion and their actual experience of emotion acted as a barrier, preventing them from seeking professional psychological services.

An in-depth exploration of men’s emotional expression, their attitudes toward emotional expression and the relationship to psychological help-seeking holds tremendous potential for the field of counseling psychology as men have begun to redefine their roles in society. Not only does the current study address men’s attitudes toward seeking assistance for psychological concerns, but it also addresses the barriers men identify for not seeking assistance, which has only recently been identified as a need in the field. More importantly, the findings from this investigation may dispel the myth that men are incapable and unwilling to express emotion and may, in fact need to be approached differently in the therapeutic setting to delve into their emotional world.
Attitudes toward Psychological Help-Seeking

Attitudes are related to one’s decision to perform or not perform an action. Unfavorable attitudes toward psychotherapy have been associated with avoidance of psychological services (Leaf & Bruce, 1987) and unwillingness to seek help (Deane & Todd, 1996). As Cramer (1999) indicated, “despite the availability of a wide range of professional services, the majority of people with psychological difficulties do not seek help, a dilemma known as the ‘service gap’” (p. 381). Cramer found that individuals are more likely to seek counseling when distress is high and attitudes toward counseling are positive; whereas individuals with more negative attitudes toward counseling are more likely to conceal information from their therapist. This seems to be a no-win situation for men; they are less likely to enter therapy due to more unfavorable attitudes, and if “coerced” into therapy by a family member, the workplace, or the court system, they are less likely to share information with their therapist than are women.

Researchers have identified several factors related to one’s decision to seek or not seek psychological help, including gender (Fischer & Turner, 1970; Ægisdóttir & Gerstein, 2009), race, education, socioeconomic status (Kushner & Sher, 1989), social stigma (Farina, Holland, & Ring, 1966), concern for monetary costs (Nadler, 1983), concerns of confidentiality (Rubanowitz, 1987), fear of emotions (Komiya, Good, & Sherrod, 2000), and ethnic minority status (Narikiyo & Kameoka, 1992). It appears that being male, less educated, of minority status, and lower socioeconomic status contributes to less favorable attitudes toward seeking professional psychological services and may deter individuals from seeking psychological assistance.
Men and Psychological Help-Seeking

The importance of a psychology of men was highlighted when a special issue of *The Counseling Psychologist (TCP)*, titled *Counseling Men* (Skovholt, Gormally, Schauble, & Davis, 1978) was published. The goal of the special issue was to “…contribute to understanding male roles and the ways human services professionals can promote the growth of men” (p. 2). Since then, interest in men’s issues, including their ability/inability to express themselves emotionally as well as identifying their attitudes toward seeking psychological help, has risen.

Prior attempts to understand men’s underutilization of psychological services focused on the concept of masculinity and research utilizing O’Neil’s (1981) Gender Role Conflict Paradigm (GRCP). Gender role conflict (GRC) occurs when “rigid, sexist, or restrictive gender roles, learned during socialization, result in the personal restriction, devaluation, or violation of others or self” (Good, et al., 1995, p. 3). Studies have shown that the construct of GRC is related to shame (Thompkins & Rando, 2003), depressive symptoms (Shepard, 2002), hostility, social discomfort, obsessive compulsiveness (Hayes & Mahalik, 2000), low self-esteem, anxiety, depression, intimacy (Sharpe & Heppner, 1991), more immature psychological defenses (Mahalik, Cournoyer, DeFranc, Cherry, & Napolitano, 1998), alexithymia (Fischer & Good, 1997), and negative attitudes related to help-seeking (Blazina & Watkins, 1996; Good et al., 1989). Alexithymia is defined as “no words for feelings” (Mallinckrodt, King, & Coble, 1998) and involves difficulty identifying feelings and difficulty communicating about them. Wilcox and Forrest (1992) compiled research demonstrating that “overconformity to a traditional male gender role keeps men from seeking psychological help” (p. 292).
Specific gender role factors that have been suggested to explain men’s mental health issues and their use of psychological services include: conflicts regarding power and control (Good et al., 1989); higher levels of gender role conflict (Good & Wood, 1995); stronger endorsement of traditional gender roles (Komiya et al., 2000); fear of homosexuality (O’Neil, Helm, Gable, David, & Wrightsman, 1986); alexithymia (Berger, Levant, McMillan, & Kelleher, 2005); restrictive emotionality (O’Neil, 1981); and age (Wills & DePaulo, 1991). Findings suggest that sex, masculinity, and adherence to gender roles play a part in help-seeking behavior; in fact, men’s gender roles have been linked with numerous variables critical to counseling psychology, including help-seeking (Tokar, Fischer, Schaub, & Moradi, 2000). It would seem, then, that the factors contributing to the difficulties men experience are the same factors that deter them from seeking professional assistance.

Although important, the findings cited above have been criticized as being contradictory and inconsistent. Moreover, the concepts of masculinity and gender roles have changed dramatically over the past thirty years as men reestablish their place in society and are encouraged to express themselves emotionally. As previously stated, it is commonly known that women hold more favorable attitudes toward psychological help seeking and use more psychological services than do men (Fischer & Turner, 1970; Rule & Gandy, 1994; Ægisdóttir & Gerstein, 2009). However, because men’s low rates of help-seeking and service utilization have only recently come to be considered problematic (Mansfield, Addis, & Courtenay, 2005), little is known about their reasons.
Men and Emotional Expression

Emotion has been understood as having multiple components, including a behavioral or expressive component, an experiential or verbal component, and a physiological component (Kring & Gordon, 1998). The actual scholarship on men and emotion is inconsistent and unfavorable. Men are portrayed as emotionally stoic and unable to “get in touch” with their emotions. An examination of the literature finds men described unable to feel emotionally alive (Brooks & Gilbert, 1995). Such claims have led to men being labeled “hypoemotional” (Heesacker et al., 1999) or, in worst cases, “alexithymic” (Levant, 1998). Although research has identified various reasons men hold for having unfavorable attitudes toward seeking professional psychological help, “emotion is one factor that has received little empirical examination for its potential contribution to individuals’ reluctance to seek professional psychological assistance” (Komiya, et al., 2000, p. 138). Those studies that have examined men’s inability or reluctance to emotionally express themselves have suggested that simple biological differences between men and women contribute to less emotional expression. What we know about emotions and emotional expression, however, may be influenced by other variables rather than just differences in biological sex.

Becoming emotionally unattached or avoiding one’s emotions is culturally taught. As boys grow, they are bombarded with messages telling them to suppress their emotional experience and their expression of emotions (Rabinowitz & Cochran, 2002). The consequence of such emotional oppression is “the creation of powerful, often unconscious, internal prohibitions against the experience and expression of…feelings” (Rabinowitz & Cochran, p. 19). These boys become men who are unaware of their
emotions and rely on their cognition to interpret what they should feel (Levant, 1998). Consequently, men are socially taught to deny their experience of emotion and rely upon their thoughts to tell them how they should feel; or, they deny the existence of emotions altogether. Balswick (1988) suggested that male role socialization might result in men thinking they are not supposed to express their emotions rather than men having an inability to be expressive. These beliefs may lead to self-stereotyping, involving the perception of oneself as a member of a group and consequently behaving in line with this social identity (Simon & Hamilton, 1994; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987). This process may also involve the assumption of relatively negative attributes (Hogg & Abrams, 1988). Such self-stereotyping may lead men to believe that they do not have the ability to express emotion when, in fact, they do.

Limited expression of emotion and fear of emotions have been linked to men’s underutilization of professional psychological services. Komiya et al. (2000) found that, compared to women, men experienced less open attitudes toward emotions, perceived greater stigma associated with counseling, and reported less severe psychological symptoms. This is one of the few studies examining men’s attitudes toward expressing emotion and their overall attitudes toward seeking professional psychological services. However, the study did not consider men’s actual emotional experience of emotion or whether emotional expression acts as a barrier to seeking mental health treatment.

**Purpose of Study**

More than thirty years of research on the relation of masculine-related constructs and emotion to mental health have reached very different conclusions (Good, Heppner, & DeBord, 2004), leaving the manner in which gender affects men’s psychological
wellbeing unclear. The aim of this study, therefore, was to examine the interrelationship of men’s ability to express emotion, their attitudes toward expressing emotion and their attitudes toward seeking professional psychological help, help-seeking intentions, and perceived barriers to help-seeking. The following investigation will add to current knowledge of men and their attitudes toward expressing emotion as well as their actual expression of those emotions. It also will delineate the specific components of emotional expression that cause men to hold more unfavorable attitudes toward and intention to seeking professional psychological services. Finally, this study will provide evidence for the reasons, in the form of self-identified barriers, men hold for not seeking professional psychological services, including the barrier of requiring emotional control.

The results of this study will hold implications for counselors as well. Knowing that men may express emotion, yet may be reluctant to do so during psychotherapeutic sessions, will allow therapists to focus on the emotions men are willing to express and to provide a safe environment for men to explore the more risky emotions reserved for their own internal worlds. Based on existing research, it is expected that the more positive men’s attitudes toward expressing emotion, the fewer barriers they will perceive in seeking professional psychological assistance and the more positive attitudes they will hold toward seeking professional psychological services.
CHAPTER II

Review of Literature

In this chapter, theories of emotion and research on the experience and expression of emotion in men are reviewed. Additionally, theories of attitude development and research regarding attitudes toward seeking professional psychological assistance are discussed. This chapter also outlines the construction of male gender roles and masculinity and their relationship to help-seeking behaviors. Findings and limitations of previous research are presented. The chapter concludes with definitions of terms and hypotheses proposed for the current study.

Overview of the Study of Emotion

Lundh, Johnsson, Sundqvist, and Olsson (2002) described the psychology of emotion as “a complex field that is only incompletely understood” (p. 362). What complicates the ability to fully define a theory of emotion is the complexity of emotional existence. As Strongman (2003) described, “Emotion permeates life…It is reflected in physiology, expression and behaviour; it interweaves with cognition; it fills the spaces between people, interpersonally and culturally. Above all, emotion is centred internally, in subjective feelings” (p. 3). Because of the numerous variables associated with emotion, it can be difficult to present a clear, chronological description. In fact, Strongman indicated that there are over 150 theories of emotion, including those with
origins outside psychology in disciplines such as philosophy, history, anthropology, and sociology. Consequently, defining emotion can be difficult, as there appear to be as many definitions of emotions as there are researchers on emotion.

Despite the difficult task to define emotion, Izard (1977) noted that a complete definition of emotion must consider the experience or conscious feeling of emotion, the processes that occur in the brain and nervous system, and the observable expressive patterns of emotion. In addition, Lazarus (1991) outlined 12 issues that a theory of emotion should address: (1) definition; (2) the distinction between emotion and non-emotion; (3) whether or not emotions are discrete; (4) the role of action tendencies and physiology; (5) the manner in which emotions are fundamentally independent; (6) the links between cognition, motivation, and emotion; (7) the relationship between the biological and socio-cultural bases of emotion; (8) the role of appraisal and consciousness; (9) the generation of emotions; (10) the matter of emotional development; (11) the effects of emotion on general functioning and wellbeing; and (12) the influence of therapy on emotion. Lazarus also noted that the causes of emotion, whether they be from personality or environment, or from culture or appraisal need to be addressed as well. In addition to the propositions outlined by Lazarus, Oatley (1992) proposed that a theory of emotion must also consider the unconsciousness of the individual and the interpersonal communication of emotion. Based on the suggestions offered by Lazarus and Izard, Frijda’s (2008) definition of emotion provides the most complete view of emotion that the present study follows. He stated, “The psychological perspective (on emotion) has two interconnected implications. First, its focus is on phenomena manifested or felt by individuals; second, the explanations of these phenomena require
hypotheses about intrapersonal causal processes” (p. 69). According to Frijda, psychological explanations of emotion phenomena are composed of three terms: the structure of the individual; incoming and stored information; and the dynamic interaction with the environment. In addition, these three components can be combined in an indefinite number of ways permitting various theoretical orientations to emphasize one over another. Finally, according to Frijda, emotions are tendencies to engage in behavior that are influenced by the needs of the person experiencing them.

Individuals vary in the extent to which they both experience and express their emotions. The psychological view of emotion is that emotion represents a meaningful and necessary concept (Frijda, 2008). Before continuing, it is important to operationally define the terms emotional experience and emotional expression, which will persist throughout this investigation. Emotional experience is the “subjective, felt sense of emotional responses” (Kennedy-Moore & Watson, 1999, p. 4); emotional expression is the “observable verbal and nonverbal behaviors that communicate and/or symbolize emotional experience” that occurs with or without conscious awareness, is somewhat controllable, and demonstrates intent (Kennedy-Moore & Watson, p. 4). Kennedy-Moore and Watson also describe emotional expression as “the link between internal experience and the outside world” (p. 4) that provides a tremendous amount of theoretical and practical importance to understanding individuals. For daily life, emotional expression is a means of communication and bonding. In the therapeutic setting, emotional experience provides information and is a foundation for exploration and possible change (Kennedy-Moore & Watson). In addition, it is also necessary to define what is considered “nonexpression” of emotion as this variable is addressed in the research literature.
Kenney-Moore and Watson describe nonexpression as “the lack of expression” (p. 4). In the literature, nonexpression is regarded as “restrictive emotionality,” “emotional inexpression,” or “alexithymia.”

As stated above, emotional experience and expression provide information, and exploration of emotional experience is sometimes necessary in the therapeutic setting for optimal improvement. For psychologists, understanding how an individual experiences and expresses emotion is fundamental for therapeutic work, as different emotions and emotional intensity require different in-session interventions. Greenberg (2002) highlighted the importance of differentiating between primary and secondary emotions as well as adaptive and maladaptive emotional experiences. In addition, Greenberg identified five principles that provide an empirically based understanding of emotional change processes: (1) increasing awareness of emotion; (2) expressing emotion; (3) enhancing emotion regulation; (4) reflecting on emotion; and (5) transforming emotion. Understanding emotion and what leads to emotional change affords the psychologist a vital approach to working with individuals in the therapeutic setting. It offers the psychologist the opportunity to develop a working alliance with a client and may be used as a “gauge” to determine therapeutic change.

**Early Theory of Emotion**

Prior to Charles Darwin mainstreaming the study of emotion and William James’s attempts to organize the experience of emotion, emotion theory was founded in philosophy. For years, emotion was contrasted with reason and seen as something to avoid and be worked against (Strongman, 2003). Solomon (2008) wrote, “…emotions have always lurked in the background—often as a threat to reason and a danger to
philosophy and philosophers” (p. 3). Solomon likens the relationship between reason and emotion to master and slave, with reason in control and the dangerous impulses of emotion safely suppressed. This war of reason versus emotion has plagued the study of emotion to the present day in two ways: (1) emotions are considered inferior to reason (cognition); and (2) emotions and cognition must remain separate. These beliefs can still be seen in present day cognitive theories of emotion that emphasize emotion and cognition are separate entities that battle each other rather than work in conjunction.

Whether described as “passions,” or “humors,” “judgments,” or “sensations,” “inclinations,” or “perceptions,” emotions have long intrigued and motivated individuals to uncover their meaning and their place in the human being. It was not until the end of the 19th century that psychologists began to take interest in understanding the complexity of emotional life as the field of psychology itself began to take off. Today, great emphasis is placed on the psychological importance of emotion and it is generally accepted that emotions augment, rather than interfere with, cognitive capacities (though cognitive theorists might disagree).

As he did in many areas, Darwin had a tremendous influence on the early study and theory of emotions. In his book, *The Expression of the Emotions in Man and Animals* (1872), Darwin wrote that emotional behavior originally served as an aid to survival and as a method of communicating intentions. He also provided detailed accounts regarding the facial expressions and bodily movements that accompany several emotions in humans and other animals. Darwin asserted that facial expressions were the residual actions of more complete behavioral responses that included vocalizations, gestures, skeletal muscle movements, and physiological responses (Matsumoto, Keltner,
Shiota, O’Sullivan, & Frank, 2008). For example, angry people bare their teeth and furrow their brow due to inherited behavior patterns their ancestors needed when fighting; baring one’s teeth would signal an intention to attack. With advances in photography and anatomy at the time, Darwin was able to study the muscle actions involved in emotion and concluded that the muscle actions around the eyes and mouth were universal and their precursors could be seen in expressive behaviors of nonhuman primates and other mammals. According to Darwin, regardless of race or culture, all people should express emotions in the face similarly. It is apparent that Darwin was concerned with the expression of emotion and did not seek to define human experience of emotion.

The universality of facial expressions of emotion has led a number of modern emotion theorists to validate that they are somehow “basic” or “primary” (Cornelius, 1996) to the entire human species. In addition, the notion is that all other emotions that we might experience or express are somehow derived from this small set of simpler emotions. Averill (1994) related that the idea that some emotions are more basic than others has had a subtle yet profound influence on psychological research and theory. For instance, Ekman (1984) argued that seven emotions, happiness, sadness, fear, disgust, anger, contempt, and surprise, have been recognized universally and comprise the set of fundamental emotions. Izard (1977; 1992) held that ten fundamental emotions exist: interest-excitement, joy, surprise, distress-anguish, anger, disgust, contempt, fear, shame, and guilt. Plutchik (1991) identified eight primary or “prototype” emotions thought to exist as polar opposites: fear/terror, anger/rage, joy/ecstasy, sadness/grief, acceptance/trust, disgust/loathing, expectancy/anticipation, and surprise/astonishment.
These are thought to be evolutionary in function as they allow the individual to adapt to environmental demands, a substantial portion of which contain social relations. Plutchik posited that emotions: (1) vary in their intensity (i.e., anger versus rage, fear versus panic); (2) vary in terms of their similarity to one another (shame and guilt are more similar than disgust and joy); (3) may be ordered by opposites; and (4) may be either primary or secondary. They are fundamental because each has a specific innately determined neural basis and a distinctive subjective quality. Whatever the number proposed, these emotions are understood to correspond to a set of fundamental emotions that evolved as a result of survival; survival not only in the wild, but also survival with others.

Vindication for Darwin’s view of the universality of emotion can be seen through the cross-cultural universality of facial expressions and in display rules that govern the expression of emotions. For instance, Shaver, Schwartz, Kirson, and O’Connor (1987) asked individuals from three different cultures (Italy, China, and the United States) to categorize a list of emotion names based on their similarity to one another. Hierarchical cluster analysis indicated that six emotions could be described as basic-level emotion categories with a great deal of overlap among the three cultures. These emotions were those described earlier by Ekman. In line with Darwin’s original assertion, the last 20 years of research has demonstrated conclusively that the facial expressions for happiness, surprise, sadness, fear, disgust, and anger are correctly identified by people from vastly different cultures.

In addition to the universality of facial expressions, the Darwinian tradition in emotion also has provided evidence for display rules of emotion. Display rules refer to
patterns of expression “management” that are part of what one learns when one is socialized into a particular culture (Friesen, 1972; Matsumoto, 1990). Brody (1999) stated that display rules are culturally shared values about emotion that dictate how, when, and where we should experience and communicate our emotional experiences. Display rules tend to mirror cultural stereotypes about gender and emotion and carry a message that certain social consequences will ensue if people do not conform.

Consequently, display rules also account for the ways in which social learning can mask universal facial expressions of emotion. For instance, men adhere to a number of display rules with and without conscious awareness. They may avoid expressing sadness in public as it may be deemed unacceptable for men to openly demonstrate weakness, but they may be less guarded to express anger.

Despite its popularity, the concept of display rules has been challenged because of methodological concerns and conceptual concerns regarding cultural variations. Safdar et al., (2009) reported that few studies have attempted to investigate their validity in a direct way. In addition, Matsumoto, Yoo, Hirayama, & Petrova (2005) reported that assessments of emotional expression operationally define display rules on a single dimension of expression—suppression. To address this, Matsumoto et al. created the Display Rules Assessment Inventory (DRAI; 1998), in which participants choose a behavioral response when they experience different emotions in different social situations. The DRAI of was created to challenge previous attempts to study display rules which have relied on reading or showing individuals stories designed to elicit emotion in various social situations and ask what emotion the protagonist would display and why. The emotions chosen (anger, contempt, disgust, fear, happiness, sadness, and
surprise) were those seven research had shown to be universally expressed and recognized. Matsumoto, Takeuchi, Andayani, Kouznetsova, & Krupp, (1998) used the DRAI in a study examining cultural differences in display rules across the United States, Japan, South Korea, and Russia. Participants also completed a measure of individualism-collectivism. The researchers found Russians to exert the highest control over their expressions, followed by South Koreans and Japanese, while Americans had the lowest scores. The cultural differences were found across all rating domains, emotions, and social situations. Based on their findings, Matsumoto et al. (2005) suggest that emotional expressions are not display rules, but rather display rules are cognitive representations of social conventions about emotional displays. In addition, the authors contended that display rules may not be directly observable, although the behaviors they regulate may be. Because display rules represent social convention, discrepancies may exist between people’s display rules and their behaviors.

Based on their research, Matsumoto, et al., (2005) noted that cultural differences in expression and display rules implicate cultural mechanisms, rather than universality of expression, most notably the difference between individualistic and collectivistic cultures. Compared to collectivistic cultures, individualistic cultures appear to promote greater expression, especially of negative emotions to in-group members. Comparatively, collectivistic cultures seem to foster greater expression of positive emotions toward in-groups and negative emotions toward out-groups (Matsumoto et al.). Also studying the relationship between cultural variables and the display and interpretation of emotions, Masuda, et al., (2008) examined how Japanese and American individuals regard the social context when judging people’s emotions from their facial
expressions. These authors found that Japanese individuals were less narrowly focused on the individual expressing emotion than Americans in judging other people’s feelings. The authors suggested that Japanese gauge what everyone in a situation is feeling rather than just the individual and include information about other people’s feelings in their judgment of the central person’s emotion whereas Americans focus narrowly on the central person’s expression, ignoring information about the others. Their findings provide further evidence regarding the difference between collectivist and individualistic societies and the rules governing the display and interpretation of emotions.

Darwin’s legacy to the study of emotions consists of his use of the theory of evolution as a framework for understanding the origin of emotional expressions, the general principles of expression that he used to study emotional expressions, and the method he used to test his ideas about the evolution of emotional expression (Cornelius, 1996). Contemporary Darwinian theorists, including Plutchik and Eckman, share the assertion that emotions cannot be understood apart from a consideration of their evolutionary history and their contribution to the survival of the species. However, critics, including Fridlund (1994), argued that Darwin and his contemporaries failed to appreciate the fundamentally social nature of human expressions. Expressions of emotions are always communicative and can be best understood as social tools. Considering Lazarus’s description of a theory of emotion described previously, Darwinian theory of emotion lacks a description of the causes of emotion, what constitutes an emotion, and the purposes emotions might serve outside an evolutionary
context. Furthermore, the Darwinian approach to understanding emotion does not account for the experience of emotion.

While Darwin was concerned with the expression of emotion, William James was concerned with the experience of emotion. Though regarded as the James-Lange Theory of Emotion as both men hypothesized their theories about the same time (1884 and 1885, respectively), James was its main proponent. Theory and research in the Jamesian tradition of emotion was inspired by James’s writings on emotion in his 1884 article, “What is an emotion?” (Cornelius, 1996). For James, common sense got the sequence of emotional experience wrong; in order to have an emotion, one must first experience bodily changes. Like Darwin, James believed that these changes were automatic responses of the body to the perception of something in the environment. For James, however, the bodily changes experienced were the emotions. Such changes include changes in heart rate, muscular tension, and skin conductance. In other words, perception leads to bodily response, which leads to emotion. James reported that based on his theory one would say that a person feels sad because one cries, not that one cries because one feels sad. James’s theory of emotion was based greatly on introspection and lacked both theoretical and methodological validity; however, it is considered the first fully psychological theory of emotion (Strongman, 2003). More importantly, James’s theory led subsequent theories of emotions to consider a dual-aspect approach that would include both physiological and cognitive components with varying degrees of emphasis.

Further criticism came from Arnold (1960) who described James’ perspective on emotion as flawed, as James never explained how perception sets in motion the bodily processes that result in the emotion. Arnold asserted that at the heart of every emotion is
a special kind of judgment, called appraisal. Without appraisal there can be no emotion because all emotions are initiated by an individual’s appraisal of his or her circumstances. Appraisals are “sense judgments” in that they are immediate, non-reflexive, nonintellectual, and automatic, producing an understanding of events. For Arnold, perception leads to appraisal, which leads to emotion. Cannon (1915, 1932) also was not content with James’s theory of emotion and proposed his views on emotion in reaction to those of James (Strongman, 2003). Cannon suggested that the neurophysiological aspect of emotional expression was subcortical and that all emotions depend on a similar chain of events. Receptors are stimulated by an environmental situation and impulses are relayed to the cortex, which in turn, stimulates thalamic processes that act in patterns corresponding to particular emotional expressions. Cannon suggested that when the thalamus discharges, we experience emotion almost simultaneously with bodily changes. The significance of Cannon’s theory is that it relies on the neurophysiology of emotion, which led to later theorists and researchers to examine the neurological basis of emotion.

Early theorists of emotion began to consider the origins and development of emotion and how to distinguish between emotion and non-emotion. In addition, these early theorists provided new insight into the physiological components of emotion and where emotions might reside in the body. However, it also can be observed that no attention is given to the cognitive aspect of emotion, as Arnold discussed; yet, this lack of attention encouraged more contemporary theorists to explore the relationship of cognition and emotion.
Behavioral Theory of Emotion

For those following the behavioral approach to the study of emotion, the focus is on what is observable and measurable. Behavioral theorists regard emotion as a response, basic to life and survival. Often, emotion is understood in the context of motivation. As Strongman (2003) noted, it is odd that the behavioral approaches to the study of emotion never embraced facial expressions or posture related to emotion; rather, these elements were considered by social psychologists working within a cognitive framework. This may be considered one of the major flaws of behavioral theories of emotion—that they did not regard observable, measurable facial expression and gestures as a point of study and application.

According to Strongman (2003), Watson (1930) proposed the first behavioral theory of emotion. For Watson, emotions were considered disorganizing, stimulated by a temporary state of chaos. Watson suggested three types of fundamental emotional reactions—fear, caused by a removal of support from an infant and resulting in gasping and crying; rage, caused by hampering movements and resulting in screaming and body-stiffening; and love, caused by gentle stimulation and resulting in smiling and cooing (Strongman, 2003). Harlow (1933) suggested that emotions were based on unconditioned affective responses and the names ascribed to the emotional state arose from social conditioning. According to Harlow, fear and rage were the same state, but if a situation required one to run, it was labeled fear; if a situation required one to attack, it was labeled rage. In line with conditioned responses to stimuli, Hammond (1970) regarded emotion as a central state that is elicited by learned and unlearned stimuli, which may be the presence or absence of rewards and punishments. Hammond’s theory
occurred within a motivational framework in that rewarding events lead to drive
reduction and punishing events lead to drive induction (Strongman, 2003).

Behavioral theories to studying emotion are simple in that they are condensed into
drive-reduction theories in which emotional experiences are learned reactions. Cognitive
theorists would argue that behavioral theories of emotion do not regard the subjective,
cognitive component related to emotional experience that is often considered vital to
understanding emotion. Likewise, behavioral theories of emotion tended to focus on
individual, discrete theories of emotion (anger, fear, joy) and not more complex,
secondary emotions, such as pride, shame, and guilt.

**Cognitive Theory of Emotion**

There exist a relatively large number of cognitive theories of emotion with an
equally large number of foci involved in the theories. While some theorists have given
centrality to cognition in understanding emotional experience, others have ignored
aspects of emotion entirely. The cognitive approach to the study of emotions rests upon
the idea that in order to understand emotions, one must understand how individuals
perceive events in their environments. Izard (1977) described two classes of theory in the
cognitive approach—self-theories and theories that view cognition as a cause or
component of emotion. While self-theories focus on the self-concept that emphasizes the
feeling content, those that follow emotion as a function of cognition treat emotion as a
response determined by cognitive processes.

According to cognitive approaches to the study of emotion, emotions are
generated by judgments about the world and require thought (Cornelius, 1996). Thought
and emotion are therefore inseparable. James’s theory of emotion sparked this dualistic
understanding of the experience and expression of emotion and paved the way for other theorists, including Schachter (1962), to hypothesize the link between cognition and emotion.

The dual-process, or two-factor approach to the study of emotion became a major focal point for cognitive theorists of emotion. Schachter’s (1962) Two-Factor Theory of Emotion rested on the belief that emotions consisted of two components: physiological arousal and a situationally-appropriate cognition. Schachter’s theory expanded on much of what was understood about emotions from the work of James and provided a theory that influenced many researchers of emotion. Schachter proposed the following: (1) When one is physiologically aroused but cannot explain why or what caused the arousal, one will give this state a name and react to it in whatever cognitive way is open; (2) When a reasonable explanation exists to describe being physiologically aroused, one will not entertain alternative cognitive accounts; and (3) When a cognition that was previously experienced is experienced subsequently, emotions will be described only if one is in a state of physiological arousal. Although Schachter’s work has drawn much attention to the cognitive aspect of emotion, Cornelius (1996) asserted that Schachter’s theory is flawed. In particular, he suggested that Schachter placed too much emphasis on the role of peripheral arousal and the links between arousal and emotion (Strongman, 2003).

Appraisal is also a factor introduced in the cognitive approaches to emotion, first introduced by Arnold (1945). Arnold suggested that individuals automatically assess everything encountered. Consequently, individuals approach things evaluated as “good,” avoid things appraised as “bad,” and ignore what is “indifferent.” Lazarus’s (1991) Cognitive –Motivational Relational Theory states that specific emotions arise from the
personal meanings people bring to situations that have relevance to their knowledge and aspirations. Zajonc (1980) took issue with Lazaurs’s model of cognitive aspects of emotion, claiming that preferences are formed after cognitive activity. According to Zajonc, it is difficult to separate thoughts (based on information) and feelings (based on energy transformations). Consequently, affect precedes cognition. For instance, one can be fearful of an object before one is aware of its presence. Zajonc believed that, unlike cognitive judgments, affective feelings cannot be avoided; one can control the expression of emotion but not the emotion itself.

Continuing with the belief in the importance of cognitive appraisals to understanding emotions, Roseman’s Structural Theory (1991) defined and delineated five appraisals underlying the experience and expression of emotion. These appraisals determine whether or not an emotion will occur and which discrete emotion it will be. Roseman describe the first dimension as motive, and proposed that events consistent with one’s motives lead to positive emotions, whereas events that are inconsistent with one’s motives lead to negative emotions. The second dimension, probability, refers to how certain or uncertain one is that a particular event or outcome in a situation will occur. Third, agency refers to who is responsible for the events in a particular situation. Fourth, one’s motivational state refers to whether the events one encounters involve obtaining a reward or avoiding punishment. Finally, power refers to whether one perceives oneself as weak or strong in a particular situation. Roseman argued that evaluations and interpretations of events, rather than the events themselves, determine whether an emotion will be felt and which emotion it will be.
In addition to appraisals influencing the likelihood of one experiencing emotions, interruptions also have been suggested to play a role in the experience of emotion. For Mandler (1975), emotions rest on arousal, cognitive interpretation (meaning), and consciousness. The starting point for the generation of emotion is arousal, defined as the activities of the autonomic nervous system. Mandler assigned special status to cognitive interruptions as a class of events having a certain adaptive significance and evaluations of perceptions of the self. Interruption in a person’s plans often signals important changes in the environment. For Mandler, arousal gives emotion a visceral quality, whereas cognitive interpretation provides a category for that experience (Strongman, 2003). In addition, emotional experience occurs in consciousness, which is transformed into conventional language. For Mandler, an environmental stimulus leads to a cognitive interpretation, which leads to perception of the arousal. This then leads to emotional experience and perception and evaluation of the experience, which may or may not change the original cognitive interpretation. For example, an individual notices that a coworker does not respond when approached with “hello.” The individual is left to reason the cause of the snubbing and a physiological state of anxiety is perceived within the individual. The individual then feels dejected and evaluates the entire situation. Afterwards, the individual may realize that the coworker’s father had just died and he or she be in a state of disorganization. The individual is then left to evaluate the experience and adjust his or her initial interpretation.

Oatley and Johnson-Laird’s (1987) “Communicative” Theory of Emotion is similar to that of Mandler (1975) in that it is also concerned with the consequences of interruptions. However, while Mandler’s focus is on interruptions in an individual’s
conditions of daily living, Oatley and Johnson-Laird’s focus is specifically on the interruption of goals, which are symbolic representations of something in the environment the individual wants to achieve. Oatley and Johnson-Laird argued that emotions are social affairs and central to the organization of cognitive processing. Their theory also lies in the belief that human cognitive processes are “modular” and have the ability to communicate with one another. Each of these modules is designed to carry out a particular task or process until it is interrupted. In essence, “emotions are part of the biological solution to the problem of how to plan and to carry out action aimed at satisfying multiple goals in environments which are not perfectly predictable” (Oatley & Johnson-Laird, p. 31). For instance, an individual may meet someone who reminds the individual of a past partner. The individual may begin to feel sad as he or she remembers the past relationship. The individual may remain with the sadness and attempt to work through it or remind him or herself that the new person is not the past partner and talk him or herself into contentment.

Theorists in the cognitive tradition to understanding emotions have provided a great deal of empirical evidence to understanding emotion. These theories are well focused and provide explanations to understanding emotional experience. However, many of the cognitive theories, not surprisingly, lack description of the physiological or behavioral components involved in emotion. Also, cognitive theories of emotion do not address the interpersonal importance of emotional experience or expression. Finally, many of the cognitive theories of emotions are quite complex and sometimes difficult to comprehend.
Social Constructivist Theory of Emotion

The youngest of the four theoretical perspectives on emotion is the social constructivist approach. In contrast to those who believe that emotions are primarily biological or evolved adaptations, social constructivists posit that emotions are the products of culture (Cornelius, 1996) and depend upon social concepts (Averill, 1982). Similar to the perspective underlying display rules of emotions, social constructivists maintain that emotions depend on a social consciousness concerning when, where, and what to feel as well as when, where, and how to act. Furthermore, the approach emphasizes “by whom” particular emotions are to be experienced and expressed. Consequently, gender differences in the expression and experience of emotions reveal how emotions are constructed within a culture to serve particular social purposes (Cornelius, 1996).

According to a social-constructivist approach, one does not have emotions in a vacuum nor can one decisively tell what he or she is feeling based solely on introspection (Saarni, 2000). This perspective emphasizes that meaning is attached to experiences through social exposure and cognitive-developmental capacities. A social-constructivist approach is highly individualized, such that one’s emotional experience is dependent on specific contexts, unique social history, and current cognitive-developmental functioning. The concepts assigned to emotional experience are full of nuance and context-dependent meaning, including the social roles individuals occupy, such as gender.

Averill’s (1982) Social Constructivist Theory of Emotion embodies this approach. Averill considered emotions to be a “transitory social role (a socially constructed syndrome) that includes an individual’s appraisal of the situation and that is interpreted as
a passion rather than as an action” (p. 307). Averill defined “syndrome” as a set of events that occur together in a systematic manner, such as subjective experiences, expressive reactions, and patterns of physiological response. While some emotions are associated with all components, others are associated with only one or two, or perhaps, none. A role, according to Averill, is a socially prescribed set of responses to be followed by a person in a given situation. The components of emotions are given consistency by the socially determined rules associated with particular emotional roles. Emotional appraisals provide a link from the person to the environment and serve to differentiate a person’s emotional responses to his or her environment. Finally, Averill refers to emotions as passions, which refer to the passive nature associated with many emotions. The social constructivist approach to understanding emotions places interpersonal relationships at the center of its theory. This approach accounts for cognitions, behaviors, and emotional expression not considered by other theories. To its credit, the social constructivist approach considers the meanings behind emotional expression and recognizes that emotional experience and expression is highly individualized.

**Gender and the Expression of Emotion**

Though the concept of emotion consists of many components, emotion expressivity has been the most widely studied component of emotion, and the most controversial. Emotional expressivity reflects the extent to which individuals outwardly display their emotions (Kring, Smith, & Neale, 1994); it is the “observable verbal and nonverbal behaviors that communicate and/or symbolize emotional experience” (Kennedy-Moore & Watson, 1999, p. 4). As a social category, gender is ever-present and
all known societies differentiate to some degree the roles assigned to the two sexes, including the rules regarding emotional expression (Maccoby, 1988). Consequently, most individuals emerge from childhood prepared with the sex-typed characteristics regarding emotional expression and what is acceptable and not acceptable. These sex-typed characteristics are regarded as a culture’s gender roles. Gender roles have been defined as “behaviors, expectations, and role sets defined by society as masculine or feminine which are embodied in the behavior of the individual man or woman and culturally regarded as appropriate to males or females” (O’Neil, 1981, p. 203). These gender roles have tremendous impact on how individuals function both intrapersonally and interpersonally (Silverstein, Auerbach, & Levant, 2002) and influence how, when, and to what degree emotions should be and are expressed.

Gender differences in emotional functioning are widely documented. However, these findings are often inconsistent across personality, social, cultural, and situational variables (Brody & Hall, 2008). Wong and Rochlen (2005) reported that in the last 20 years, men’s alleged difficulty in expressing emotions has been one of the most controversial and frequently discussed topics in the study of masculinity. In addition, years of research on the relation of masculinity-related constructs and emotion to mental health have reached very different conclusions (Good, Heppner, & DeBord, 2004) leaving the precise manner in which masculine role conflict affects men’s psychological wellbeing unclear (Heppner, 1995).

One well-established assessment for men’s supposed emotional inexpressivity (nonexpression) has been the gender-role socialization paradigm (Pleck, 1981, 1995). According to this perspective, boys and men internalize cultural messages about what it
means to be male. Included in these messages is the indication that being emotionally expressive is related to femininity and weakness and should be avoided. Research has examined these assertions. Interestingly, boys enter this world more emotionally expressive than girls. Malatesta and Haviland (1982) reviewed data from 12 studies and concluded that male infants were more emotionally reactive and expressive than their female counterparts. In addition, Malatesta and Haviland studied the facial expressions of mothers interacting with their infant children in order to assess facial expressions of emotion and to what degree mothers shape their children’s’ expression of emotion. They found evidence to suggest that mothers shape the regulation of emotion along gender lines. The authors noted that few differences in the types and frequencies of various facial expressions between male and female infants exist at this early age. The mothers of boys match their sons' behavior more and also display more contingent positive affect than the mothers of daughters. Based on these findings, Malatesta and Haviland suggested that socialization of affect expression occurs during early infancy and that the infants' expressivity becomes appropriate according to cultural, gender, and familial demands well before the first birthday. Other researchers have found similar findings. Further evidence for this interactional pattern was provided by Dunn, Bretherton, and Munn (1987) who found that mothers used fewer emotion words when interacting with their 18 to 24 month old sons than with their same aged daughters. Finally, Fitzgerald and Cherpas (1985) found that when “sex-inappropriate behavior” is exhibited by sons and by daughters, parents demonstrate greater concern when sons violate the norms than when daughters do. Levant (1996) concluded, “Despite this initial advantage in emotional expressivity, men learn to tune out, suppress, and channel their emotions,
whereas the emotion socialization of women encourages their expressivity” (p. 262).
Thus, it appears that becoming emotionally unattached or avoiding one’s emotions is culturally taught. As boys grow, they are bombarded with messages telling them to suppress their emotional experience and their expression of emotions (Rabinowitz & Cochran, 2002). Consequently, men are socially encouraged to think rather than feel.

In addition to the gender socialization paradigm, physiological inability and communication deficits in expressing emotion have been a common explanation for male emotional noneexpression. Levant (1998) noted that this inability, labeled “normative male alexithymia,” is typically attributed to a lack of awareness of emotion and is widespread among men. Alexithymia literally means “no words for feelings” (Mallinckrodt, King, & Coble, 1998) and involves three components: (1) difficulty identifying feelings and distinguishing among feelings; (2) difficulty communicating about emotions; and (3) an externally oriented cognitive style. Studies indicate that alexithymia and fear of intimacy are strongly related to more traditional masculine gender roles. Fischer and Good (1997) found that the restrictive emotionality gender role conflict pattern emerged as a predictor of alexithymia. Also, Levant, Richmond, and Sellers (2003) suggested that alexithymia appears to be associated with higher degrees of endorsement of traditional masculinity ideology. Carpenter and Addis (2000) found that men and women who scored higher on a measure of alexithymia reported a lower likelihood of seeking help from friends and thinking about the reasons for one’s problems. However, the authors found that for both men and women, alexithymia was specific to difficulty describing feelings rather than difficulty identifying them. These findings indicate that alexithymia has stronger relationships to thinking about the causes
of depressive symptoms for men than for women; men’s lesser likelihood of introspecting about emotional issues may be due to a difficulty with emotion-related language. Zimmerman et al. (2005) found alexithymia to be associated positively with Neuroticism, external locus of control, and irrational beliefs and the tendency to experience anger, anxiety, shame, depressive affect, and the inability to cope with stress.

According to Kring and Gordon (1998), some research indicates that women are more expressive of all emotions than men are. These authors assessed the expressive, experiential, and physiological emotional responses of men and women and found that compared to men, women were more expressive. Men and women did not differ in reports of experienced emotion, but did demonstrate differences in physiological responses to emotion, as determined by responses skin conductance measures. Still, other authors have acknowledged that reviews of studies that have investigated gender differences in the experience and expression of emotions have found many inconsistencies resulting from methodological problems (Fischer, Rodriguez Mosquera, van Vianen & Manstead, 2004). For instance, self-report measures have been criticized as being situational and retrospective and not reflecting the true occurrence of emotion (Robinson, Johnson, & Shields, 1998).

In fact, Wester, Vogel, Pressley, and Heesacker (2002) reviewed the empirical evidence on sex differences in emotionality and concluded that men’s and women’s emotional behaviors are more similar than they are different. Kelly and Hall (1992) stated that the observations about men that have been consistently made in the counseling literature are that men are unaware of their feelings and are emotionally inexpressive. What is remarkable about these claims, according to Kelly and Hall, is the near-complete
absence of empirical support. Furthermore, when differences do exist, they tend to be insignificant and related to context-specific situations. Much of what has been studied regarding gender differences in emotion has been accounted for in terms of the social and cultural context, especially as a result of gender-stereotypic socialization (Brody & Hall, 1993). Baron and Byrne (2004) suggested that differences in emotional expression may be more a reflection of the impact of the stereotypes and their self-confirming nature than of basic differences between men and women. These findings put the utility of gender as a heuristic for accurately understanding people’s affective behavior into question.

Recently, the view that men are emotionally inexpressive has been challenged. Heesacker et al., (1999) stated that previous reviews of the empirical literature on gender and emotion do not accurately portray the true relationship between gender and one’s affective behaviors. The authors found a “double-edged sword” of gender stereotypes regarding gender and emotion and argued that men’s and women’s emotional behaviors are more similar than they are different. While examining six studies exploring the portrayal of men as “hypoemotional,” Heesacker et al. (1999) found few differences in men’s and women’s abilities to express emotion and no evidence suggesting that men and women differ in their confidence to express or understand emotions. Moreover, the authors were unable to find any evidence to suggest that men fear their emotions more than women do or that men need more assistance in expressing their emotions than do women. Furthermore, Heesacker and Prichard (1992) suggested that men’s emotions and emotional expression are different from women’s, not better or worse. The authors proposed that because of this, “men’s emotions need to be understood, not corrected” (p. 275).
Heesacker and Prichard’s (1992) proposition implies a model in contrast with the pathology model employed by many counselors. Men should not be understood as lacking emotion or unwilling to express themselves emotionally. Rather, they should be approached with empathy and regard to understand that they do, indeed, experience emotion and then should be educated on how to recognize and verbalize their emotions. Consequently, men’s emotions need to be understood, not corrected. Brody and Hall (2008) noted that recent research on men’s emotional functioning has recognized these shortcomings and researchers have begun to acknowledge that gender differences are both mediated and moderated by sociocultural, cognitive, behavioral, and biological variables.

One model of emotional expression that may help to explain gender differences in emotional functioning and the circumstances in which some men are unable or unwilling to express emotion can be found in Kennedy-Moore and Watson’s (1999) process model of emotional expression. The model describes how covert emotional experience is translated into overt emotional expression through a five-step cognitive-evaluative process. According to Kennedy-Moore and Watson, “The basic model represents expression as the culmination of a series of internal, cognitive-evaluative steps that influence and are influenced by affective experience” (p. 11). The model also describes how disruptions at each step may lead to nonexpression of emotion and can be applied to both general dispositions to express or to specific instances of expression, and to either positive or negative emotions.

The first step in Kennedy-Moore and Watson’s (1999) process model of emotional expression, Prereflective Reaction, occurs when a potentially emotion-
provoking stimulus activates a primary physiological arousal in a person, including increased heart rate, sweating, and trembling. This process is generally preconscious and automatic for individuals. Nonexpression occurs when only minimal prereflexive reaction is stimulated. Men differ in the strength of their emotional reactions to the same stressors. When men have a high threshold for emotional activation, no emotion is produced. Thus, no expression occurs. Counseling interventions at this step might include assisting men in reading their physiological reactions to emotion-provoking stimuli.

In step 2 of the process model of emotional expression, *Awareness of Affective Response*, once a stimulus triggers a basic affective state in a person, he or she typically becomes consciously aware of this experience. When an experience is considered too threatening, one might block it through motivated lack of awareness. Disruption at this level is regarded as emotional defensiveness (Kennedy-Moore & Watson, 1999). Because some men are taught to inhibit their vulnerable emotions, they may not be aware of what they feel. When men convince themselves that they are not experiencing feelings, they do not express them. Counseling interventions at this stage might include assisting men in mindfulness training or extended focus in becoming aware of what their bodies are telling them.

*Labeling and Interpretation of Response* is the third step in the process model of emotional expression (Kennedy-Moore & Watson, 1999). When a person is aware of an affective state, the person attempts to label and interpret the emotion. Disruption at this stage is associated with alexithymia. Some may have difficulty describing what they feel and therefore, are unable to express their emotions. Providing individuals with the
vocabulary for what they are experiencing could provide them with the tools to define their experiences. Step 4, *Evaluation of Response as Acceptable*, allows the individual to assess, in conjunction with his or her beliefs and values, whether the emotion is acceptable (Kennedy-Moore & Watson). Some men’s backgrounds, governed by the socialization paradigm, have taught them that certain emotions, or even all emotions, are negative. Again, there will be no expression of emotion should the emotion be regarded negatively. Encouragement and normalizing of emotional experience could help change men’s beliefs regarding the devaluation of emotional expression.

Finally, during step 5, *Perceived Social Context for Expression*, a person must determine whether or not the immediate social context encourages the expression of emotion (Kennedy-Moore & Watson, 1999). Some men may feel that the public expression of vulnerable feelings is unacceptable and thus suppress the expression of their emotions. An intervention at this stage might involve encouraging men to be vulnerable and informing them that expression of emotion is a natural human process that allows for the building and maintenance of relationships. According to Wong and Rochlen (2005), this process model of emotional expression and nonexpression represents a promising model for understanding the diverse ways in which gender-role socialization influences men’s emotional behavior.

**Gender and Emotion as Social Constructions**

To understand how the construction of maleness creates difficulties for men in general and in expressing emotion, O’Neil (1981) created the Gender Role Conflict Paradigm (GRCP), which asserts that gender role conflict (GRC) occurs when “rigid, sexist, or restrictive gender roles, learned during socialization, result in the personal
restriction, devaluation, or violation of others or self” (Good et al., 1995, p. 3).

According to the GRC paradigm, men experience four patterns of maladaptive interactions: (1) success, power, and competition; (2) restrictive emotionality; (3) restrictive affectionate behavior between men; and (4) conflict between work and family relations (Mahalik, 2000). These four factors are believed to permeate men’s lives and affect them individually as well as their relationships with others.

The first of the four factors, success, power, and competition, refers to an overemphasis that men place on achievement and the struggle to control others. Restrictive emotionality, the second GRC pattern, illustrates men’s difficulty with self-disclosure, “as well as discomfort with the emotional expressiveness of others” (Mahalik, 2000, p. 279). The third factor, restrictive affectionate behavior between men, describes men’s discomfort in the expression of caring with other men. Finally, conflict between work and family relations “describes the level of distress experienced by men due to the impinging of work or school on personal and family life” (Mahalik, 2000, p. 279). Taken together, these four patterns greatly affect the relationships men have with others, as well as inhibit their ability to proactively seek professional psychological services. Previous studies have shown that, for men, the construct of GRC is related to shame (Thompkins & Rando, 2003), depressive symptoms (Shepard, 2002), hostility, social discomfort, and obsessive compulsiveness (Hayes & Mahalik, 2000), low self-esteem, anxiety, depression, and intimacy (Sharpe & Heppner, 1991), more immature psychological defenses (Mahalik, Cournoyer, DeFranc, Cherry, & Napolitano, 1998), alexithymia (Fischer & Good, 1997), and negative attitudes related to psychological help-seeking (Blazina & Watkins, 1996; Good et al., 1989). Levant (1996) described the GRC
paradigm as a “failure-prone process” which results in homosexuality, negative attitudes toward women, or hypermasculinity. Similarly, Mahalik (1999) reported that men who experience gender role conflict feel less positively about themselves, are less intimate with important others, experience greater psychological distress, and are less willing to seek help for their distress.

To account for variables not considered in the GRC paradigm, Pleck (1981) created the Gender Role Strain Paradigm (GRSP), which attempts to explain how maleness is itself, self-defeating. In contrast to the GRCP, the GRSP postulates that prevailing gender ideologies influence parents, teachers, and peers, who in turn, socialize children to behave according to the prevailing gender role ideologies. These gender roles are formed to serve particular purposes within a society. According to Pleck (1995), the proportion of individuals who violate sex roles is high. Pleck stated, “the norms for each sex role may be so idealized that only the tiniest minority…can fulfill them. In this sense, everyone feels they fail to live up to their sex role” (p. 144). Consequently, violation of sex roles leads to social condemnation and negative psychological consequences due to social disapproval and self-devaluation.

In an update on the GRSP, Pleck (1995) identified three varieties of male gender role strain, which he labeled discrepancy-strain, dysfunction strain, and trauma-strain. Discrepancy strain results when one realizes that he has not lived up to his internalized ideal of manhood. Dysfunction strain results even when one fulfills the requirements of the maleness as those elements considered desirable in men can have negative side effects on men themselves and on those close to them. Finally, trauma strain results from the ordeal of the male role socialization process. The GRSP recognizes that, although
violating gender roles has negative consequences for both men and women, the consequences are more severe for men (Pleck, 1981; Silverberg, 1986). Pleck also noted that for men, both violating sex roles and fulfilling sex roles cause adverse consequences. The implication here is that male sex roles represent a no-win situation for men. Although both men and women experience sex role strain in work and family roles, men experience greater strain because “more is expected of them than they can realistically provide” (Pleck, 1995, p. 151). Finally, Pleck (1995) noted that sex role strain is caused, in part, by historical changes. As societal notions of what roles should characterize men change, men become increasingly affected. Understanding Pleck’s (1995) propositions assists in understanding men’s reluctance to seek psychological services. In particular, societal expectations of how men must behave and stereotypes of the effeminate male may deter men from seeking assistance, as they may fear condemnation from their peers.

Research supports Pleck’s (1995) propositions. For instance, studies have found that the more men endorse traditional masculinity ideologies, the more they experience a range of presenting issues, including poorer self-esteem (Cournoyer & Mahalik, 1995), problems with interpersonal intimacy (Fischer & Good, 1997), greater depression and anxiety (Sharpe & Heppner, 1991), abuse of substances (Blazina & Watkins, 1996), as well as greater overall psychological distress (Hayes & Mahalik, 2000). Other issues related to greater adherence to male gender role socialization include: increased risk-taking and self-destructive behaviors (Meth, 1990) and emotional inexpressivity (Pleck, 1981). This research validates the notion that endorsement of certain masculine ideologies, including restricted emotionality, is associated with a full range of presenting
problems and has direct clinical relevance for men’s psychological help-seeking (Addis & Mahalik, 2003).

Other theorists also have attempted to identify the variables related to being male that negatively shape men’s existence. Similar to Pleck’s (1995) GRSP, Solomon (1982) defined five dimensions of the male sex role prevalent in the literature and clinical arenas which negatively affect how men relate in the world. Three of these dimensions were based on the work of David and Brannon (1976). The first dimension is described as “no sissy stuff”, or the avoidance of anything feminine (Solomon, 1982). This avoidance includes any cognitions, behaviors, or affect that might be considered feminine. Men, therefore, must devalue the expression of feelings, the notable exceptions being anger, hostility, and aggression. The second dimension of the male sex role described by Solomon portrays men as “the sturdy oak.” According to Solomon, men engaging in this dimension must be confident, self-reliant, and incapable of feeling. Solomon’s third dimension, labeled “sexual dysfunctioning”, describes men as having difficulty separating sex from affection. At the extreme, this tendency may manifest itself as an overwhelming emphasis on sexuality in a relationship. According to the fourth dimension of Solomon’s (1982) depiction of the male sex role, “homophobia,” men fear becoming or appearing homosexual. This causes many men to avoid nonstructured social contact with other men. Finally, Solomon described the fifth dimension of the male sex role as the “Give ‘em hell” philosophy. According to Solomon, men in this dimension are encouraged to prove their masculinity by being daring and aggressive, frequently in the process of working toward success. Despite the importance in understanding adherence to traditional male norms and the male sex role, neither Pleck’s (1995)
paradigm nor Solomon’s (1982) dimensions has been thoroughly investigated in explaining men’s underutilization of mental health services. Good et al. (1989) called this lack of attention “surprising” given that adherence to “a role characterized by instrumentality, strength, aggressiveness, and emotional inexpressiveness…seems intuitively antithetical to the behavior of seeking help for psychological concerns” (p. 295). Consequently, further research is needed to address these dimensions, particularly the rejection of anything emotional.

The relationship between emotional expression and men’s attitudes toward emotional expression has not been explored in the literature. What has been examined related to attitudes toward expressing emotion was drawn on ideas of Aaron Beck, who argued that the underlying assumptions held by individuals are a major factor in the etiology of psychological disorders (Joseph, Williams, Irving, & Cammock, 1994). Williams (1993) suggested that negative attitudes toward expressing emotion may act to block the processing of emotionally charged information following exposure to a traumatic event. What has been researched regarding attitudes toward emotional expression has evolved from clinical work with survivors of natural disasters and individuals exposed to traumatic events. Mitchell-Gibbs and Joseph (1996) found that police officers have more negative attitudes toward expressing emotion than the general population. Also Williams, Hodgkinson, Joseph, and Yule (1995) found that more negative attitudes toward expressing emotion are associated with greater severity of distress in civilian survivors of disaster. However, no studies were located in which attitudes toward expressing emotion were examined in the general population, and none were found that address the relationship between attitudes toward expressing emotion and
emotional expression in the context of psychological help-seeking. This is the purpose of the current study.

**Defining Attitudes**

In order to explore men’s attitudes toward help-seeking, the concept of attitude must first be defined. Ajzen and Fishbein (1980) credited Thomas and Znaniecki in 1918 with the first use of the concept of attitude to explain social behavior, defining it as “individual mental processes that determine a person’s actual and potential responses” (p. 13). Since then, an attitude has been defined in various ways, including: “a mental and neural state of readiness, organized through experience, exerting a directive or dynamic influence upon the individual’s response to all objects and situations with which it is related” (Allport, 1967, p. 8); and “an implicit, drive-reducing response considered socially significant in the individual’s society” (Doop, 1967, p. 43). Thurstone (1967) argued that attitudes regarded an individual’s total tendencies, feelings, biases, fears and convictions about any topic. LaPiere (1967) suggested that, “attitudes are acquired out of social experience and provide the individual organism with some degree of preparation to adjust, in a well-defined way, to certain types of social situations if and when these situations arise” (p. 26). In 1967, Fishbein declared that the concept of attitude “ha(d) grown into a complex, multidimensional concept consisting of affective, cognitive, and conative components” (p. 477). It can be noted that, by this time, theorists began to conceptualize a multidimensional approach to understanding the concept of attitudes which include one’s social experience as well as his or her “preparedness” to act in certain, meaningful ways.
Attitudes play an important role in understanding behavior through its influence on behavioral intentions (Ajzen, 1991). In their Theory of Reasoned Action (TRA), Ajzen and Fishbein (1980) conceived that attitudes and behavior guide a person’s intention to perform a behavior. Ajzen and Fishbein (1980) stated that the TRA was “based on the assumption that human beings are usually quite rational and make systematic use of the information available to them” (p. 5). The authors believed that a person’s intention to perform an action is the result of two basic determinants: (1) evaluation of performing the behavior (attitude toward the behavior) and (2) perception of the social pressures to perform or not perform the behavior (subjective norm). Ajzen and Fishbein proposed that people tended to perform a behavior when they have a positive attitude toward that behavior and when they believe others think they should perform it. The more positive attitudes individuals have about a behavior, the greater their intentions and likelihood to perform the behavior. Individuals whose referents think he or she should comply, will do so; individuals whose referents think he or she should not comply, will not do so. In addition, Ajzen and Fishbein proposed that people learn to like those objects with positive characteristics and learn to dislike objects with negative characteristics. These then become one’s salient beliefs and will affect whether or not a person will perform an action.

The Theory of Planned Behavior (TPB) was developed as an extension of the TRA, and was made necessary by the original model's limitations in dealing with the prediction of behavioral goals and with behaviors over which people do not have complete volitional control (Doll & Ajzen, 1992). According to the TPB, intentions to perform a behavior and perceptions of control over the behavior can predict behavioral
performance. When a situation allows an individual complete control over behavioral performance, intention alone should be sufficient to predict behavior (Doll & Ajzen, 1992). In sum, the TPB describes how attitudes and normative beliefs predict intentions to perform volitional behavior.

Halgin, Weaver, Edell, and Spencer (1987) asserted that Ajzen and Fishbein’s TRA is particularly effective in predicting health-related behaviors because it uncovers those beliefs that contribute to the formation of attitudes toward seeking professional psychological services. Attitudes toward seeking professional psychological services are one predictor of intentions to seek help. Likewise, a number of studies have employed the TPB to account for the relationship between attitudes and intentions to perform behaviors, such as leisure activities (Ajzen & Driver, 1991), weight loss (Schifter & Ajzen, 1985); and committing driving violations (Parker, Manstead, Stradling, Reason, & Baxter, 1992). Halgin, Weaver, Edell, and Spencer (1987) asserted that Ajzen and Fishbein’s TRA is particularly effective in predicting health-related behaviors because it uncovers those beliefs that contribute to the formation of attitudes toward seeking professional psychological services.

**Attitudes toward Psychological Help-Seeking**

Several factors have been linked with attitudes toward seeking professional psychological help, including gender role adherence, sex differences, levels of psychological distress, and problem type (Cusack, Deane, Wilson, & Ciarrochi, 2006); sex (Chandra & Minkovitz, 2006; Ægisdóttir & Gerstein, 2009); stigma (Corrigan, 2004; Ægisdóttir & Gerstein); self-concealment (Kelly & Achter, 1995); and race, education, socioeconomic status, and religion (Cramer, 1999). The most commonly cited reason
people avoid professional psychological services is the stigma associated with mental illness and help-seeking (Corrigan, 2004). Consequently, individuals who fear the stigma of being labeled “mentally ill” will avoid seeking professional psychological services and continue to suffer. Inversely, Cramer (1999) found that individuals are more likely to seek counseling when distress is high and attitudes toward psychological treatment are positive. It also has been suggested that the factors important for the first help-seeking episode differ from those factors important for subsequent episodes (Cusack et al., 2006; Halgin et al., 1987). The experience of having sought professional psychological help in the past was significantly related to how one would feel about seeking such help again in the future (e.g., Ægisdóttir & Gerstein).

Addis and Mahalik (2003) concluded that empirical evidence supports the notion that “men are reluctant to seek help from health professionals” (p. 5) and statistics corroborate these findings. Good, et al. (1989) reported that two-thirds of all clients seeking psychological help are women; and one in three women versus one in seven men seeks services from a mental health professional at some point during his or her lifetime. In sum, men seek help less often than do women and represent only a small proportion of individuals seeking professional psychological services.

Ajzen (1991) defined attitudes as “the degree to which a person has a favorable or unfavorable evaluation or appraisal of the behavior in question” (p. 188). Consequently, the more positive attitudes an individual has regarding a behavior, the greater their intentions will be to perform that behavior. In regards to seeking professional psychological assistance, individuals who hold positive attitudes toward seeking psychological help are more likely to seek psychological help compared to those with
more negative attitudes toward that behavior (Cramer, 1999; Deane & Todd, 1996). A number of factors have been linked with attitudes toward seeking professional psychological help, including adherence to gender role (Addis & Mahalik, 2003), characteristics of psychologists (Ágisdóttir & Gerstein, 2009) and stigma (Corrigan, 2004; Ágisdóttir & Gerstein, 2009).

Characteristics of the professional and of treatment in general have been suggested to affect one’s attitudes toward seeking professional psychological services. Wood, Jones, and Benjamin (1986) found lack of information regarding health care professionals and their credentials, and confusion regarding their services to be associated with negative attitudes toward psychological help-seeking as well as underutilization of psychological services. Wood et al. examined data from published and unpublished studies regarding the image of psychology and found that despite having generally favorable attitudes toward psychology, the general public did not fully understand its field. Likewise, Von Sydow and Reimer (1998) reported that the general public could not differentiate between various mental health professionals and considered all mental health professionals to be “obtrusive, twisted, complicated, unpredictable, ‘fuzzy thinkers,’ more feminine, and emotionally labile” (p. 472). Farberman (1997) conducted focus groups and a random telephone survey to examine the public’s general attitudes toward professional psychological help. Farberman’s research demonstrated that, in general, people have very little understanding of the qualifications and credentials of psychologists and are not able to distinguish one mental health provider from another. It can be inferred that the less knowledgeable people are regarding mental health
professionals, the more negative attitudes they hold toward help-seeking and the less likely they will be to seek services.

Stigma associated with seeking psychological services and labels attached to mental illness have also been suggested to affect one’s attitudes toward seeking professional psychological services. In fact, Corrigan (2004) noted that the most commonly cited reason people avoid seeking professional psychological services is the stigma associated with mental illness and help-seeking. Treatment fear and stigma associated with seeking mental health treatment was also found to be a factor by Ægisdóttir, O’Heron, Hartong, Haynes, and Linville (2011) in predicting attitudes toward seeking mental health treatment. Ægisdóttir et al. studied the effects of addressing and validating clients’ negative attitudes and fears associated with seeking counseling and willingness to engage in counseling past the first session. Their findings suggest that by addressing fears and stigma associated with seeking treatment during an initial intake, male students who had not sought counseling services in the past demonstrated reduced fears and increased tolerance for stigma associated with seeking treatment. Ægisdóttir et al. (2011) suggested that for men who are seeking psychological treatment for the first time, addressing fears and negative attitudes about counseling in the first session affects attitudes toward seeking psychological treatment. In addition, the authors suggest that the findings regarding men’s fear of and stigma toward psychological treatment may be related to the need for power and control.

Negative stigma regarding mental health services as well as being labeled “mentally ill”, has repeatedly been suggested an important barrier to psychological help-seeking. Individuals who feel stigmatized constrict their social contacts in order to avoid
experiencing negative experiences (Bathje & Pryor, 2011). In an examination of endorsement of public stigma and its relationship to attitudes and intentions to seeking counseling, Bathje and Pryor found that endorsement of public stigma as well as lower ratings of sympathy, were found to predict self-stigma. In addition, endorsement of public stigma and self-stigma were directly related to attitudes to seeking counseling. They also found that attitudes toward help-seeking were most strongly related to intentions to seek counseling. More importantly, Bathje and Pryor found that gender did not moderate the relationship between attitudes and intentions toward help-seeking or between self-stigma and attitudes. Yet, Ægisdóttir, et al. (2011) found that discussing treatment fears and negative attitudes toward counseling in the first session of a counseling experience was related to attitude change and greater tolerance for stigma for men who had never received previous counseling services. This effect was not found for women. These findings suggest that men may endorse greater intolerance for stigma prior to the first counseling experience, but adjust their attitudes and modify stigma associated with seeking professional psychological services once they are introduced to the field.

Although attitudes toward performing a behavior indicate whether or not a behavior will be performed, one’s intentions toward performing the behavior may be a greater indicator of that behavior being performed. The greater one’s intentions are to perform a behavior, the more likely it is that one will perform the behavior. According to the Theory of Planned Behavior (TPB; Ajzen, 1991), intentions to perform a behavior are greatly influenced by an individual’s attitudes toward the behavior. A number of studies have employed the Theory of Planned Behavior to account for the relationship between
attitudes and intentions to perform behaviors, such as leisure activities (Ajzen & Driver, 1991), weight loss (Schifter & Ajzen, 1985); and committing driving violations (Parker, Manstead, Stradling, Reason, & Baxter, 1992).

Men and Attitudes toward Psychological Help-Seeking

Because of researchers such as Addis and Mahalik (2003) and Pleck (1981, 1995), a new psychology of men has attempted to explain and understand the behaviors of men in a manner that accounts for cultural and societal contributors to underutilization of psychological services. Levant (1996) proposed that this new psychology of men assists in the understanding and solution of the male problems that “have long affected women, men, children, and society in negative ways” (p. 259). The empirical research and the pervasiveness of popular beliefs about men’s help seeking raise important questions for psychologists.

Despite the said low utilization rates, some men do enter therapy; however, the reasons they seek therapy are questionable. It has been stated that those men who do enter therapy are “disproportionately represented among many problem populations” (Levant, 1996, p. 259), including substance abusers, perpetrators of family and interpersonal violence, fathers estranged from their children, sex addicts and sex offenders, victims of homicide, suicide, and fatal automobile accidents; and victims of life-style and stress-related fatal illnesses. Often these men have been court-ordered to attend domestic violence workshops and drug or alcohol programs to avoid serving time in prison. Kelly and Hall (1992) claimed that men who enter counseling, either on their own accord or reluctantly, are “unaware and inexpressive of their feelings … seek to avoid intimacy, (and) … are angry and violent” (p. 264). However, the authors added
that no empirical evidence exists to support these claims. One only has to do a brief literature review to find that these are the overwhelming perceptions of men in therapy and, unfortunately, men in general.

From a socialization perspective, many of the tasks associated with psychological help-seeking, such as relying on others, admitting that a problem exists, or recognizing and labeling an emotional problem, are incongruent with masculine ideologies. For instance, Berger et al. (2005) found higher levels of some types of gender role conflict, specifically restrictive affectionate behavior between men, and traditional masculinity ideology to be associated with negative attitudes toward psychological help seeking. In addition, no significant relationship was found between alexithymia (nonexpression) and psychological help seeking. Interestingly, the authors did find a correlation between age and attitudes toward seeking professional psychological help. Namely, they found older men to have more positive attitudes toward seeking psychological help than younger men. In a similar study, Carpenter and Addis (2000) found that compared to men, women were more likely to seek professional psychological services or share feelings with friends or family when faced with symptoms of depression.

Smith, Tran, and Thompson (2008) found that the TPB provided a helpful framework to understand the relationship between traditional masculinity ideology and psychological help-seeking. The authors found a mediating effect of attitudes toward psychological help-seeking on the relationship between traditional masculinity ideology and psychological help-seeking intentions. Therefore, one approach to understanding men’s psychological help-seeking behavior is to understand help-seeking as a product of masculine gender-role socialization (Addis & Mahalik, 2003). Addis and Mahalik
described the process of constructing masculinity in regards to help-seeking contexts as a five-part process. The first of these processes includes perceptions of the *normativeness* of problems. Men may feel that their behaviors or problems are at odds with the standards or norms shared by other men in society and feel ashamed to ask for assistance. The second process includes the perceived *ego centrality* of problems, or “is the problem a central part of me?” According to Addis and Mahalik, individuals are least likely to seek help when they feel the problem is a central part of themselves. Because of socialization, men see their masculinity as a central part of themselves and a threat to that masculinity compels men to avoid seeking assistance. A third social psychological process includes the *characteristics of potential helpers*. Men may look for help when they have a better opportunity to reciprocate. Fourth, men also consider the *characteristics of the social groups* to which they belong. Men may experience barriers to seeking help when they perceive other men in their social networks as hindering the process. Finally, Addis and Mahalik proposed that the social psychological process of *loss of control* can deter a man from seeking professional help. Because men value self-reliance and avoidance of dependence, they may experience reactance when seeking professional help.

Other researchers have also attempted to explain the underutilization of psychological services by men. Wilcox and Forrest (1992) compiled research demonstrating that “overconformity to a traditional male gender role keeps men from seeking psychological help” (p. 292). Mahalik, Good, and Englar-Carlson (2003) proposed that those elements that contribute to men’s psychological distress are also those elements that prevent them from getting help for those stressors and having more
negative attitudes toward help-seeking, including success/power/and competition and restrictive emotionality. Good et al. (1989) investigated the relationship of attitudes toward the male role and factors associated with gender role conflict to attitudes toward seeking professional psychological help in college men. The results of their study indicated that there was a significant relationship between components of the male role and men’s attitudes. Specifically, traditional attitudes about the male role in society, concern about expressing affection toward other men, and concern about expressing emotions were all related to negative attitudes toward seeking professional psychological help.

Based on a review of literature, Pollack and Levant (1998) outlined six factors related to the norms of the male role that appear to stand in the way of men receiving psychological services. The first factor stemmed from a depiction of male behavior as the “sturdy oak.” This notion captures the difficulty men have in admitting the existence of a problem. Pollack and Levant’s second factor described men as having difficulty in asking for help; dependency on others is intolerable. Third, men have difficulty in identifying and processing vulnerable emotions as a result of their socialization. Fear of intimacy, Pollack and Levant’s fourth factor, results from a man’s early socialization experiences in boyhood. The authors argued that the fifth factor in men’s underutilization of psychological services stems from fear of perceived sexualized encounters with female therapists and homophobic situations with male therapists. Finally, Pollack and Levant stated that appropriate psychotherapeutic treatments empathic to men’s needs, struggles, and conflicts are severely lacking. Men, it seems, are
caught in a double bind: they are reluctant to enter therapy and when they do, they are not adequately treated.

As reported, limited expression of emotion, or restrictive emotionality has been found to be one variable that prevents men from seeking professional psychological services (Good et al, 1989; Pollack & Levant, 1998; Tsan, Day, Schwartz, & Kimbrel, 2011). In fact, Komiya et al. (2000) found the primary reason for an individual’s negative attitude toward seeking psychological treatment to be a fear of emotions. These authors found that, compared to women, men possessed less open attitudes to emotions, perceived greater stigma associated with counseling, and reported less severe psychological symptoms. The implications of these findings may explain the expectations gender role places on men to be emotionally restricted. Restrictive emotionality involves the difficulty men have, or the reluctance men possess, in demonstrating their emotions to others (David & Brannon, 1976; O’Neil et al. 1986). Fischer and Turner (1970) studied help-seeking behaviors and attitudes and found interpersonal openness to be a significant aspect of help-seeking behavior. Both restrictive emotionality and interpersonal openness address one’s willingness to share concerns and request assistance from others. Male clients may expect that they will be demanded to explore “the emotional context of their life experiences” (Mahalik et al., 2003, p. 127). Because men are socialized to inhibit strong emotional expression and believe that the expression of emotions is more related to the feminine role, the may feel reluctant to enter therapy or discontinue therapy early. Men may also be leery of sharing emotion with other men for fear of being considered homosexual (David & Brannon,
1976; O’Neil, 1981). As described in O’Neil’s Gender Role Conflict paradigm, traditional male sex role restricts affectionate behavior with other men.

In addition to limited expression of emotion, the values of success, power, and competition may also affect men’s attitudes toward help seeking. Because men are traditionally socialized to seek power and control, and to be autonomous and self-reliant, help-seeking may be directly incongruent with those values acquired through socialization (Good et al., 1989). Pollack (1998) suggested that seeking help implies dependence and vulnerability and if men are to seek help, that indicates a release of power and feelings of helplessness—feelings that directly contradict societal pressures demanding men to be independent and strong. Men may experience seeking psychological assistance as admitting failure and weakness. Good et al. (1989) also suggested that the nature of the therapeutic relationship itself may conflict with the traditional male sex role regarding need for power and control. Men may hesitate to enter therapy for fear of an apparent subordinate role they would assume. Blazina and Watkins (1996) suggested that it is the anticipation of losing power that either prevents men from entering therapy or causes them to terminate early. Treatment fear and stigma associated with seeking mental health treatment also was found to be a factor by Ægisdóttir, O’Heron, Hartong, Haynes, and Linville (2011) in predicting attitudes toward seeking mental health treatment. Ægisdóttir et al. studied the effects of addressing and validating clients’ negative attitudes and fears associated with seeking counseling and willingness to engage in counseling past the first session. Their findings suggested that by addressing fears and stigma associated with seeking treatment during an initial intake, male students who had not sought counseling services in the past demonstrated reduced fears and
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associated with seeking professional psychological services once they are introduced to the field.

**Barriers to Psychological Help-Seeking**

What is known about specific barriers preventing individuals from seeking professional psychological assistance is based on the research related to attitudes toward seeking professional psychological assistance. For instance, Mansfield, Addis, and Courtenay (2005) created the Barriers to Help Seeking Scale (BHSS) to assess variables men identify as obstacles to seeking help for physical or mental health problems. The authors found five subscales relevant to identified barriers to seeking professional psychological assistance: (1) Need for Control and Self-reliance; (2) Minimizing Problem and Resignation; (3) Concrete Barriers and Distrust of Caregivers; (4) Privacy; and (5) Emotional Control. Although a great deal of research has been conducted to address attitudes toward help-seeking in the context of professional psychological services, only one study was located which examined self-identified barriers to seeking professional psychological assistance (Ouimette et al., 2011). The researchers modified several items of the Barriers to Help-seeking Scale (Mansfield et al., 2005) to address the barriers veterans identify for not seeking treatment with the VA. Stigma (not one of the original subscales to the BHSS) was found to be the major barrier for not seeking professional psychological services. McKelley and Rochelen (2007) and Rochlen, McKelley, and Pituch (2006) noted that investigations identifying barriers to seeking professional psychological services and overcoming those barriers have just recently begun to be investigated and demonstrate and new and exciting line of research. The present investigation does just this. That is, it examines the interrelationship between emotional
expression, attitudes toward emotional expression, psychological help-seeking attitudes, and barriers to seeking such help.

Summary

Given the prevalence of psychological problems that affect men and the negative consequences of men’s reluctance to seek help for these same problems, it becomes important for researchers to identify factors involved in men’s negative attitudes toward seeking professional psychological assistance, namely men’s actual emotional expression and their attitudes toward expressing emotion. As stated previously, prior research has been inconsistent regarding the true nature of men’s ability and willingness to express emotion, and the differences in emotional expression between men and women have been found to be insignificant and context-specific (Fischer et al., 2004; Heesacker et al., 1999; Kelly & Hall, 1992; Kring & Gordon, 1998). What is needed is an assessment of men’s overall attitudes toward expressing emotion as well as their actual, self-reported general tendencies to express emotion, not only how men express themselves in specific situations or with specific emotions. The view that men are emotionally inexpressive has been challenged (Heesacker et al.). Heesacker et al. found that previous reviews of literature on gender and emotion do not accurately portray the true relationship between gender and one’s affective behaviors. In fact, the authors argued that men’s and women’s emotional behaviors were more similar than they were different. In addition, past research has been prone to methodological problems (Robinson et al., 1998) including reliance on retrospective reports and situationally-specific emotions. Also highly important is the fact that very little is currently known regarding men’s attitudes toward expressing emotion and no studies have sought to identify the variables involved in
attitudes toward expressing emotion with populations other than those individuals exposed to trauma on a consistent basis (police officers) or individuals following a natural disaster (Mitchell-Gibbs & Joseph, 1996; Williams et al., 1995). Like attitudes towards seeking professional psychological treatment, attitudes toward expressing emotion also contain underlying factors. The factors that have been suggested to affect men’s attitudes toward expressing emotion include: (1) the belief that the expression of emotion is a sign of weakness; (2) the belief that emotions should be kept under control; (3) the belief that other people will be rejecting; and (4) the behavioral tendency to express or not express emotion (Joseph et al., 1994). While the first three factors address the cognitive components of attitudes, the fourth addresses behaviors associated with attitudes. Identifying which factor, or factors may influence men’s expression of emotion holds tremendous value for researchers and counseling psychologists. By knowing which of the factor has a greater impact on men’s attitudes toward expressing emotion could provide direction in the therapeutic setting. For instance, understanding that men may hold the belief that expressing emotion is a sign of weakness or the belief that emotions must be controlled would provide insight into an individual’s background and familial involvement in emotional expression. Additionally, fear of rejection as a result of expressing emotions is a powerful factor in support of providing a safe, accepting, non-judging therapeutic relationship.

In addition, what is currently known about the relationship between men’s emotional expression and their attitudes toward seeking professional psychological assistance is inconsistent and outdated, and has been based on Fischer and Turner’s (1970) Attitudes toward Seeking Professional Psychological Services Scale (ATSPPS).
The ATSPPS has been questioned in regards to its validity, such as using outdated language, having non-replicable factor structure, being too broad in its scope in its long form (1970) and too narrow in its short form (Fischer & Farina, 1995) (see Ægisdóttir & Gerstein, 2009 for more information). Ægisdóttir and Gerstein created the Beliefs about Psychological Services Scale (BAPS) as a measure of attitudes toward and intentions to seek psychological help. The BAPS offers an alternative to Fischer and Turner’s ATSPPS. Whereas individuals generally receive an overall score representing their attitudes toward seeking professional psychological service on the ATSPPS (Fischer & Farina, 1995), the BAPS offers the advantage of organizing attitudes toward seeking professional psychological treatment along three dimensions: (1) stigma tolerance; (2) expertness; and (3) intent. These three factors can be addressed individually to examine which component(s) of attitudes toward seeking psychological treatment are representative of men.

While some researchers have provided support that men hold less favorable attitudes toward seeking professional psychological help than women (Good et al., 1989; Mahalik et al., 2003; Wilcox & Forrest, 1992), these studies have relied on O’Neil’s (1981) Gender Role Conflict Paradigm (GRCP), which defines maladaptive interactions in regards to (1) success, power, and competition; (2) restrictive emotionality; (3) restrictive affectionate behavior between men; and (4) conflict between work and family. Because this understanding of men was constructed over 30 years ago, it may not be a valid assessment of the internal emotional struggles that men today face. Finally, little is known about the barriers to seeking professional psychological services men identify as important factors preventing them from seeking professional services. Research is
needed to understand how barriers affect men’s decisions to seek or not seek professional psychological assistance. In particular, examining the need for emotional control as a barrier to seeking said services would provide greater insight into how to encourage men to engage in professional services, how to prevent them from prematurely ending therapy, and directions to conceptualize men in the therapeutic setting.

Much research has examined the relationship between the emotional inexpression of men and attitudes toward seeking professional psychological service. However, no research has been conducted examining the relationship between men’s attitudes toward expressing emotion, men’s actual emotional expressivity, and their attitudes toward seeking professional psychological services. In addition, no research has examined the relationship between men’s attitudes toward expressing emotion and men’s actual emotional expressivity and their self-identified barriers to seeking professional psychological assistance. The relationship between all of these variables has not been examined to date, and such an investigation can provide additional knowledge about the relationship between men’s emotional behaviors and their attitudes toward seeking psychological assistance.

Present Study

The current study investigated the relationship between men’s attitudes toward emotional expressivity, their actual emotional expressivity and their attitudes toward and intent to seeking professional psychological assistance and their self-identified barriers to seeking professional psychological assistance. The present investigation extends current knowledge of the emotional experience and expression of men and men’s attitudes toward seeking professional psychological assistance. In addition, the current study adds
to the literature on men, emotional experience and expression and attitudes toward and barriers to seeking professional psychological assistance. In contrast to past research that examined men’s attitudes toward seeking psychological services (Blazina & Watkins, 1996; Fischer & Farina, 1995; Fischer & Turner, 1970; Good et al., 1989), the current study employed a newer, more contemporary instrument to assess attitudes toward seeking professional psychological assistance, the BAPS (Ægisdóttir & Gerstein, 2009). Also, in contrast to previous studies that examined the Restricted Emotionality subscale of O’Neil’s (1986) Gender Role Construct Scale (Good et al., 1989; Mahalik et al., 2003; Wilcox & Forrest, 1992) to determine emotional expressivity, the current study again employed a more contemporary instrument to address emotional expressivity.

Furthermore, as mentioned previously, no studies to date have examined the relationship between men’s actual emotional expression, their attitudes toward expressing emotion, and barriers to and attitudes toward seeking professional psychological services. Likewise, no research has examined the relationships between these variables at the same time. This is deemed important in order to add to current knowledge on men’s emotional behavior and psychological help-seeking and may provide information about how to design therapeutic approaches to reach and retain male clients. In addition, information from a study like this one may provide suggestions about devising strategies to address how emotional expression should be addressed with men in the therapeutic setting.

**Description of Variables**

**Predictor variables**

*Attitudes toward emotional expression:*
**Beliefs about meaning.** The belief that the expression of emotion is a sign of weakness (Joseph et al., 1994).

**Behavioral tendencies.** The tendency to express emotions or keep things inside (Joseph et al., 1994).

**Beliefs about expression.** The belief that emotions should be kept under control (Joseph et al., 1994).

**Beliefs about consequences.** The belief that other people will be rejecting (Joseph et al., 1994).

**Actual emotional expressiveness.** The extent to which individuals outwardly display their emotions, regardless of valence (positive or negative) or channel (facial, vocal, or gestural) (Kring, Smith, & Neale, 1994).

**Criterion variables**

**Barriers toward help-seeking.**

**Need for control and self-reliance.** Describes barriers that reflect concerns regarding self-reliance and autonomy (Mansfield et al., 2005).

**Minimizing problem and resignation.** Consists of barriers that keep individuals from seeking help because they do not believe the problem they are experiencing is serious enough to warrant treatment (Mansfield et al., 2005).

**Concrete barriers and distrust of caregivers.** Reflects concrete barriers (lack of finances, lack of insurance, lack of transportation) and distrust of care providers (Mansfield et al., 2005).

**Privacy.** Reflects concerns about physical and emotional vulnerability (Mansfield et al., 2005).
**Emotional control.** Consists of barriers that center around concerns with keeping one’s emotions under control and out of public view (Mansfield et al., 2005).

**Beliefs about psychological services (attitudes toward help-seeking).**

**Intent.** Refers to an individual’s sense that a need for services exists and willingness to seek help when in need (Ægisdóttir & Gerstein, 2009).

**Stigma Tolerance.** Refers to one’s perception of how others feel about seeking counseling services and how these feelings affect the person’s motivation to comply (Ægisdóttir & Gerstein, 2009).

**Expertness.** Relates to a person’s belief regarding expert characteristics about psychologists and their services (Ægisdóttir & Gerstein, 2009).

**Hypothesis**

Based on a review of the literature regarding the relationship between emotional expressivity and attitudes toward seeking professional psychological assistance (Berger et al., 2005; Blazina & Watkins, 1996; Cusack et al., 2006; Fischer & Farina, 1995; Fischer & Turner, 1970; Good et al. 1989) the following hypothesis was tested:

There will be a relationship between one’s attitudes toward expressing emotion and actual emotional expression and one’s identified barriers to and attitudes toward seeking professional psychological assistance. Specifically,

(a) attitudes toward emotional expression will be inversely related to attitudes towards seeking psychological services and positively to barriers to seeking professional psychological assistance;
(b) actual reported emotional expressivity will be positively related to attitudes towards seeking professional psychological services and negatively to barriers to seeking professional psychological assistance.
CHAPTER III

Method

The purpose of this study was to examine how men’s attitudes toward expressing emotion and their actual emotional expression was related to barriers men identify as preventing them from seeking professional psychological services and their attitudes and intentions toward seeking professional psychological services.

Participants

A total of 628 undergraduate and master’s level students from a large Midwestern university were recruited to participate in this study, of which, 240 identified as male. Only data from the male participants was used in the current study. Twelve male participants who did not respond to three or more items on a single scale were omitted from the study, leaving usable responses from 228 men. Participants were recruited via a mass email sent to the entire university population by the university’s Institutional Review Board, inviting them to participate in research. The mean age for participants was 23.34 years (SD = 6.03). Of the 228 participants, 86% (N = 196) identified as Caucasian, 6% (N = 13) identified as African-American, 2% (N = 4) identified as Hispanic/Latino, and 3% (N = 7) identified as Asian/Pacific Islander. Three percent (n = 6) identified as “other” (see Table 1). Ninety-six percent (N = 220) of the participants identified as U.S. citizens, 90% (N = 204) identified as straight, followed by 6.6% (N =
15) who identified as gay. Additional demographic information for the participants can be found in Table 1.

Table 1

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For their participation, individuals received either one credit hour applied toward research requirements for an undergraduate counseling class, the chance to be entered into a drawing to win a $100 gift certificate, or both.

**Instruments**

Four instruments and a demographic questionnaire were employed in the current investigation. These instruments included The Emotional Expressivity Scale (EES; Kring et al., 1994), which measures one’s emotional expressivity; the Attitudes toward Emotional Expression Scale (AEE: Joseph et al., 1994), which assesses an individual’s attitudes toward expressing emotion; the Barriers to Help Seeking Scale (BHSS: Mansfield et al., 2005), which assesses variables men identify as obstacles to seeking help for physical or mental health problems; and the Beliefs about Psychological Services (BAPS: Ægisdóttir & Gerstein, 2009), which taps an individual’s attitudes and intentions toward seeking psychological help from psychologists.

**Demographic Information.** A demographic questionnaire was developed by the author to obtain information about respondents’ background information pertinent to the study. This included information about participants’ sex, race, age, sexual orientation, citizenship, current year in college, major area of study, and prior counseling experience (see Appendix A).

**Emotional Expression.** The Emotional Expressivity Scale (EES; Kring et al., 1994) was used to measure reported emotional expression. It is a 17-item Likert-type
scale that allows individuals to indicate the extent to which each item applies to them (1 = never true and 6 = always true). Of the 17 items, six items are positively worded (e.g., “I think of myself as emotionally expressive”; “I display my emotions to other people”; “I am able to cry in front of other people”), whereas 11 items are negatively keyed (e.g., “I keep my feelings to myself”; “I am not very emotionally expressive”; “The way I feel is different for how others think I feel”). The instrument is presented in Appendix B.

Scoring consists of summing the total item response, with higher scores indicating greater emotional expressivity.

Kring et al. (1994) developed the EES as a self-report instrument that is intended to be used as a general measure of one’s emotional expressivity. According to the authors, emotional expressivity “recognizes individual differences in the extent to which people outwardly display their emotions…” (p. 934). They defined emotional expressivity as “the outward display of emotion, regardless of valence (positive or negative) or channel (facial, vocal, or gestural)” (p. 934). Theirs is a conceptualization that emphasizes a general disposition toward expressing different emotions across various channels.

Kring et al. (1994) reported an average alpha of .91 across seven administrations. A 4-week test-retest correlation was .90. The authors indicated that, although females tended to score significantly higher than males on the EES, reliability was not significantly affected by sex. An examination of convergent validity showed that responses on the EES correlated to measures that assess affect intensity and more specific aspects of expressivity, including the Emotional Expressivity Questionnaire (King & Emmons, 1990), which measures the expression of positive and negative emotions and
the expression of intimacy \((r = .64)\); the Affect Intensity Measure (Larsen, 1984), which measures the strength of individuals’ emotional experience \((r = .47)\); the Affectometer 2 (Kammann & Flett, 1983), which measures the frequency of positive and negative affect \((r = .45)\); the Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985), which measures global life satisfaction \((r = .49)\); and the Self-Monitoring Scale (Gangestad & Snyder, 1985), which captures the ability to self-observe and self-control verbal and nonverbal expressive behavior \((r = .24)\). Kring et al. noted that the SMS, though not a pure measure of expressivity, does tap the motivational and skill-related aspects of expression and should somewhat be related to the EES. There was also a significant relationship between self-report on the EES and ratings of expressivity by mothers \((r = .49)\).

In addition to being related conceptually to similar constructs, the EES was also uncorrelated with constructs conceptually unrelated to expressivity. Divergent validity demonstrated that the EES was not contaminated by social desirability \((r = -.01)\) as measured by the Marlowe-Crowne Social Desirability Scale (Crowne & Marlow, 1964) or self-esteem \((r = .04)\) as measured by the Rosenberg Self-esteem Scale (Rosenberg, 1965).

For the purposes of the current investigation, the participants’ total score was calculated and used to determine the single construct of emotional expressivity. Moreover, the EES acted as a predictor variable for the main analysis of the study, examining the relationship between emotional expressivity and barriers to help-seeking and attitudes toward seeking psychological help. For the current sample of men, Cronbach’s alpha for the EES was .93.
Attitudes Toward Emotional Expression. The Attitudes toward Emotional Expression Scale (AEE; Joseph et al., 1994) was employed to measure individual’s attitudes toward emotional expression. The AEE is a 20-item, self-report measure (see Appendix C). Respondents rate each item on a 5-point Likert-type scale ranging from strongly disagree (1) to strongly agree (5). Joseph et al. found four underlying factors to reflect attitudes toward emotional expression: 1) the belief that the expression of emotion is a sign of weakness (Beliefs about Meaning); 2) the belief that emotions should be kept under control (Beliefs about Expression); 3) the belief that other people will be rejecting (Beliefs about Consequences); and 4) the tendency to express emotions (Behavioral Tendencies). While the first three factors address the cognitive components of attitudes, the fourth addresses behaviors associated with attitudes. Joseph et al. noted that the four factors were correlated and loaded together on a single, higher order factor. Therefore, the 20 items may also be summed to yield a total score reflecting individual differences in attitudes toward emotional expression. Scores on the total scale range from 20 to 100, with higher scores indicating more negative attitudes toward emotional expression. The AEE may be scored using subscale scores or full scale scores. For the purposes of the current investigation, subscale scores were used.

The AEE was constructed to address the hypothesis that negative attitudes towards emotional expression may act to block processing of emotionally charged information following exposure to a traumatic event. In addition, Joseph et al. (1994) noted that such a measure would hold promise for the study of dysfunctional attitudes and psychopathology, as well. The AEE was constructed following Kennedy-Moore and
Watson’s (1999) cognitive-evaluative model of emotional expression to assess both the negative cognitions and the negative behaviors concerning emotional expression.

Thirty items were initially constructed to represent attitudes toward expressing emotion. A Principal Components Factor analysis with varimax rotation was conducted on the 30 items, resulting in a 7-factor solution. Four factors had five or more items loading at .40 in the principal components factor analysis. A second principal components factor analysis was conducted on all four factor stipulated to be extracted. In order to create subscales, Joseph et al. utilized two criteria: First, all items with an item-total correlation less than .40 were rejected; Second, those items with the best face validity in terms of the each factor’s characterization were retained. This resulted in four five-item subscales.

A Principal Component Factor analysis was then conducted on the 20 AEE items without stipulation of the number of factors to be extracted. Four factors were generated which corresponded to the 4 subscales. However, seven of the items loaded on two of the subscales at greater than .40. For instance, subscales one and two shared two items on which the items loaded greater than .40; subscales one and three shared three items on which loadings were greater than .40; and subscales two and four shared two items. Joseph et al. (1994) noted that they retained subscale items that had a loading higher than .47 on its respective factor and lower than .46 on the other factors, thus confirming that the subscales represented separate constructs. Although items should be positively related as they represent a higher order factor (attitudes toward emotional expression), items may not be different enough to represent separate constructs. Cronbach’s alpha for each of the subscales were as follows: Factor 1: Beliefs about Meaning (emotional
expression is a sign of weakness) = .85; Factor 2: Behavioral Tendencies (bottle up feelings when upset) = .88; Factor 3: Beliefs about Expression (keep in control) = .82; and Factor 4: Beliefs about Consequences (social rejection) = .70. A Principal Component analysis was conducted on the 4 subscales to test for a higher order factor. Results demonstrated that one factor was extracted which had an eigenvalue of 2.36 and accounted for 59.1% of the variance. All 4 subscales loaded on this factor at about .70.

Internal reliability of the total scale (Cronbach’s alpha = .90) was high. Convergent validity was demonstrated by higher scores on the total 20-item AEE scale being associated with lower scores on the Seeking Social Support scale \( r = -.46 \) from the Ways of Coping Questionnaire (Folkman & Lazarus, 1988). This scale assesses individuals’ efforts to seek informational, tangible, and emotional support.

Later findings suggested that the AEE is a reliable and valid measure of attitudes toward expressing emotion. Mitchell-Gibbs and Joseph (1996) attempted to clarify the operational definition of attitudes towards emotional expression with an assessment of 600 police officers. The questionnaire battery provided to the participants included the AEE and the 12-item General Health Questionnaire (GHQ-12; Goldberg & Williams, 1988). To replicate the previous findings, a Principal Component Factor analysis with varimax rotation was conducted on the scores for all respondents from the 20-item AEE scale, which resulted in four factors with eigenvalues greater than 1.00, confirming Joseph’s et al. previous results about the instruments factor structure. Correlations between the subscales showed them to be significantly associated (lowest \( r = .19, p < .001 \)). A total score for the 20 items was found to have satisfactory internal reliability (Cronbach’s alpha = .90).
Laghai and Joseph (2000) further investigated the factor structure of the AEE, its convergent validity with the Ambivalence over Emotional Expressiveness Questionnaire (AEQ; King & Emmons, 1990), and its association with the Big 5 personality dimensions (NEO-FFI; Costa & McCrae, 1992). Again, the AEE was found to consist of four clearly identifiable factors, as suggested by the AEE authors, which loaded together to form a higher order factor. Internal reliabilities of the four subscales were found to be satisfactory: Cronbach’s alphas = .90 (Beliefs about Meaning), .90 (Behavioral Tendencies), .83 (Beliefs about Consequences), .77 (Beliefs about Expression) and the four subscales strongly inter-correlated (lowest $r = .45 p < .001$). In support of AEE convergent validity, higher scores on the AEE were associated with higher scores on the AEQ. The five NEO personality dimensions were then entered into a simultaneous regression to predict scores on the AEE. Regression of scores on the AEE onto the NEO-FFI showed that higher scores on the AEE, indicating more negative attitudes toward emotional expression, were associated with lower scores on agreeableness, extraversion, and openness of the NEO-FFI, providing further support for convergent validity of the AEE.

For the current study, Cronbach’s alpha for the total scale score was .92. Cronbach’s alpha for the four subscale scores were .87, .87, .79, and .77 for Meaning, Tendencies, Expression, and Consequences, respectively. The four subscales served as predictor variables in the main analysis of the current project, examining the interrelationship between emotional expression, attitudes toward emotional expression, barriers to psychological help-seeking, and attitudes toward seeking psychological help.
**Barriers to Help-Seeking.** The Barriers to Help Seeking Scale (BHSS; Mansfield et al., 2005) is a 31-item scale developed to assess variables men identify as obstacles to seeking help for physical or mental health problems (see Appendix D). In addition to a total scale score, participants can receive scores on five subscales that were constructed based on factor analysis: Need for Control and Self-reliance (10 items); Minimizing Problem and Resignation (6 items); Concrete Barriers and Distrust of Caregivers (6 items); Privacy (5 items); and Emotional Control (4 items). The BHSS has a 5-point Likert-type scale (0 = not at all, 4 = very much) to rate reasons for not seeking help for the problem depicted in the authors’ scenario:

Imagine that you begin to experience some pain in your body. The pain is not so overwhelming that you can’t function. However, it continues for more than a few days and you notice it regularly. You consider seeking help from a medical doctor or other clinician at the student health center. Below are several reasons why you might choose NOT to seek help. Please read each reason and decide how important it would be in keeping you from seeking help (p. 98).

Calculation of the total score and the scores for the subscales consist of totaling each item with lower numbers indicating that the item is less of a barrier to seeking help and higher numbers denoting a stronger identified barrier to seeking help for physical or emotional concerns.

Although the BHSS was constructed to identify barriers to seeking help for both physical and emotional concerns, the instructions noted above and five items focused solely on physical concerns. Therefore, the instructions and five items of the scale were
modified to better fit the focus of this study, and a pilot study was conducted to test the modification. The instruments’ modification and results of the pilot study are reported later in this section.

Mansfield et al. (2005) based the development of the BHSS on research and theory derived from a theoretical integration of gender-role socialization and the social psychology of help-seeking. In addition, the authors constructed the BHSS to broaden the availability of instruments, as most early studies examining the use of health services relied on Fischer and Turner’s (1970) Attitudes toward Seeking Professional Psychological Help (ASPPH) Scale noting that Fischer and Turner’s scale measures attitudes, not specific barriers. Therefore, Mansfield et al. created a measure that would target specific barriers to help seeking for both physical and emotional health problems. With no previous empirical evidence supporting barriers to help seeking, the authors based their assumptions on gender-role socialization and social psychological analyses of help seeking. The authors took steps to incorporate specific masculinity norms and roles as context-specific barriers to seeking help for a particular problem. Items were created to tap male gender-role norms, social psychological processes related to help seeking, and more concrete barriers to seeking help, such as lack of time, money, and transportation. According to the authors, four principles related to the social psychology of help-seeking were instrumental to the development of the BHSS: (1) the ego-centrality of a problem or the degree to which a problem is perceived to reflect an important quality of oneself; (2) the normativeness of a problem, or how common the concern is considered to be in the population; (3) reactance, or the tendency to reclaim autonomy when that autonomy has been threatened; and (4) reciprocity, which refers to the extent that the person receiving
help will have the opportunity in the future to return the help. The authors reported that
each of these principles had been shown to affect help-seeking behavior in experimental
and correlational research on help seeking.

Mansfield et al. (2005) demonstrated good psychometric properties for the BHSS.
Internal consistency for the entire scale ranged from .94 to .95. The subscales
demonstrated good to excellent internal consistency, with coefficient alphas for each
subscale as follows: Factor 1: Need for Control and Self-reliance = .93; Factor 2:
Minimizing Problem and Resignation = .89; Factor 3: Concrete Barriers and Distrust of
Caregivers = .79; Factor 4: Privacy = .83; and Factor 5: Emotional Control = .89. Two-
week test-retest for the entire scale demonstrated adequate reliability \( r = .73 \). Two-
week test-retest reliability for each of the subscales was as follows: Need for Control and
Self-reliance: .68; Minimizing Problem and Resignation: .35; Concrete Barriers and
Distrust of Caregivers: .95; Privacy: .79; and Emotional Control: .93. As the authors
noted, test-retest reliability for the Minimizing Problem and Resignation subscale was
“poor.”

Validity tests of the BHSS demonstrated a convergence with the Gender Role
Conflict Scale (GRCS; O’Neil, Good & Holmes, 1986) total score \( r = .58 \). Responses
on each of the BHSS subscales showed small to moderate correlations with responses on
each of the GRCS subscales, including Success, Power and Competition, Restrictive
Emotionality, Restrictive Affectionate Behavior between Men, and Conflict between
Work and Family. However, responses on the Minimizing Problem and Resignation
subscale of the BHSS revealed consistently large correlations with responses on each of
the GRCS subscales. As the authors predicted, the Restrictive Emotionality subscale of
the GRCS correlated significantly with the Emotional Control subscale of the BHSS ($r = .47$). The Success, Power, and Competition subscale of the GRCS correlated significantly with the Need for Control and Self-reliance subscale of the BHSS ($r = .31$).

Further tests of construct validity were performed by correlating scores on the BHSS with scores on the ASPPH (Fischer & Turner, 1970). As expected, the BHSS total score was negatively correlated with the ASPPH ($r = -.55$) and all BHSS subscales were negatively correlated with the ASPPH.

**BHSS pilot study.** Prior to the undertaking of the main study, a pilot study was conducted in order to determine the reliability of the BHSS following modifications to the instrument’s directions and 5 items of the instrument. Although Mansfield et al. (2005) contended that the BHSS may be used to assess an individual’s barriers to seeking help for both medical and psychological concerns some items were reworded to focus solely on issues related to mental health concerns.

For the purposes of the pilot study and for use in the main investigation, the scenario that was previously presented was changed to represent a “psychological concern” rather than a medical concern. Specifically, the scenario read:

Imagine that you begin to increasingly worry and become easily upset over the course of several days. As your worry continues, you become concerned that you have not begun to feel better. You consider seeking help from a therapist at the student counseling center. Below are several reasons why you might choose NOT to seek help. Please read each reason and decide how important it would be in keeping you from seeking help.
Five items from three factors were also amended to assess one’s perceived barriers to seeking assistance for a mental health concern rather than for a physical medical concern. Item 16 from Factor 2 (Minimizing Problem and Resignation) was changed from “I would prefer to wait until I’m sure the health problem is a serious one” to “I would prefer to wait until I’m sure the problem is a serious one.” Item 21 from Factor 3 (Concrete Barriers and Distrust of Caregivers) was changed from “I don’t trust doctors and other health professionals” to “I don’t trust counselors and other mental health professionals.” Three items from Factor 4 (Privacy) that addressed being touched or taking off one’s clothes in a medical setting were modified to represent being emotionally vulnerable in a mental health setting. For instance, item 25 was changed from “I don’t want a stranger touching me in ways I’m not comfortable with” to “I don’t want some stranger knowing things about me that I’m not comfortable with.” Item 26 was changed from “I don’t like taking off my clothes in front of other people” to “I don’t want to talk about intimate matters with other people.” Finally, item 27 was modified from “I wouldn’t want someone of the same sex touching my body” to “I wouldn’t want someone getting close to me.” The modified instrument is presented in Appendix E.

Fifty-one male undergraduate students from a large Midwestern university participated in the pilot study. These men were recruited through the sociology department of the university and received extra credit towards their sociology class for participating. Participants responded completed the same demographic questionnaire described previously (Appendix A). Results from the pilot study demonstrated that that changes made to the items did not affect its reliability. Internal consistency for the entire scale was .91. The subscales demonstrated acceptable internal consistency, with
coefficient alphas for each subscale as follows: Factor 1: Need for Control and Self-reliance = .86; Factor 2: Minimizing Problem and Resignation = .81; Factor 3: Concrete Barriers and Distrust of Caregivers = .61; Factor 4: Privacy = .78; and Factor 5: Emotional Control = .81. These numbers were comparable to those found by Mansfield et al. (2005) on the original measure. Therefore, the amended instrument was deemed acceptable to be used in the main study. For the current study, Cronbach’s alpha for the modified BHSS total scale score was .91. For the subscale scores Cronbach’s alphas were .88, .83, .60, .81, and .79 for Need for Control and Self-reliance, Minimizing Problem and Resignation, Concrete Barriers and Distrust of Caregivers, Privacy, and Emotional Control, respectively. Each of the BHSS subscales served as criterion variables in the main analysis. Additional results from the pilot study are discussed in Chapter IV.

**Attitudes and Intentions to Seek Psychological Help.** The Beliefs about Psychological Services scale (BAPS; Ægisdóttir & Gerstein, 2009) is an 18-item measure of an individual’s attitudes toward and intention to seeking psychological help from psychologists (see Appendix F). Items were created by the authors based on free-list responses from undergraduate students about attitudes toward seeking psychological help, and items from Fischer and Turner’s (1970) ATSPPS. Ægisdóttir and Gerstein developed the BAPS as an alternative to the ATSPPH, whose validity and reliability has been considered questionable.

The BAPS consists of three subscales: Intent (6 items), Stigma Tolerance (9 items), and Expertness (4 items). Intent taps into tendencies to seeking psychological assistance if needed. This subscale is represented by items such as: “If a good friend
asked my advice about a serious problem, I would recommend that he/she see a psychologist;” Stigma Tolerance refers to a person’s perception of how others feel about them seeking counseling services, and how these feelings affect their motivation to comply. An example of an item tapping Stigma Tolerance includes: “I would feel uneasy going to a psychologist because of what some people might think.” The Expertness factor relates to a person’s belief regarding characteristics about psychologists and their services. A sample item examining Expertness includes: “It is good to talk to someone like a psychologist because everything you say is confidential.” Respondents rate items on a 6-point Likert-type scale ranging from 1 (Strongly Disagree) to 6 (Strongly Agree). After reversing negatively worded items, a total score is found by adding scores of all the items and dividing by number of items. Subscale scores are found by adding items pertaining to each of the subscales divided by number of items on that subscale. Higher scores indicate more positive expertness beliefs in professional psychological services, greater stigma tolerance, and greater intentions to seek psychological help. The three subscales to the BAPS were used for the current study.

Ægisdóttir and Gerstein (2009) reported good reliability for the 18-item BAPS. Cronbach’s alpha for the total scale score was .87 and Cronbach’s alphas for the three subscale scores were .81, .81, and .72 for Intent, Stigma Tolerance, and Expertness, respectively. Two-week test-retest reliability demonstrated that the BAPS total scale score was stable over time (.87). For the subscale scores, test-retest reliability coefficients were .88 for Intent, .79 for Stigma Tolerance, and .75 for Expertness.

Convergent validity was demonstrated by comparing the BAPS total and subscale scores to the total and subscale scores of the ATSPPH (Fischer & Turner, 1970). The
correlation of the total scores of the two measures was .83. Also, the subscale scores of
the BAPS correlated significantly with total score and subscale scores of the ATSPPH.
Discriminant validity was established by examining the correlation of the BAPS total and
three subscale scores with the total score of the Marlowe-Crowne Social Desirability
Scale (MCSDS; Crowne & Marlowe, 1964). The correlation between the BAPS total
score and the MCSDS total score was not significant ($r = .08$); nor did any of the BAPS
subscales correlate significantly with social desirability.

For the current sample, Cronbach’s alpha for the total BAPS was .86. Cronbach’s
alphas for the subscales were as follows: Intent = .83; Stigma Tolerance = .77; and
Expertness = .74. Each of the subscales from the BAPS acted as criterion variables in the
present study.

Procedure

After receiving an invitational email through the university’s Institutional Review
Board, participants were directed to the website surveymonkey.com, an online
assessment tool, where they were presented with the Informed Consent and information
regarding their voluntary participation (see Appendix A). Students could either agree to
participate by continuing with the study or declining by exiting the program. If students
agreed to participate they entered a webpage containing the instruments. At the time of
the study, surveymonkey.com did not allow for random ordering of the instruments.
Therefore the instruments were introduced in the following order: Informed Consent
(Appendix G); BHSS (Appendix E); EES (Appendix B); Demographic Questionnaire
(Appendix A); BAPS (Appendix F); and AEE (Appendix C). A final page appeared
upon completion of the survey thanking participants for their time and providing
instructions on how to submit their name for participation credit and for submission in the drawing to win the $100 gift card.

**Research Design and Statistical Procedure**

The design of the study was nonexperimental, utilizing a survey-type methodology at a single point in time. By gathering responses at a single point in time, history, maturity, testing and attrition threats were avoided. All four instruments (EES, AEE, BHSS, and BAPS) and the demographic questionnaire contain a fixed set of questions that enabled quantitative comparisons and insured that all participants received the same set of stimuli. This controlled for instrumentation as a threat to the project’s internal validity. In addition, instrumentation was avoided by using instruments with demonstrated validity and reliability. As stated, the instruments were presented in a fixed order, which can result in order effect. A discussion of this study’s potential threats to internal and external validity is presented in Chapter 5.

Once collected, the data were entered into PASW. As previously stated, the data from 228 male participants was used in the current project. When missing values were encountered for these participants (three or less items omitted on a scale), mean score substitution was used to replace the missing values.

**Canonical Correlation Analysis.** A canonical correlation analysis (CCA) was employed to identify interrelationship between a set of emotionality variables (EES and four subscales to the AEE) and a set of attitudinal variables using PASW. The emotionality variables (predictor set) consisted of emotional expressivity (EES) and attitudes toward expressing emotion (BM, BT, BC, BE). The set of attitudinal variables (criterion set) consisted of perceived barriers to seeking psychological services (NCS,
MPR, CBD, PRI, EMC) and attitudes and intentions toward seeking psychological services (INT, STT, EXP). Therefore, the canonical correlation analysis included five predictor variables, and eight criterion variables.

CCA is a multivariate technique that allows for the examination of correlation between two sets of variables. It may be considered an extension of multiple regression (Pedhazur, 1997), as it allows one to examine if and how two sets of variables relate to each other (Tabachnick & Fidell, 2001). Tabachnick and Fidell noted that in CCA, sets of variables on each side of the equation are combined to produce a predicted value that has the highest correlation with the predicted value on the other side.

Sherry and Henson (2005) described two advantages to CCA. First, CCA limits the probability of committing Type I error anywhere within the study because simultaneous comparisons among the variables may be made rather than requiring many statistical tests. Second, CCA may “best honor the reality of psychological research” (p. 38) as many variables in psychological research may have multiple causes and multiple effects, which require a more sophisticated type of analysis. For the current study, threats to statistical conclusion validity were reduced as only one analysis was performed to test the study’s hypotheses. To reduce Type II error and allow for the rejection of the null hypothesis, a large sample size was gathered. Tabachnick and Fidell (2001) recommended about ten cases for every variable in the social sciences where reliability is around .80. The current investigation utilized a total of 228 participants with 13 variables, a ratio of 17.5 participants per variable; therefore, results can properly be evaluated according to Tabachnick and Fidell’s suggestion.
The Canonical Correlation procedure creates linear combinations of variables, called canonical variates. These variates represent possible combinations of predictor and criterion variables to be discerned (Tabachnick & Fidell, 2001). The maximum number of variates that can be extracted is equal to the number of variables in the smaller set. CCA finds the linear combination of variables (root) that produces the largest correlation with the second set of variables. The root is extracted and the process is repeated for the residual data until a successive linear combination is no longer significant. The correlation between the two sets represented by the root is the canonical correlation between the two sets of variables and symbolized as $R_c$. The square of the canonical correlation ($R_c^2$) provides an estimation of the amount of variance shared by the two canonical variates (Pedhazur, 1997).

Canonical function coefficients (weights) and structure correlation coefficients (loadings) are used to interpret the findings. Weights are calculated for each canonical variate that is retained and provide information about the unique contribution of each variable to a given canonical correlation. Weights are used as indices of the relative contribution of the variables with which they are associated and are used to create two linear equations, one for the predictor variables and one for the criterion variables (Sherry & Henson, 2005). These two equations then yield the largest possible correlation between the two synthetic variates. The synthetic variable is a combination of the observed variables in each set (predictor and criterion). Structure coefficients (loadings) indicate the correlation between an observed variable and a synthetic variable (Sherry & Henson), or the correlation between an original variable and the canonical variate scores on a given function (Pedhazur, 1997). As Sherry and Henson noted: “The most central
statistic in a CCA is the canonical correlation between the two synthetic variables, and this statistic is nothing more or less than a Pearson $r''$ (p. 39). In the present study, model fit using Wilks’s lambda, $R_c, R_c^2$, variable weights, and loadings (structure coefficients) were used to interpret the relationship between the predictor and criterion variables.
CHAPTER IV

Results

BHSS Pilot Study

Barriers to help-seeking. As stated previously in Chapter III, the Barriers to Help-Seeking Scale (BHSS; Mansfield, Addis, & Courtenay, 2005) is a 31-item scale created to assess variables men identify as obstacles to seeking help for both physical or mental health problems (see Appendix D). In addition to a total score, participants can receive scores on five subscales: Need for Control and Self-reliance (10 items); Minimizing Problem and Resignation (6 items); Concrete Barriers and Distrust of Caregivers (6 items); Privacy (5 items); and Emotional Control (4 items). The BHSS has a 5-point Likert-type scale (0 = not at all, 4 = very much) to rate reasons for not seeking help for physical pain (see scenario in Chapter III). As the scenario focused on a physical problem and seeking help from a medical doctor, it was modified to focus on feeling worried and upset and seeking help from a university counseling center. Five of the instrument’s items (Items 16, 21, 25, 26, & 27) from three factors were also amended to assess one’s perceived barriers to seeking assistance for a mental health concern rather than for a physical medical concern (see Chapter III for item modifications). To assess reliability of the modified instrument it was pilot tested on 51 male undergraduate students taking classes at a sociology department at a large Midwestern university. Mean
scores ranged from 1.10 ($SD = .74$) for the Concrete Barriers and Distrust of Caregivers subscale (CBD) to 2.45 ($SD = .86$) for the Minimizing Problem and Resignation subscale. Cronbach’s alpha for the modified BHSS total scale score was .91 (see Table 2).
### Table 2

**Means, Standard Deviations, and Cronbach’s Alphas for Barriers to Help-seeking Scale from Pilot Study**

<table>
<thead>
<tr>
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<td>.93</td>
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<td>.61</td>
<td>.79</td>
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</tr>
<tr>
<td>EMC</td>
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<td>.81</td>
<td>.89</td>
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**Scale Items**

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<td>31</td>
<td>1.73</td>
<td>1.31</td>
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</table>

*Note.* NCS refers to Need for Control and Self-reliance. MPR refers to Minimizing Problem and Resignation. CBD refers to Concrete Barriers and Distrust of Caregivers. PRI refers to Privacy. Bolded items were modified. Original BHSS alpha coefficients are from Mansfield et al. (2005).
For the subscale scores, Cronbach’s alphas were .88, .83, .60, .81, and .79 for Need for Control and Self-reliance, Minimizing Problem and Resignation, Concrete Barriers and Distrust of Caregivers, Privacy, and Emotional Control, respectively.

Mean scores and reliability coefficients were somewhat lower than those found by Mansfield et al. (2005) on the original measure, but were considered acceptable. Because variations in psychometrics between the modified and original BHSS were attributed to sampling differences (pilot study participants had accessibility to counseling services free of cost), and the reliability coefficients were considered acceptable and only seemed to affected in the CBD scale which looks at cost and accessibility issues of services, the validity of the instrument was not considered compromised and the amended instrument was deemed acceptable for use in the main study.

**Main Study**

**Data preparation and preliminary analysis.** Once the data were collected for the main study, it was entered into PASW and screened through the PASW frequencies analysis to identify missing items. Tabachnick and Fidell (2001) reported that when missing items appear random, little concern is posed, as was the case in the current investigation. The authors also indicated that when 5% or less of the total items are missing, any procedure for handling missing data may be employed. Because less than 5% of items were missing in the current investigation, mean score substitution was used to replace the missing values. Subscale and total scores for the instruments were then computed. Means and standard deviations for the predictor and criterion variables are reported in Table 3. Mean scores for the predictor variables ranged from 2.02 (SD = .82)
for the Beliefs about Meaning (BM) subscale of the AEE to 3.33 ($SD = .84$) for the Emotion Expressivity Scale (EES). Mean scores for criterion variables ranged from 2.21 ($SD = .71$) for the Concrete Barriers and Distrust of Caregivers (CBD) subscale of the BHSS to 4.49 ($SD = .82$) for the Stigma Tolerance subscale of the BAPS. The correlation matrix for the predictor and criterion variables are reported in Table 4.

Table 3
Means, Standard Deviations, and Cronbach’s Alphas for BHSS, EES, BAPS and AEE

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<th></th>
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<th>α</th>
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</tr>
<tr>
<td>CBD</td>
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</tr>
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<td>PRI</td>
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<td>EMC</td>
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<td><strong>BAPS</strong></td>
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<tr>
<td>Total</td>
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<td>INT</td>
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<td>Total</td>
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<tr>
<td>BC</td>
<td>2.64</td>
<td>.78</td>
<td>.77</td>
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</tbody>
</table>

Note. NCS refers to Need for Control and Self-reliance. MPR refers to Minimizing Problem and Resignation. CBD refers to Concrete Barriers and Distrust of Caregivers. PRI refers to Privacy. EMC refers to Emotional Control. INT refers to Intent. STT refers to Stigma Tolerance. EXP refers to Expertness. BM refers to Beliefs about Meaning. BT refers to Behavioral Tendencies. BE refers to Beliefs about Expression. BC refers to Beliefs about Consequences. Scores for the BHSS range from 0 to 4; higher scores indicate more perceived barriers to seeking help. Scores for the BAPS range from 1 to 6; higher scores indicate more positive attitudes toward psychological help-seeking. Scores for the EES range from 1 to 6; higher scores indicate more emotional expressivity. Scores for the AEE range from 0 to 4; higher scores indicate more negative attitudes toward expressing emotion.

In the current study, the means for each of the subscales and total scale of the BHSS were slightly higher than those reported by Mansfield et al. (2005) in previous
studies with two groups of men, one Midwestern sample and one New England sample, all of whom were undergraduate male students. For the current investigation, overall, it appears that men reported more barriers to seeking professional psychological treatment. In particular, the MPR subscale of the BHSS, which represents a cluster of barriers that keep men from seeking help because they do not believe the problem they are experiencing is serious enough, represented the strongest group of barriers identified by participants ($M = 3.37; SD = .87$). Mansfield et al. found that the MPR subscale was the strongest group of barriers for the Midwest sample, yet the least strong group of barriers for the New England sample. The participants in the current study were men enrolled at a university in the Midwest. Kring et al. (1994) reported overall means for the EES ranging from 3.60 to 4.03, on which ratings range from 1 to 6. The total scale mean for the EES in the current investigation was 3.33 ($SD = .84$), indicating that the current sample of men is neither very emotionally expressive nor very emotionally inexpressive, but somewhere in the middle. Ratings for the subscales of the AEE range from 0 to 4, with higher scores indicating more negative attitudes toward expressing emotion. In the present study, means ranged from 2.02 for the beliefs about meaning (BM) to 3.16 for the behavioral style factor of attitudes toward expressing emotion. The means in the current investigation were slightly higher than those found in the Joseph et al. (1994) initial study, indicating that men in the current investigation had slightly more negative attitudes toward expressing emotion. Finally, means for the BAPS total scale (4.13) as well as the subscales (Intent = 3.51; Stigma Tolerance = 4.49; and Expertness = 4.34) indicate that participants in the current investigation had slightly positive attitudes toward seeking professional psychological assistance. In particular, the men reported somewhat positive
beliefs regarding Stigma Tolerance and Expertness, whereas their intention to seek psychological help if in distress was somewhat lower and closer to neutral. The correlation matrix for the predictor and criterion variables are reported in Table 4.
Table 4

**Correlations among and between BHSS, EES, BAPS and AEE**

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<td>.823**</td>
<td>.839**</td>
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_Note._ NCS: Need for Control and Self-reliance; MPR: Minimizing Problem and Resignation; CBD: Concrete Barriers and Distrust of Caregivers; PRI: Privacy; EMC: Emotional Control; INT: Intent; STT: Stigma Tolerance; EXP: Expertness; BM: Beliefs about Meaning; BT: Behavioral Tendencies; BE: Beliefs about Expression; BC: Beliefs about Consequences. ** = p < .001; * p < .01, two tailed
The correlations among criterion variables ranged from a low of -.10 for the Minimizing Problem and Resignation (MPR) subscale of the BHSS and the Expertness (EXP) subscale of the BAPS to a high of -.61 for the Privacy (PRI) subscale of the BHSS and the Stigma Tolerance (STT) subscale of the BAPS. The correlations among predictor variables ranged from -.27 for the EES and the Beliefs about Meaning (BM) subscale of the AEE to -.81 for the EES and the Behavioral Tendencies subscale of the AEE. It can also be seen in Table 4 that the correlations among the predictor and criterion variables ranged from -.06 for Expertness (EXP) subscale of the BAPS and the Behavioral Tendencies (BT) subscale of the AEE to -.64, with the largest correlation occurring between the Stigma Tolerance (STT) subscale of the BAPS and the Beliefs about Meaning (BM) subscale of the AEE.

**Hypothesis testing.** The following hypothesis was tested: There will be a relationship between one’s attitudes toward expressing emotion and actual emotional expression and one’s identified barriers to and attitudes toward seeking professional psychological assistance. Specifically, (a) attitudes toward emotional expression will relate inversely with attitudes towards seeking psychological services and positively to barriers to seeking professional psychological assistance; and (b) actual emotional expressivity will relate positively with attitudes towards seeking professional psychological services and negatively to barriers to seeking professional psychological assistance.

To test the hypothesis, a canonical correlation analysis (CCA) was conducted. The predictor variables consisted of the Emotional Expressivity Scale (EES) and the four subscales of the Attitudes toward Emotional Expression (AEE), including Beliefs about
Meaning (BM), Behavioral Tendencies (BT), Beliefs about Expression (BE), and Beliefs about Consequences (BC). The criterion variables consisted of the five subscales of the Barriers to Help-Seeking Scale (BHSS), including the Need for Control and Self-reliance (NCS), Minimizing Problem and Resignation (MPR), Concrete Barriers and Distrust of Caregivers (CBD), Privacy (PRI), and Emotional Control (EMC) as well as the three subscales to the Beliefs about Psychological Services (BAPS) scale, including Intent (INT), Stigma Tolerance (STT), and Expertness (EXP).

The current analysis yielded five canonical functions (roots) with canonical correlation ($R_c$) of .73 ($p < .001$), .51 ($p < .001$), .33 ($p < .05$), .17 (ns), and .12 (ns) for each successive function. Collectively, the full model was statistically significant: Wilks’s $\lambda = .29$, $F(40, 939.96) = 7.70, p < .001$. Therefore, the null hypothesis that there was no relationship between variable sets can be rejected. There is, in fact, a relationship between the variable sets. In addition, it is important to report significant tests for the additional functions. Wilks’s $\lambda$ for the remaining functions were as follows: Function 2: Wilks’s $\lambda = .63$, $F(28, 780.22) = 3.81, p < .001$; Function 3: Wilks’s $\lambda = .85$, $F(18, 614.25) = 3.81, p < .05$; Function 4: Wilks’s $\lambda = .96$, $F(10, 436.00) = 1.00$, (ns); Function 5: Wilks’s $\lambda = 1.00$, $F(4, 219.00) = .81$, (ns). Function 1 explained 54% of the variance of the relationship between the two variable sets; Function 2 explained 26%. Functions 3, 4, and 5 explained 11%, 3%, and 1%, respectively. Even though the first three functions were statistically significant, only the first two functions were interpreted as they explained a large enough proportion of the variance of the relationship between the two variable sets (i.e., 54% and 26%), whereas third explained only 11% and did not add more information about the relationship between the two variable sets. Because Wilks’s
\( \lambda \) represents the variance unexplained by the model, \( 1-\lambda \) yields the full model effect size in an \( r^2 \) metric. Therefore, the \( r^2 \) type effect size was .71, which indicates that the full model explained a substantial portion, or about 71% of the variance shared between the variable sets. One may notice that the sum of the first two functions (80%) was larger than the overall effect size found from the Wilks’s \( \lambda \) (71%) due to the orthogonal nature of the functions. This means that the second function was created after the first function explained as much of the variability in the observed variable sets as possible and the second function explained what remains of the leftover variance.

Table 5 presents the standardized canonical function coefficients and structure coefficients for Functions 1 and 2. The squared structure coefficients are also given as well as the communalities (\( h^2 \)) across the two functions for each variable. Communalities describe the amount of variance in the observed variable that was reproducible across the functions and can be understood as how useful the variable was for the solution (Sherry & Henson, 2005). Structure coefficients (loadings) greater than or equal to .40 on each function were interpreted.
Table 5
Canonical Solution for Emotion Predicting Attitudes and Barriers to Seeking Psychological Help, Functions 1 and 2

<table>
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<tr>
<th>Variable</th>
<th>Coef</th>
<th>rs</th>
<th>rs² (%)</th>
<th>Coef</th>
<th>rs</th>
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Note: Structure coefficients (rs) greater than .40 are underlined. Communal coefficients (h²) greater than 45% are underlined. Coef = standardized canonical function coefficient; rs = structure coefficient; rs² = squared structure coefficient; h² = communality coefficient. NCS refers to Need for Control and Self-reliance. MPR refers to Minimizing Problem and Resignation. CBD refers to Concrete Barriers and Distrust of Caregivers. PRI refers to Privacy. EESTotal refers to Emotional Expressivity Scale. EMC refers to Emotional Control. INT refers to Intent. STT refers to Stigma Tolerance. EXP refers to Expertness. BM refers to Beliefs about Meaning. BT refers to Behavioral Tendencies. BE refers to Beliefs about Expression. BC refers to Beliefs about Consequences.

Looking at the Function 1 structure coefficients, one sees that the relevant criterion variables were lower STT, followed by higher NCS, higher EMC, higher PRI and CBD. This conclusion was supported by the squared structure coefficients. In addition, with the exception of STT, all of the relevant variables’ structure coefficients had the same sign, indicating that they were all positively related. That is, lower stigma tolerance was related to higher need for control and self-reliance, higher need for emotional control, greater need for privacy, and more concrete barriers and distrust of
caregivers. Of the predictor set, the highest contribution was BM, followed by BE, BC, BT and lower EES Total. Because the structure coefficient for EES was negative, it was inversely related to all criterion variables. Namely, greater beliefs about meaning, beliefs about expression, beliefs about consequences, and behavioral tendencies regarding expressing emotion were inversely related to actual emotional expressivity. Finally, all subscales of the AEE (BM, BT, BE, and BC) were positively related to all criterion variables except for STT. That is, beliefs about meaning, beliefs about expression, beliefs about consequences, and behavioral tendencies regarding expressing emotion were positively related to need for control and self-reliance, need for emotional control, need for privacy, and concrete barriers and distrust of caregivers and inversely related to stigma tolerance.

These results were generally supportive of the theoretically expected relationships between emotional expressiveness, attitudes toward emotional expression and perceived barriers to and attitudes towards seeking professional psychological services. Overall, lower emotional expressiveness (EES) and more negative attitudes toward expressing emotion (BM, BE, BC, and BT) were related to lower stigma tolerance and increased identified barriers to seeking psychological help. More specifically, men’s lower actual expression of emotion (EES), their belief that emotional expression is a sign of weakness (BM), their discomfort expressing emotions (BT), their belief that one should keep emotions under control (BE), and their belief that expressing one’s emotions has negative consequences (BC) related to lower stigma tolerance (STT) related to psychological help-seeking and increased identified concrete barriers to seeking help, including the need for
control and self-reliance (NCS), higher need for emotional control (EMC), increased need for privacy (PRI), and increased concrete barriers and distrust of caregivers (CBD).

Moving to Function 2, the coefficients in Table 5 suggest that the only criterion variable of relevance was the emotional control (EMC) subscale of the BHSS. For the predictor variable set, actual emotional expressivity (EES) and the behavioral tendencies (BT) subscale of the AEE were prominent predictors. These emotional factors were inversely related on Function 2. The structure coefficients for the function indicate that EES was inversely related to EMC, and BT was positively related to EMC. These results demonstrate that lower emotional expressivity and higher behavioral tendencies (bottling up feelings) were related to an increased need for emotional control. In the context of barriers toward psychological help-seeking, it can be stated that the less men outwardly express themselves emotionally and the more negative attitudes they have regarding emotion, the more the need for emotional control acts as a barrier to seeking professional psychological assistance. As Function 1 appears to represent negative connotation regarding actual emotional expression, attitudes toward emotional expression and stigma associated with psychological help-seeking, Function 2 appears to represent the general tendencies of emotional expression and the openness toward expressing them in the context of counseling and psychotherapy.

Results from the CCA partially support the hypothesis proposed at the outset of this investigation; there is a relationship between one’s attitudes toward expressing emotion and one’s actual emotional expression and perceived barriers to and attitudes towards seeking professional psychological assistance. The results supported the first part of the hypothesis; in particular, attitudes toward emotional expression were inversely
related to components of attitudes towards seeking psychological services and positively
to barriers to seeking professional psychological assistance. More specifically, as men’s
attitudes toward expressing emotion were more positive, the perceived stigma associated
with seeking professional psychological services decreased as did perceived barriers to
seeking mental health services. However, attitudes toward emotional expression were
not related to men’s intentions to seeking professional services or the expertness beliefs
related to services. The results also provided partial support for the second part of the
hypothesis as greater emotional expressiveness was related to lower perceived barriers to
help-seeking and greater tolerance for stigma related to seeking psychological services.
In addition, greater emotional expressivity and more positive attitudes toward displaying
emotions were related to lower need for emotional control in the context of counseling.
As with attitudes toward emotional expression, actual emotional expression was neither
related to intentions to seek psychological help, nor beliefs in the merits of seeking such
services (expertness beliefs).
In this study the relationship between men’s attitudes toward expressing emotion, their actual expression of emotion and barriers to and attitudes toward seeking assistance for psychological concerns were examined. It was hypothesized that there would be a relationship between men’s attitudes toward expressing emotion and actual emotional expression and one’s identified barriers to and attitudes toward seeking professional psychological assistance.

Specifically, it was expected that attitudes toward emotional expression would relate inversely to attitudes towards seeking psychological services and positively to barriers to seeking professional psychological assistance. Also, it was expected that actual emotional expressivity would relate positively to attitudes towards seeking professional psychological services and negatively to barriers to seeking professional psychological assistance. To test the hypotheses, a canonical correlation analysis (CCA) was performed on data received from 228 male students from a large Midwestern university.

The CCA yielded two functions deemed large enough to explain the proportion of the variance of the relationship between the two variable sets (i.e., 54% and 26%). Therefore, interpretations of the findings were based on these two functions. Function
1 revealed that the more negative men’s attitudes were toward expressing emotion and the lower their reported emotional expression, the lower was their tolerance for the stigma attached to seeking psychological help and the more barriers they perceived to seeking psychological help. Function 2 indicated that the lower men’s reported emotional expressivity and the more negative men’s attitudes regarding expression, the greater the men perceived the need for emotional control in the context of professional psychological services. These findings offer partial support for the hypothesis.

Partial support for the first (a) and the second (b) portion of the hypothesis was evidenced in the relationship displayed in Function 1 of the CCA. In support of the first section regarding attitudes toward emotional expression’s relationship on help-seeking, it was found that attitudes toward emotional expression were inversely related to stigma tolerance and positively to barriers to seeking professional psychological assistance. More specifically, the more negative attitudes men had toward expressing emotion, the more barriers to seeking professional psychological treatment they identified, namely need for control and self-reliance, concrete barriers and distrust of caregivers, need for privacy, and need for emotional control. However, attitudes toward emotional expression was not related to men’s intentions to seeking professional services, their expertness beliefs related to services, or minimizing problem and resignation as a barrier related to seeking services.

According to Joseph et al. (1994), attitudes toward expressing emotion consists of four dimensions: (1) beliefs about meaning; (2) beliefs about expression; (3) beliefs about consequences; and (4) behavioral tendencies. While beliefs about meaning refers to one’s belief that expressing emotion is a sign of weakness, beliefs about expression
describes the belief that the expression of emotion should be kept under control. Beliefs about consequences describes the belief that other people will be rejecting when emotion is expressed; behavioral tendencies refers to one’s tendency to be emotionally expressive or nonexpressive. These four factors are found to influence one’s overall attitudes toward emotional expression. Based on the findings of the current study, it can be stated that some men who believe that expressing emotion is a sign of weakness, emotions should be kept under control, there are negative consequences to expressing emotion to others and tend to be nonexpressive with their emotions perceive, more barriers involved in psychological help-seeking. These findings are not surprising given that research and theory have indicated that men are encouraged from an early age to suppress their emotions as emotional expression is related to femininity and weakness. Pleck (1981) suggested that boys and men internalize messages about what it means to be male, as well as understand what it means to be female. These messages teach that being emotionally expressive is related to femininity and weakness and should be avoided. This assertion was also found in research (O’Neil, 1981; Silverstein, Auerbach, & Levant, 2002). Therefore, it is possible that negative attitudes toward expressing emotion may reflect a fear about appearing feminine and weak, which may translate into views about seeking psychological help as that may be a sign of weakness and femininity as well.

Four barriers toward seeking psychological help appeared most greatly related to negative attitudes toward psychological help-seeking. Need for control and self-reliance reflects men’s need for autonomy and the tendency to act with reactance when autonomy is threatened. Gender role norms and stereotypes demand that men be strong and stoic, independent and self-sufficient (Solomon, 1982). Men may feel that seeking
psychological help is handing over their autonomy to another individual, which is akin to surrendering their masculinity. The need for emotional control dictates that men must keep their emotions under control and out of public view. Again, when socialized to believe that expressing emotion is a sign of weakness, suppression of emotion is sure to follow. Consequently, the view that expressing emotions is a sign of weakness may result in men developing negative attitudes toward emotional expressiveness. Though not directly explored in this study, negative attitudes toward expressing emotion might lead men to deny the existence of one’s emotional experience, thus affecting their ability to experience emotion.

Negative attitudes toward expressing emotion were also found in this study to be related to the need for privacy. As a barrier to psychological help-seeking, the need for privacy is concerned with the fear of appearing or being vulnerable (Mansfield et al., 2005). Thus, because vulnerability is a sign of weakness and femininity, not demonstrating it to others, such as a professional counselor, protects men from appearing less than strong. Lastly, this study found that negative attitudes toward expressing emotion was related to concrete barriers and distrust of caregivers, reflecting a lack of finances, insurance, transportation, knowledge about available help, and lack of trust in care providers preventing men from seeking psychological services. These barriers describe inaccessibility to reaching services and a general distrust and avoidance of professional help. Scholars have suggested in the research that negative attitudes towards psychological help-seeking as well as underutilization of services is related to lack of information about health care professionals and their credentials (Wood et al., 1986) and confusion related to the various mental health professionals (Faberman, 1997; Von
Sydow & Reimer, 1998). These results might indicate that the negative attitudes toward expressing emotion these men held is reflected in their lack of awareness of available mental health services and negative opinion about healthcare professionals.

Results of the present study also found that negative attitudes toward expressing emotion were related to lower tolerance for stigma associated with psychological help-seeking. The role of stigma in men’s psychological help-seeking has been studied previously (Komiya et al., 2000; Ægisdóttir et al., 2011) and findings suggest that stigma associated with seeking psychological services affects men’s decision to seek or not seek treatment. Corrigan (2004) suggested that stigma consists of both public stigma and self stigma. While public stigma refers to the negative views individuals have regarding persons who seek mental health services, self stigma refers to the internalization of negative stereotyped messages one inherits from seeking mental health services. In the current study, it was found that need for control and self-reliance, need for emotional control, need for privacy, and concrete barriers and distrust of caregivers were all highly related to the fear of the stigma attached to seeking psychological help.

Results of this study also indicated that in addition to attitudes toward expressing emotion, actual reported expression of emotion was related to perceived barriers to psychological help-seeking and lower tolerance for stigma associated with seeking psychological services. These results offer partial support for the second part of the study’s hypothesis (b). As stated previously, expressivity has been the most widely studied component of emotion and reflects the extent to which individuals outwardly display their emotions (Kring et al., 1994). The literature describes men as “unable to feel emotionally alive” (Brooks & Gilbert, 1995). Although this investigation did not
assess men’s ability to emotionally express themselves, it did investigate the relationship between reported emotional expressivity and barriers to and attitudes toward seeking professional psychological services. The findings suggest that less emotional expression in men is related to more negative attitudes to psychological help-seeking, in the form of stigma, and more perceived barriers to seeking psychological services. These findings support past research examining the relationship between emotional expression and help-seeking (Blazina & Watkins, 1996; Good et al., 1989). Yet, current findings suggest that the stigma associated with help-seeking seems to be the strongest component of help-seeking attitudes linked with emotional expression. Past research on emotional expression and psychological help-seeking has relied on instruments (ATSPPH scales; Fischer & Farina, 1995; Fischer & Turner, 1970) upon which attitudes are conceptualized as a unidimensional construct, whereas the current study employed a measure of attitudes that conceptualizes psychological help-seeking attitudes as having three dimensions: stigma tolerance, intent, and expertness (BAPS; Ægisdóttir & Gerstein, 2009). Based on the findings of the current investigation, it appears that stigma attached to seeking psychological services is the attitude component related to low emotional expression, rather than other components of the attitude construct. It appears, therefore, that men who are less emotionally expressive have a greater concern about how others might perceive them for seeking psychological services. Also, men who are less emotionally expressive may have a greater concern for being stereotyped or judged based on seeking help.

As stated earlier, function 2 of the canonical relationship discovered that the lower men’s reported emotional expressivity and the more negative men’s attitudes
regarding expression, the greater the men perceived the need for emotional control in the context of professional psychological services. Again, these results were in line with what was predicted and reflect previous findings (Berger et al., 2005; Komiya, Good, & Sherrod, 2000; O’Neil, 1981). Thus, emotional behavior and attitudes toward emotional expression were related to the need for emotional control as a deterrent to seeking psychological help. These findings may be suggestive of the negative consequences fear of emotion and masculine gender roles have, as they may deter men from seeking services that may benefit them (Lambert & Bergin, 1994; Smith, Glass, & Miller, 1980).

As discussed previously, not all emotion variables examined were related to men’s view of psychological help-seeking as conceptualized in the current study. For instance, men’s attitudes toward expressing emotion were not related to the need to minimize problems and resignation subscale of the BHSS, which measures barriers to help-seeking (Mansfield, et al. 2005). This subscale describes men’s tendency to not want to overreact to problems for fear that they are not serious enough. Thus, having negative attitudes toward expressing emotion was not related to the fear of overreaction to problems as a deterrent to seeking psychological help. Perhaps a complete denial of anything emotional allows men to minimize problems or not even realize them, which in turn may act as prevention against overreaction and looking foolish in others’ eyes.

In addition to fear of overreaction as a barrier to psychological help-seeking, attitudes toward emotional expression were neither linked to intent to seek services in the future nor beliefs in the expert services provided by mental health providers. Only the stigma associated with seeking help was related to attitudes toward emotional expression and actual emotion expression. Some items on the stigma tolerance subscales of the
BAPS (Ægisdóttir & Gerstein, 2009) reflect the idea that treatment will involve exploration into the client’s world and release of negative, pent up emotions. Thus, having negative attitudes toward expressing emotions and a low tendency toward expressing emotion may be reflected in men’s perception that any such exploration is uncomfortable for their self-image as well as the image they want others to have of them. Yet, the lack of link between the emotion variables to the attitude variables to the BAPS (intent and expertness factors) was not expected. This is the first study to examine emotion expression and attitudes toward expressing emotion in relation to a multidimensional conceptualization of psychological help seeking attitudes. Based on these findings, it appears that men’s views about emotion in this study were not directly related to intent to seek services in the future (e.g., “At some future time, I might want to see a psychologist”, BAPS; Ægisdóttir & Gerstein, 2009), suggesting that there are other predictors of men’s intention to seek help than their view of emotion expression. This is important information as it may challenge previous research suggesting that men’s view of emotions discourages them from seeking psychological services (Komiya et al., 2000). Perhaps the idea of seeking psychological services in the future is not out of the question for those men who tend to view emotion expression negatively in general and in therapy. Also, current findings suggested that men’s view of counselor expertness does not depend on men’s attitudes toward expressing emotion or actual emotional expression. It is important to note that past research has examined attitudes toward help-seeking by relying on an overall score representing attitudes toward seeking professional psychological service (i.e., ATSPPS, Fischer & Farina, 1995; Komiya et a., 2000), thus not being in a position to offer focused analysis of the specific component of the attitude
construct related to fear or aversion to emotion expression. Future research may assess attitudes toward seeking professional psychological services employing an instrument that targets other dimensions (e.g., BAPS, Ægisdóttir & Gerstein), including factors such as stigma tolerance, expertness, and the intent to seek services, in order to discover what aspects of men’s attitudes need to be targeted for them to approach seeking psychological help with a more open mind.

Considering Corrigan’s (2004) description of public and self stigma related to help seeking and Farina et al. (1966) suggestion that public stigma explains men’s underutilization of psychological services, it appears from this study that stigma beliefs revolving around psychological services were highly related to men’s views of emotion expression. This may be a reflection of Solomon’s (1982) theoretical depiction of the male gender role resulting in men’s “no sissy stuff” philosophy and the “sturdy oak” stance. “No sissy stuff” refers to the avoidance of anything feminine, including cognitions, behaviors, or affect. The “sturdy oak” stance demands that men must be confident, self-reliant, and incapable of feeling. From a socialization perspective, the tasks associated with psychological help-seeking, including relying on others, admitting that a problem exists, or recognizing and labeling an emotional problem, are incongruent with masculine ideologies.

Limitations

The results of the current investigation should be interpreted with caution due to the limitations regarding the nature of the study’s design. First, the relative lack of diversity among participants (e.g., Caucasian, heterosexual, U.S. citizens) and homogeneity of the sample (e.g., college students) increased the threat to external
validity. Therefore, generalizations to other populations are limited. In addition, the study was nonexperimental, utilizing a survey-type methodology at a single point in time, which indicates that causal inferences cannot be made. Due to the nature of the website utilized to collect data, counterbalancing the instruments was not possible. Therefore, order effect may have biased the data and limited the study’s internal validity. Although participants were assured of anonymity to reduce the likelihood of a socially desirable response set, the nature of self-report methodology did not guarantee honest responses.

Tabachnick and Fidell (2001) described theoretical limitations with using a canonical correlation analysis, including interpretability of the findings as “canonical solutions are often mathematically elegant but uninterpretable” (p. 179) because procedures that maximize correlation do not necessarily maximize interpretation of pairs of canonical variates. This was not a concern in the current study as measures were taken to select pairs of variables that were inherently and theoretically related (emotion variables and help-seeking variables) and were believed to have a linear relationship. This procedure made interpretation of the pairs of canonical variates and their relationship more comprehensible and interpretable. Although CCA is a correlational procedure that does not offer inferences about the causal relationships between the variable sets, the current study did not rely on causation, rather it relied on correlation.

Another limitation of the study may be the selection of instruments employed. Despite acceptable reliability and validity, the BAPS and BHSS are relatively new measures and the AEE and EES have received little attention or use in the literature. Therefore, further investigations that utilize these scales are suggested to support their validity. In addition, reliability of the BHSS subscale, Concrete Barriers and Distrust of
Caregivers, was compromised after changes were made to the instrument’s directions and five of its items; one of which was an item on this subscale. Reliability for this subscale was surprisingly low, though acceptable. In particular, Cronbach’s alpha of .61 was reported in the pilot study, and .60 in the main study, which is lower than the Cronbach’s alpha of .79 reported in the original study of the instrument (Mansfield et al., 2005). Items on this scale address concrete barriers to seeking psychological help and distrust of caregiver, including lack of money, health insurance and transportation, lack of knowledge of what sort of help is available and lack of trust in care providers. The lower alphas may have resulted from the items having little variance for college students (college students typically hold health insurance as a stipulation of enrollment and live on campus close to health and counseling services). Future research using college student populations should modify items reflecting this content in order to mirror concrete barriers that college students may confront. Also a limitation related to the use of the BHSS results from modifications made to its Privacy subscale. Specifically, item 27 of the original BHSS was changed from “I wouldn’t want someone of the same sex touching my body” to “I wouldn’t want someone getting close to me.” The modification was made to address the vulnerability one might fear from seeking psychological help and the gender component of the question (someone of the same sex) was deleted to make the question more general. However, the removal of the gender component of the question may have affected its validity as it relates to men’s fear of emotional connectedness with other men or their fear of being perceived as homosexual. Future studies employing the BHSS and the Privacy subscale should consider utilizing the original conception of the question and include a statement about getting close to someone of the same sex. Finally,
the 20 items of the AEE may not represent separate constructs. After a Principal Component Factor analysis was then conducted on the 20 AEE items without stipulation of the number of factors to be extracted, four factors were generated which corresponded to the 4 subscales. However, as stated previously, seven of the items loaded on two of the subscales at greater than .40. To account for this, Joseph et al. (1994) noted that they retained subscale items that had a loading higher than .47 on its respective factor and lower than .46 on the other factors. Although items should be positively related as they represent a higher order factor (attitudes toward emotional expression), items may not be different enough to represent separate constructs. Further investigations utilizing the AEE should be cautious when considering use of the subscales as representing separate constructs of attitudes toward emotional expression.

Finally, the sample of men in the current investigation was not divided based on previous counseling experience. Due to a limited sample size this was not considered feasible (146 men had no previous counseling experience; 81 men had previous counseling experience). It is suggested that future research examine the relationship between emotion expression and attitudes and psychological help-seeking attitudes separately for those with and without previous counseling experience, as it is conceivable that the relationship pattern of the two sets of variables examined in this study may have differed between those who had and had not sought psychological services in the past.

**Implications for Research, Theory, and Practice**

Findings from the present investigation have a number of research implications. Given the preliminary findings regarding the relationship between attitudes toward emotional expression, stigma tolerance, and barriers to seeking professional
psychological services, future research is needed to replicate and validate the results. Furthermore, the relationship among emotional expression, attitudes toward emotional expression, help seeking attitudes and intentions and barriers to help-seeking need to be examined using structural equation modeling guided by a theoretical framework.

Reports that men are born more emotionally expressive than their female counterparts provides credibility to the view that men are socialized to inhibit or restrict their emotional expression (O’Neil, 1981; Silverstein et al., 2002). More studies are needed that examine the messages men learned regarding expressing their emotions in the context of their families and peer groups and how expressive or nonexpressive they are currently with their emotions.

This was only one of a few studies that sought to identify perceived barriers to psychological help-seeking; such studies provide an important line of research to address men’s underutilization of psychological services. More studies utilizing the BHSS in relation to other gender related variables and personality variables are needed. Furthermore, studies are needed to enhance this scale in order to address barriers to help-seeking specific to the unique needs and attitudes of college males, men of color, and gay and bisexual men. This research could employ qualitative methods, such as focus groups with interviews, to help delineate these unique needs. Once these needs are identified, quantitative methods might be used to determine items for use in a survey, in which reliability and validity could then be addressed. Future research addressing barriers to help seeking and attitudes toward seeking psychological help in relation to emotion might also include a sample of women in order to evaluate whether differences among perceived barriers exist between men and women or whether the barriers of the need for
emotional control, the need for privacy, and the need for control and self-reliance are unique to men and if the relationship pattern discovered in the current study between emotion and help-seeking is unique to college males.

Though stigma has been found to be an important factor in attitudes toward seeking professional treatment (Komiya et al., 2000; Ægisdóttir et al., 2011), this was the first study to examine the relationship between attitudes toward expressing emotion and stigma related to seeking help. Therefore, it is recommended that future research continue to explore the relationship between attitudes toward expressing emotion and attitudes toward seeking professional psychological help. Additional research that addresses emotional socialization and gender role development in both men and women could provide researchers insight regarding how men and women are alike in their emotional expression, rather than how different they are. Also, future research is needed addressing the relation between men’s emotional experience and attitudes toward and barriers to psychological help-seeking, as emotional experience has been investigated less than expression as was done in the current study.

In addition to implications for research, the results from the present investigation may be applied to clinical practice. For instance, understanding that men might have negative attitudes toward expressing emotion could determine treatment approaches employed with men. Knowing that men are uncomfortable with expressing emotion, rather than having the inability to express emotion, might offer counselors and psychologists information regarding the inner worlds of men. Reluctance to and discomfort with expressing emotions can then be addressed and processed in the safety of the therapeutic environment, where men may be more inclined to explore the more risky
emotions reserved for their internal worlds. Greenberg (2008) described the importance of emotional processing to good therapy and the results of the current study highlight the importance of normalizing emotional experiences of men in order to reduce the stigma and fear attached to emotion. In addition, a multifaceted understanding of expression and nonexpression may provide further avenues to explore in clinical settings. For instance, Kennedy-Moore and Watson (1999) proposed looking at which disruptions at different points in the process of recognizing and naming an emotion results in nonexpression. While some men may deny the experience of emotion such that they do not recognize when physiological components of emotion are felt, other men may recognize that they do indeed express emotion, but because of social norms dictating when emotional expression is appropriate and inappropriate, they deny the experience. Thus, normalizing the fear regarding the expression of emotion in the context of another individual might provide men with greater confidence to explore their emotional worlds. Attitudes are partially determined by the evaluation of performing the behavior and by the perception of the social pressures to perform or not perform the behavior (subjective norm). Addressing these components of attitudes with men who restrict their emotional expression may normalize their feelings and enhance their attitudes.

Men underutilize therapy. Providing education about what counseling entails prior to the onset of therapy may be beneficial. For instance, advertisement of counseling services, through the use of written material (brochures) and video tours of a counseling center and mock counseling sessions, may help to reduce potential fears regarding the counseling process (Ægisdóttir et al., 2011). Hammer and Vogel (2010) found that gender-specific, male-sensitive brochures that incorporated information regarding men
and masculinity, improved participants’ attitudes and reduced their stigma toward seeking counseling. In addition, discussing negative attitudes and fears about counseling at the beginning of therapy, especially with men seeking services for the first time, may help to dispel myths and barriers, and enhance attitudes toward counseling (Ægisdóttir et al., 2011). To combat negative stigma associated with seeking psychological help and attitudes toward expressing emotion, emotion education and exploration in therapy should be addressed in the first session, and/or in advertising material.

Because gender roles have been suggested to have an impact on how individuals function both intrapersonally and interpersonally (Silverstein et al., 2002), understanding gender roles in the context of psychological help-seeking offers suggestions of how to address men’s needs in therapy. In addition, gender roles influence how, when, and to what degree emotions should be and are expressed. The gender-role socialization paradigm offered by Pleck (1981) describes the internalized cultural messages men and boys acquire regarding what is considered masculine and feminine through interactions with society. The findings from the current investigation have implications for theory regarding men, emotional expression, and psychological help-seeking attitudes. In particular, it might be found that stigma related to psychological help-seeking and stigma regarding the expression of emotion might be related on a different factor, which is determined by gender-role socialization.

Conclusions

An examination of the relation between emotional expression, attitudes toward emotional expression, psychological help-seeking attitudes and intentions and barriers to help-seeking was conducted. It was revealed that attitudes toward expressing emotion
and actual emotional expression were related to attitudes toward seeking psychological help, in the form of stigma tolerance, and some barriers to seeking professional psychological treatment, including the need for control and self-reliance, concrete barriers and distrust of caregivers, the need for privacy, and the need for emotional control. These findings are in line with previous research (Good, et al. 1989; Mansfield et al., 2005; Silverstein et al., 2002) as well as theoretical approaches (Addis & Mahalik, 2003; O’Neil, 1981; Pleck, 1995; Pollack & Levant, 1998; Solomon, 1982). Further research that includes a multidimensional approach to measuring attitudes toward seeking psychological assistance is encouraged. In addition, it is also suggested that men’s experience of emotion be addressed in future research to examine the relationship between men’s experience of emotion, their expression of emotion, and their attitudes toward expressing emotion. In addition, further research is needed to substantiate current results.

As in every study, there are inherent and sometimes unforeseen limitations involved. Despite its limitations, this study provided insight into the study of emotion, attitudes toward expressing emotion, and attitudes toward and barriers related to seeking professional psychological services. In particular, a strong relationship was found between attitudes toward expressing emotion and stigma associated with help-seeking. In addition, attitudes toward expressing emotion and actual emotion expression were linked to barriers to seeking psychological services, which offers insight into the complexity of men’s emotional behaviors. Men have often been considered less emotionally expressive than women (Fischer, et al. 2004; Heesacker, et al. 1999; Kelly & Hall, 1992; Kring & Gordon, 1998) which may be due to their fear of appearing feminine and vulnerable
(Pleck, 1981). However, addressing their emotional world may be just as detrimental as avoiding it. For instance, Pleck (1995) identified three varieties of male gender role strain, labeled discrepancy-strain, dysfunction strain, and trauma-strain, that described the difficulties men have when they do or do not adhere to the concept of masculinity. Whereas discrepancy strain results from not living up to the internalized ideal of manhood, dysfunction strain results when one fulfills the requirements of maleness as those elements considered desirable in men can have negative side effects on the men themselves and on those close to them. Finally, trauma strain results from the ordeal of the male role socialization process. The GRSP recognizes that, although violating gender roles has negative consequences for both men and women, the consequences are more severe for men. Pleck also noted that violating sex roles and fulfilling sex roles cause adverse consequences. The concept of the GRSP helps to explain the negative attitudes men have toward expressing emotion and the negative stigma they find associated with help-seeking. In addition, the GRSP may provide counseling psychologists with information regarding where they might intervene to address men’s issues and promote the utility of expressing emotion and encourage men to take the risk and explore their “feminine” side.
REFERENCES


APPENDIX A

Demographic Questionnaire

Instructions
Please answer the following questions about yourself. Either circle or fill in your responses accordingly.

1. What is your sex? Please circle.
   1. Female
   2. Male

2. What is your present year in school? Please circle.
   1. Freshman
   2. Sophomore
   3. Junior
   4. Senior
   5. Other: ______________

3. What is your age? ___________

4. What is your major area of study? ______________________________________

5. What is your race? Please circle.
   1. African American
   2. White/Caucasian
   3. Hispanic or Latino
   4. Native American/Alaskan Native
   5. Asian or Pacific Islander
   6. Biracial: __________ and __________
   7. Other: ___________________________

6. Are you…
   1. A U.S. student?
   2. An International student?

   1. Straight
   2. Gay
   3. Lesbian
   4. Bisexual
   5. Questioning

8. Have you ever seen a counselor / psychologist for vocational problems? Please circle.
   1. Yes
   2. No

9. How many times have you seen a counselor / psychologist for vocational problems? (Not number of sessions, but number of times you sought their services). ________
10. Have you ever seen a counselor / psychologist for personal problems? **Please circle.**
   1. Yes
   2. No

11. How many times have you seen a counselor / psychologist for personal problems? (Not number of sessions, but number of times you sought their services). ________

12. If you had a mental health concern or a personal problem, where would you seek assistance? List the most preferable location first followed by the second most preferable location, and so on.

   1. _____________________
   2. _____________________
   3. _____________________
   4. _____________________
   5. _____________________
EMOTION AND PSYCHOLOGICAL HELP-SEEKING IN MEN

APPENDIX B

Emotional Expressivity Scale (EES)

DIRECTIONS: The following statements deal with you and your emotions. Please select a number from the following scale that best describes YOU in each of the statements and place the number in the blank provided.

<table>
<thead>
<tr>
<th>Never True</th>
<th>Rarely True</th>
<th>Occasionally True</th>
<th>Usually True</th>
<th>Almost Always True</th>
<th>Always True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

1. _____ I don’t express my emotions to other people.
2. _____ Even when I’m experiencing strong feelings, I don’t express them outwardly.
3. _____ Other people believe me to be very emotional.
4. _____ People can “read” my emotions.
5. _____ I keep my feelings to myself.
6. _____ Other people aren’t easily able to observe what I’m feeling.
7. _____ I display my emotions to other people.
8. _____ People think of me as an unemotional person.
9. _____ I don’t like to let other people see how I am feeling.
10. _____ I can’t hide the way I am feeling.
11. _____ I am not very emotionally expressive.
12. _____ I am often considered indifferent by others.
13. _____ I am able to cry in front of other people.
14. _____ Even if I am feeling very emotional, I don’t let others see my feelings.
15. _____ I think of myself as emotionally expressive.
16. _____ The way I feel is different from how others think I feel.
17. _____ I hold my feelings in.
### Attitudes toward Emotional Expression (AEE)

<table>
<thead>
<tr>
<th>Disagree Very Much</th>
<th>Somewhat agree</th>
<th>Agree Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

1. I think you should always keep your feelings under control. 0 1 2 3 4
2. I think you ought not to burden other people with your problems. 0 1 2 3 4
3. I think getting emotional is a sign of weakness. 0 1 2 3 4
4. I think other people don’t understand your feelings. 0 1 2 3 4
5. When I’m upset I bottle up my feelings. 0 1 2 3 4
6. You should always keep your feelings to yourself. 0 1 2 3 4
7. Other people will reject you if you upset them. 0 1 2 3 4
8. My bad feelings will harm other people if I express them. 0 1 2 3 4
9. If I express my feelings I’m vulnerable to attack. 0 1 2 3 4
10. You should always hide your feelings. 0 1 2 3 4
11. When I’m upset I usually try to hide how I feel. 0 1 2 3 4
12. I seldom show how I feel about things. 0 1 2 3 4
13. Turning to someone else for advice or help is an admission of weakness. 0 1 2 3 4
14. It is shameful for a person to display his or her weaknesses. 0 1 2 3 4
15. I should always have complete control over my feelings. 0 1 2 3 4
16. If other people know what you are really like, they will think less of you. 0 1 2 3 4
17. When I get upset, I usually show how I feel. 0 1 2 3 4
18. People will reject you if they know your weaknesses. 0 1 2 3 4
19. If a person asks for help, it is a sign of weakness. 0 1 2 3 4
20. I don’t feel comfortable showing my emotions. 0 1 2 3 4
APPENDIX D

Original Barriers to Help-Seeking Scale (BHSS)

There are a variety of reasons why people choose to seek help or not seek help from doctors, nurses, or other medical professionals. We’re interested in the sorts of reasons why you might choose not to seek help for a particular problem.

Imagine that you begin to experience some pain in your body. The pain is not so overwhelming that you can’t function. However, it continues for more than a few days and you notice it regularly. You consider seeking help from a medical doctor or other clinician at the student health center.

How likely would you be to seek help for this health problem? (Please circle a number to indicate your answer).

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all likely</td>
<td>Somewhat likely</td>
<td>Extremely likely</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Below are some reasons why you might not seek help. Please read each reason and decide how important it is in keeping you from seeking help. If you think that a reason is very important in keeping you from seeking help, you should circle a 4. If you think that a reason is not at all important, you should circle a zero. You can also circle any number in between to indicate how important a reason is for not seeking help.

<table>
<thead>
<tr>
<th>Reason</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I would think less of myself for needing help.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. The problem wouldn’t seem worth getting help for.</td>
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<td></td>
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<tr>
<td>3. People typically expect something in return when they provide help.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Privacy is important to me, and I don’t want other people to know about my problems.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. I don’t like to get emotional about things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I don’t like other people telling me what to do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. The problem wouldn’t be a big deal; it would go away in time. 0 1 2 3 4
8. I would have real difficulty finding transportation to a place where I can get help. 0 1 2 3 4
9. This problem is embarrassing. 0 1 2 3 4
10. I don’t like to talk about feelings. 0 1 2 3 4
11. Nobody knows more about my problems than I do. 0 1 2 3 4

<table>
<thead>
<tr>
<th>Not at all a reason</th>
<th>Very important reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>4</td>
</tr>
</tbody>
</table>

12. I wouldn’t want to overreact to a problem that wasn’t serious. 0 1 2 3 4
13. I wouldn’t know what sort of help was available. 0 1 2 3 4
14. I don’t want some stranger touching me in ways I’m not comfortable with. 0 1 2 3 4
15. I’d rather not show people what I’m feeling. 0 1 2 3 4
16. I’d feel better about myself knowing I didn’t need help from others. 0 1 2 3 4
17. Problems like this are part of life; they’re just something you have to deal with. 0 1 2 3 4
18. Financial difficulties would be an obstacle to getting help. 0 1 2 3 4
19. I don’t like taking off my clothes in front of other people. 0 1 2 3 4
20. I wouldn’t want to look stupid for not knowing how to figure this problem out. 0 1 2 3 4
21. I don’t like feeling controlled by other people. 0 1 2 3 4
22. I’d prefer just to suck it up rather than dwell on my problems. 0 1 2 3 4
23. I don’t trust doctors and other health professionals. 0 1 2 3 4
24. I wouldn’t want someone of the same sex touching my body. 0 1 2 3 4
25. It would seem weak to ask for help. 0 1 2 3 4
26. I would prefer to wait until I’m sure the health problem is a serious one. 0 1 2 3 4
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>A lack of health insurance would keep me from seeking help.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>28</td>
<td>I like to make my own decisions and not be too influenced by others.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>29</td>
<td>I like to be in charge of everything in my life.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>30</td>
<td>Asking for help is like surrendering authority over my life.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>31</td>
<td>I do not want to appear weaker than my peers.</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>
APPENDIX E

Revised Barriers to Help-Seeking Scale

Barriers to Help-Seeking Scale (BHSS)

There are a variety of reasons why people choose to seek help or not seek help from mental health professionals. I am interested in the sorts of reasons why you might choose not to seek help for a particular problem.

Imagine that you begin to experience episodes of anxiety or depression that last more than a little while. Every day you are feeling either very anxious, very down, or lacking interest in things you used to enjoy. In addition, you begin to experience symptoms such as having difficulty sleeping, worrying quite a bit, changes in your appetite, or an overall increase in your level of stress. Imagine that these experiences continue most of the time for at least two weeks.

How likely would you be to seek help for this health problem? (Please circle a number to indicate your answer).

1. Not at all likely
2. Somewhat likely
3. Somewhat likely
4. Very likely
5. Extremely likely

Below are some reasons why you might not seek help. Please read each reason and decide how important it is in keeping you from seeking help. If you think that a reason is very important in keeping you from seeking help, you should circle a 4. If you think that a reason is not at all important, you should circle a zero. You can also circle any number in between to indicate how important a reason is for not seeking help.

<table>
<thead>
<tr>
<th>Reason</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I would think less of myself for needing help.</td>
<td></td>
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<tr>
<td>2. The problem wouldn’t seem worth getting help for.</td>
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<tr>
<td>3. People typically expect something in return when they provide help.</td>
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<tr>
<td>4. Privacy is important to me, and I don’t want other people to know about my</td>
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</tr>
</tbody>
</table>


problems.

5. I don’t like to get emotional about things. 0 1 2 3 4

6. I don’t like other people telling me what to do. 0 1 2 3 4

7. I wouldn’t want to overreact to a problem that wasn’t serious. 0 1 2 3 4

<table>
<thead>
<tr>
<th>Not at all a reason</th>
<th>Very important reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

8. The problem wouldn’t be a big deal; it would go away in time. 0 1 2 3 4

9. I would have real difficulty finding transportation to a place where I can get help. 0 1 2 3 4

10. This problem is embarrassing. 0 1 2 3 4

11. I don’t like to talk about feelings. 0 1 2 3 4

12. Nobody knows more about my problems than I do. 0 1 2 3 4

13. I wouldn’t know what sort of help was available. 0 1 2 3 4

14. I don’t want some stranger knowing things about me that I’m not comfortable with. 0 1 2 3 4

15. I’d rather not show people what I’m feeling. 0 1 2 3 4

16. I’d feel better about myself knowing I didn’t need help from others. 0 1 2 3 4

17. Problems like this are part of life; they’re just something you have to deal with. 0 1 2 3 4

18. Financial difficulties would be an obstacle to getting help. 0 1 2 3 4

19. I don’t want to talk about intimate matters with other people. 0 1 2 3 4

20. I wouldn’t want to look stupid for not knowing how to figure this problem out. 0 1 2 3 4

21. I don’t like feeling controlled by other people. 0 1 2 3 4

22. I’d prefer just to suck it up rather than dwell on my problems. 0 1 2 3 4

23. I don’t trust counselors and other mental health professionals. 0 1 2 3 4
24. I wouldn’t want someone getting close to me.  
25. It would seem weak to ask for help.  
26. I would prefer to wait until I’m sure the problem is a serious one.  

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all a reason</td>
<td>Very important reason</td>
<td></td>
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<td></td>
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</tbody>
</table>

27. A lack of health insurance would keep me from seeking help.  
28. I like to make my own decisions and not be too influenced by others.  
29. I like to be in charge of everything in my life.  
30. Asking for help is like surrendering authority over my life.  
31. I do not want to appear weaker than my peers.  

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
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<th>4</th>
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</thead>
</table>
APPENDIX F

Beliefs about Psychological Services (BAPS)

Instructions: Please read the following statements and rate them using the scale provided. Place your ratings to the left of each statement by recording the number that most accurately reflects your attitudes and beliefs about seeking psychological help. There are no “wrong” answers, just rate the statements as you honestly feel or believe. It is important that you answer every item.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If a good friend asked my advice about a serious problem, I would recommend that he/she see a psychologist.</td>
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<td>2. I would be willing to confide my intimate concerns to a psychologist.</td>
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<td>3. Seeing a psychologist is helpful when you are going through a difficult time in your life.</td>
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<td>4. At some future time, I might want to see a psychologist.</td>
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<td>5. I would feel uneasy going to a psychologist because of what some people might think.</td>
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<td>6. If I believed I was having a serious problem, my first inclination would be to see a psychologist.</td>
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<td>7. Because of their training, psychologists can help you find solutions to your problems.</td>
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<td>8. Going to a psychologist means that I am a weak person.</td>
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<td>9. Psychologists are good to talk to because they do not blame you for the mistakes you have made.</td>
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<td>10. Having received help from a psychologist stigmatizes a person's life.</td>
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<td>11. There are certain problems that should not be discussed with a stranger such as a psychologist.</td>
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<td>12. I would see a psychologist if I was worried or upset for a long period of time.</td>
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<tr>
<td>13. Psychologists make people feel that they cannot deal with their problems.</td>
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<td>14. It is good to talk to someone like a psychologist because everything you say is confidential.</td>
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<td>15. Talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.</td>
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</table>
16. Psychologists provide valuable advice because of their knowledge about human behavior.

17. It is difficult to talk about personal issues with highly educated people such as psychologists.

18. If I thought I needed psychological help, I would get this help no matter who knew I was receiving assistance.
APPENDIX G

Invitation to Participate in Research and Informed Consent

Dear Ball State University Student,

My name is Scott G. Olenick and I am a doctoral student in Counseling Psychology and Guidance Services at Ball State University. I am completing my doctoral dissertation and am requesting your assistance. I am working under the supervision of Dr. Stefánía Ágisdóttir. I would like to invite you to participate in a brief study on the relationship between emotional expressiveness and psychological help seeking. In particular, I am examining the relationship between emotional experience and emotional expression and attitudes toward seeking psychological assistance.

I understand that your time is extremely valuable and that mine may not be the first research project you have been asked to complete this year. Therefore, I have designed this study to take as little time as possible and to be convenient for you. The survey is available on-line and should take you approximately 15 minutes to complete. Upon completion of this study, you will have the opportunity to be randomly selected to receive a $100 Visa gift card in addition to receiving research participation credit if you are currently enrolled in a class in the Counseling Psychology and Guidance Services (CPSY) department. Providing this incentive is just one way to say “thank you” for taking time to complete this questionnaire. This selection of the $100 gift card will be held on August 15, 2010.

Your privacy is important to me, and your survey responses will be anonymous. No names or emails will be tracked when using the on-line survey assistant as no IP addresses will be gathered. Any information you provide for the random selection for the $100 gift card and/or for CPSY research credit will be kept confidential. The results will not be linked to your program or department and professors in your program will not have access to any survey data.

To participate in this survey simply click on the survey link below and follow the on-screen instructions. I will be happy to answer any questions that you have. Just address them to scottgolenick@gmail.com. Thank you in advance for your time and input in this study. If you have previously completed the study, please do not continue.

To take the survey click on the following link:
http://www.surveymonkey.com/s/XCCRDGH.

Sincerely,
Scott G. Olenick, M.A.
Counseling Psychology and Guidance Services
Ball State University
scottgolenick@gmail.com
Informed Consent

Information for the Participant
Barriers to Seeking Mental Health Services

The purpose of this study is to examine self-identified barriers to seeking professional mental health services. For this study you will be asked to complete five questionnaires, one relating to demographic information, two involving questions related to barriers to seeking mental health services and two related to emotional expression. This study requires approximately 15 minutes in order to complete.

All of the information obtained will be confidential. As such, there will be no way to identify individuals by the information they provide. Furthermore, all the information gathered will be transformed into numerical data that will be kept in a secure location to which no one but I will have access. This data will be kept only for the duration necessary to complete the study.

One benefit that you might gain from participating in the study is the knowledge of the availability of mental health services. In addition, you will receive research credit for your involvement in this study. At the end of the final survey, you will be provided with information regarding how to enter your name into a raffle for a chance to win a $100 Visa gift card.

Any foreseeable risks or ill effects from participating in the study may be the result of answering questions on the questionnaires that revisit memories of difficult times or events that may have been unpleasant for you. Should you experience any feelings of anxiety or discomfort you may visit the Counseling and Psychological Services Center in Lucina Hall, (765) 285-1736.

Your participation in this study is completely voluntary and you are free to withdraw from the study at any time for any reason without penalty or prejudice from the investigator.

For your rights as a research participant, you may contact the following department: Sponsored Programs Office, Ball State University, Muncie, Indiana, 47306, (765) 285-1600, spo@bsu.edu.

If you are completing this survey to fulfill research requirement and/or would like to be entered into the lottery to win the $100 Visa gift card, please follow the instructions on the final page.

IF YOU WISH TO CONTINUE, CLICK "NEXT" ON THE BOTTOM OF THE PAGE.

Principal Investigator:
Scott G. Olenick, M.A., Doctoral Candidate