THE PROBLEM AND THE SOLUTION: EXPLORING FACTORS RELATED TO MASCULINITY AND SELF-STIGMA ASSOCIATED WITH SEEKING PSYCHOLOGICAL HELP

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Dissertation

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ABSTRACT

Research has widely found that masculinity is negatively associated with men's help-seeking self-stigma, attitudes, and intentions (Mahalik & Di Bianca, 2021; McDermott et al., 2018; Ramaeker & Petrie, 2019). Recently, research has begun exploring how other factors such as emotional expression, disclosure, and shame might be contributing to that relationship (Buhrmester et al., 1988; O'Loughlin et al., 2018; Wong et al., 2006). Using a diverse sample of participants, the present study revealed multiple bivariate correlations that indicate relationships between most variables. Unfortunately, no significant race-related differences were uncovered in either partial or moderation analyses despite hypotheses. Multiple path analysis models were conducted with Emotional Control and Self-Reliance being run separately.

Results indicated significant relationships between Emotional Control and Self-Reliance to NMA and Threatened Masculinity Related Shame (TMRS). Emotional Control was related to Disclosure as hypothesized; however, Self-Reliance was not. NMA and TMRS were found to be significantly related to feelings of inadequacy and deficiency for both Emotional Control and Self-Reliance models. Contrary to expectations, Disclosure failed to be related to Inadequacy and Deficiency in both models. In both models, Inadequacy and Deficiency was significantly related to Self-Stigma Associated with Seeking Psychological Help. To account for possible confounding variables, Psychological Well-being was inserted in both Emotional Control

and Self-Reliance models. Even after accounting for Psychological Well-being the relationships in both models remained with the exception of Self-Reliance and TMRS which became insignificant. Interestingly, in both models, Disclosure became significantly and positively related to feelings of inadequacy and deficiency. The findings of this study provided many new findings not yet uncovered in current research and were also consistent with previous literature in areas already examined (Levant et al., 2014; Levant & Parent, 2019). Several implications for future therapeutic interventions and contributions to research in the study of men and masculinities were discussed.

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CHAPTER I

INTRODUCTION

Research has recently studied men's help-seeking attitudes (i.e., one's beliefs about seeking help) and intentions (i.e., whether one plans to seek help). For example, in a review of the research spanning from the 1970s to the early 2000s, Addis and Mahalik (2003) found that men were less likely than women to seek both psychological and medical help across racial, ethnic, and age groups. More current research indicates that men continue to struggle with seeking psychological help (Mahalik & Di Bianca, 2021; McDermott et al., 2018; Ramaeker & Petrie, 2019). Research has been trying to understand why this might be the case. One possibility is self-stigma associated with seeking psychological help. For example, a meta-analysis of help-seeking literature found that stigma was considered the fourth highest barrier to help-seeking with men, younger people, ethnic minorities, military, and health professionals reporting the most stigma (Clement et al., 2015). Within the stigma barrier, they found that shame and disclosure concerns were the most prominent.

There are two identified types of stigma, self-stigma and public stigma (Corrigan, 2004). Public stigma is how others (e.g., friends, family, strangers, acquaintances) think about or react to another person. It is through this stigma that stereotypes, prejudice, and discrimination may arise. By contrast, self-stigma is how one reacts to the self, such as feeling as if there is something wrong with them or that they are somehow inferior to

everyone else. The present study will evaluate men's self-stigma associated with seeking psychological help. Self-stigma was consistently shown in masculinity literature to be a significant barrier to seeking help (Clement et al., 2015; Mahalik & Di Bianca, 2021; McDermott et al., 2017; Pederson & Vogel, 2007; Vogel et al., 2006; Vogel et al., 2011; Wood et al., 2017). Men might hold higher self-stigma than women because of the perceived need to solve their problems on their own, which was shown in a national population study (Mojtabai et al., 2011). In masculinity research, the tendency for one to want to solve problems on their own is called Self-Reliance and is generally found to be negatively associated with help-seeking (Johnson et al., 2012; Mahalik & Di Bianca, 2021; McDermott et al., 2018).

This chapter aimed to provide an introduction to the current study, which examined masculinity and self-stigma associated with seeking psychological help. Specifically, this project examined two norms of masculinity, Emotional Control and Self-Reliance, which have been linked to negative mental health and negative psychological help-seeking attitudes (Wong et al., 2017). Furthermore, it aimed to explore how other factors, such as men's disclosure of their problems to others, difficulty identifying and expressing emotions (i.e., alexithymia), shame associated with one's masculinity being threatened, and feelings of inadequacy and deficiency interacted to predict men's self-stigma associated with seeking psychological help. First, I will discuss several theories that contribute to emotions and masculinity and how masculinity socialization impacts men's emotional expression and their ability to ask for help. Second, I will introduce the concept of Normative Male Alexithymia (NMA; Levant 1992, 1995) and its relationship with emotion theory. Third, I will review the connections

among masculinity, emotions, and disclosure. Fourth, I will introduce shame and how masculinity can lead to feelings of inadequacy and deficiency (one aspect of shame; Cook, 1988). I will then discuss a more recent concept called threatened masculinity and how shame can be directly related to one's masculinity as well as general feelings of inadequacy and deficiency. Finally, I will summarize the present study and related hypotheses.

Masculinity Theory

The most widely accepted theory of masculinity is the Gender Role Strain Paradigm (GRSP; Pleck 1981, 1995). The GRSP replaced an older and inaccurate theory called the Gender Role Identity Paradigm (GRIP; Terman & Miles, 1936). The GRIP was an essentialist idea which stated that masculinity and femininity were naturally inherent within men and women (Bohan, 1993). By contrast, the GRSP posits that masculinity and femininity are social constructs that are taught and reinforced throughout childhood development and until death (Pleck, 1981, 1995).

The socialization process required to become masculine has been determined by literature to have detrimental effects, including the emotional stunting of boys. For instance, the process of teaching boys to forgo emotions in favor of stoicism has been shown by fathers minimizing their sons' emotions at a young age (O'Neil, 2008). It has also been identified to occur during formative school years during which boys' emotions are often monitored by their peers (Reigeluth & Addis, 2016). It is possible that this socialization process prevents boys from feeling and understanding their emotions and instills a need to be appropriately masculine. Unfortunately, very few men feel as if they

can do so to the extent perceived to be expected by society and can feel significant distress as a result, a term Pleck called discrepancy strain (Pleck, 1995). Pleck identified two other strains in addition to discrepancy strain: trauma strain (e.g., that the socialization process is traumatic) and dysfunction strain (e.g., gender norms are inherently negative and therefore cause negative effects), which will be discussed in more detail in Chapter II.

A second popular masculinity theory in the help-seeking literature is the Gender Role Conflict Theory (GRC; O'Neil, 1981). Based on the GRSP, the GRC discusses the various gender role conflicts that arise throughout one's lifetime such as marriage, having children, or getting a new job. O'Neil et al. (1986) believed that the core of masculinity was a fear of appearing feminine. This fear would incite men to behave opposite of what was considered feminine (e.g., being tough, emotionless, and self-reliant). The GRC was traditionally operationalized by the Gender Role Conflict Scale (GRCS; O'Neil et al., 1986), now the Gender Role Conflict Scale – Short Form (GRCS-SF; Wester et al., 2012), which allows researchers to quantitatively measure masculinity based on Pleck's (1981, 1995) GRSP theory. The GRC theory has been used in multiple studies examining men's help-seeking (Berger et al., 2005; Levant et al., 2013; O'Neil, 2008; Pederson & Vogel, 2007; Simonsen et al., 2000).

In addition to the GRCS, numerous other masculinity measures have been created. One of the most popular is the Male Role Norms Inventory (MRNI; Levant, 1992). In contrast to the GRCS, which measures gender role conflict, the MRNI measures traditional masculinity ideology (TMI). TMI assesses one's adherence to male role norms

(e.g., “A man should have home improvement skills”). Like the GRCS, the MRNI has been used often in help-seeking literature (Berger et al., 2015; Gerdes et al., 2018; Johnson et al., 2013; Levant et al., 2013; Yousaf et al., 2015). This literature has found that high levels of TMI are associated with low levels of help-seeking.

The final masculinity theory is Mahalik’s gender norms model (2000) that underlies the Conformity to Male Norms Inventory (CMNI; Mahalik et al., 2003) which will be used in the current study. Unlike the masculinity theories that came before, the gender norms model discusses the sociocultural influences dictated by the most powerful in society (e.g., White, male, heterosexual, Christian). It states that these norms are communicated to all other members of society. However, because the gender norms are based in the dominant culture, gender norms for men of differing racial, SES, ethnic, religious, sexual, or gender orientations will be experienced differently. Failure to conform to masculine norms is allegedly met with resistance by the dominant culture according to this theory. It is through the CMNI that emotional control and self-reliance will be measured. The CMNI offers eight other factors of masculinity, which are (1)Winning, (2) Violence, (3) Heterosexual Self-Presentation, (4) Power Over Women, (5) Primacy of Work, (6) Pursuit of Status, (7) Playboy, and (8) Risk-Taking which will be discussed in the next chapter. Whereas the MRNI measured attitudes and beliefs about masculine norms, the CMNI assesses for one’s level of conformity to masculine norms and to what extent they behave according to gender norms (e.g., “I never ask for help”). The CMNI has been a very popular measure in help-seeking literature and has been used in more help-seeking studies than previous masculinity measures (Berger et al., 2013; Herbst et al., 2014; Levant et al., 2009; Mahalik et al., 2003; Mahalik & Di Bianca, 2020;

McDermott et al., 2018; Ramaeker & Petrie, 2019; Vogel et al., 2011; Wong et al., 2017). The findings associated with CMNI and help-seeking mirror those of TMI and help-seeking in which higher levels of CMN are related to lower levels of help-seeking.

As mentioned above, men are socialized to control and suppress their emotions. In addition to this, men are often taught to be self-reliant (e.g., to never ask for help). Over the last twenty years, research has consistently found negative relationships between Emotional Control and Self-Reliance with men's help-seeking attitudes and intentions (Johnson et al., 2012; Mahalik et al., 2003; Mahalik & Di Bianca, 2021; McDermott et al., 2018; Wong et al., 2017). In addition to help-seeking issues, mental health issues also seem to arise out of conforming to masculine norms, aligning with Pleck's dysfunction strain (1981, 1995). For example, Self-Reliance has also been discovered to be positively related to negative mental health as men typically wait until their condition is so severe that they are forced to enter into treatment (Johnson et al., 2012; Levant et al., 2013). Research has found that, out of the 11 factors of the CMNI, Emotional Control and Self-Reliance were found to be the most robust inverse predictors of men's intentions to seek help (McDermott et al., 2018). Most recently, it was found that Self-Reliance and Emotional Control were predictive of greater self-stigma for seeking psychological help (Mahalik & Di Bianca, 2021). The masculinities theories introduced in this section were created in the image of the dominant culture (e.g., White, heterosexual, male, cisgender). To understand masculinity within racially diverse populations it is important that we discuss the role of intersectionality and how masculinity is conceptualized and experienced for men of color. In the next section, I will introduce the concept of

intersectionality and briefly describe the unique aspects of masculinity for Black/African American men, Hispanic/Latino American men, and Asian American men.

Hegemonic Masculinity and Intersectionality

The field of men and masculinities has been criticized for its lack of attention to underprivileged populations and its overemphasis on the dominant culture (Connell & Messerschmidt, 2005). *Hegemony* refers to "power that is won and held" (Carrigan et al., 1985, p. 594), and the term *hegemonic masculinity* arose from sociologists in the 1980s (Kessler et al., 1982) and posits that masculinity reinforces a gender hierarchy of masculinity over femininity and heterosexual masculinity over sexual minority masculinities (Carrigan et al., 1985; Messerschmidt, 2019). Most recent literature has also examined the impact that gender fluid, expansive, and non-binary identities have on the hegemonic social structure (Anderson, 2020). Hegemonic masculinities not only reinforce a gender order but also a class order in which "men's work" is often more valued and higher paid than jobs considered to be "women's work" (Carrigan et al., 1985). In addition, hegemonic masculinities reinforce that individuals identifying as a sexual minority should be barred from certain jobs (e.g., teaching; Carrigan et al., 1985). The popularization of research on hegemonic masculinity helped push current research to begin moving away from only studying masculinity through one cultural lens (Rogers et al., 2015; Thompson & Bennett, 2015; Vogel et al., 2011). Reformations of the concept of hegemonic masculinity expanded to include the intersectionality of gender and other identities such as race, ethnicity, class, sexuality, and nation (Messerschmidt, 2019). Consequently, it is imperative that the concept of intersectionality be understood.

Intersectionality is the intersection of a person's various identities (e.g., race, sexual orientation, class, ability status, ethnicity, religion, gender, nationality, age) as it relates to societal power structures (Collins, 2015). According to Collins (2015), each identity is considered as either privileged or oppressed based on what is valued in a particular culture. The idea of intersectionality is an understanding that these numerous identities are not mutually exclusive but integrated and reciprocal in nature. The current study will be examining masculinity in a sample of racially diverse men. The theory of intersectionality states that how a Black American man experiences masculinity will be different from how an Asian American man or a Latino American man will experience masculinity because each holds an oppressed racial identity that brings with it unique cultural context, social situations, and systemic barriers. The cultural context and social situations are often based on the values that an oppressed identity holds contrasted with hegemonic ideologies, or ideals valued by the dominant culture (Collins & Bilge, 2020). I will now briefly introduce some of the unique contexts and barriers inherent in how racially diverse men experience and conceptualize masculinity, beginning with Black/African American men, then Hispanic/Latino American men, and ending with Asian American men.

Masculinities in Racially Diverse Populations

Although the majority of masculinity theory and research has been completed on White, heterosexual men, the research on masculinities within racially diverse populations demonstrates many differences and similarities to the hegemonic group. The first major difference is context, or how men of color are treated and perceived in contrast

to White men. For Black/African American men, years of oppression and discrimination have influenced negative attitudes around Black masculinities that are often considered hypersexual, violent, athletic, delinquent, and uneducated (Allen, 2017; Ferber, 2007; Frazier, 1939). For Hispanic/Latino American men, they are often seen by the dominant culture as abusive to women and dominant, characteristics often associated with the term *machismo* (Abalos, 2005). Studies show racism has been a negative factor associated with many Latino American men getting jobs to provide for their families, creating immense strain (Acosta et al., 2020; Arellano-Morales et al., 2020; Liang et al., 2011). For Asian American men, they are often viewed by the hegemonic culture through inaccurate myths that state they are all smart, asexual, and lacking traditional masculinity characteristics (e.g., facial hair, muscle, height; Keo & Noguera, 2018; Lu & Wong, 2013; Shek, 2006).

Underneath these stereotypes and myths surrounding the masculinities of men of color, there are cultural traditions. For instance, Black/African American men value leadership, being a good role model, taking care of the family, religion/spirituality, and understanding the impacts of racism and systemic oppression (Rogers et al., 2015). Hispanic/Latino men value elements associated with *caballerismo* and *familismo* such as providing for the family, having a code of ethics, building emotional and interpersonal connections, and providing nurturance for the family (Arciniega et al., 2008). Finally, Asian American men value responsibility, respect, and taking care of others (Kyler-Yano and Mankowski, 2020).

Although each masculinity is different and unique for each racial identity, they also have similarities with one another. These similarities largely consist of providing for others and responsibility. Men, regardless of race, are less likely to seek help (Johnson et al., 2012; Mahalik et al., 2003; Mahalik & Di Bianca, 2021; McDermott et al., 2018; Wong et al., 2017), but men of color may be even less likely to seek help than White men (Levant et al., 2015; Terlizzi & Zablotsky, 2020). The detrimental effects of lack of emotionality, dominance, and self-reliance are also similar among racial groups, including as they influence outcomes such as depression and lower life satisfaction (Acosta et al., 2020; Arellano-Morales et al., 2016).

More masculinity research should use intersectional theories to appropriately analyze diverse samples and make well-informed and positive contributions to a broader community outside of the hegemony. As seen above, masculinity has been found to negatively impact men of various backgrounds. Consequently, there is a need to understand factors that might be contributing to this relationship, such as alexithymia, disclosure and interpersonal competency, and shame. Those will be discussed next.

Normative Male Alexithymia and Emotion Theory

The term alexithymia originated from Sifeneos in 1967 and translates to *without words for emotions*. This is a neurological feature often seen in patients who have suffered a stroke or traumatic brain injury (Hobson et al., 2020; Williams et al., 2019) but was first described in psychosomatic disorders. The term was then adapted in 1992 by Levant to explain men's general difficulties with understanding and expressing emotions. This difficulty was termed Normative Male Alexithymia (NMA) and posits that TMI

leads to deficits in naming and understand one's emotions. The Normative Male Alexithymia Scale (NMAS; Levant et al., 2006) operationalized this construct. Using the NMAS, Levant et al. (2014) found that negative affect and suppressing one's emotions were predictive of NMA. They further found that men who scored as alexithymic struggled to accurately name words associated with vulnerability and attachment compared to men who scored as non-alexithymic.

Using masculinity measures like the GRCS, MRNI, and CMNI, researchers have found a trend in which the restricting of emotions was associated with normative male alexithymia for White men as well as men of color (Berger et al., 2005; Hayashi, 1999; Levant & Wong, 2013; O'Neil, 2008). Research has also found links between restrictive emotionality, emotional dysregulation (i.e., an inability to self-regulate strong emotions such as anger in a healthy way), and aggression in men (Cohn et al., 2010; Tager et al., 2010). Unfortunately, emotional research in the field of men and masculinities has typically not used official emotion theory or literature.

One exception in which emotion theory was used is provided by Wong and Rochlen (2005). These authors examined a popular emotion model called the Kennedy-Moore and Watson model (KM-W; 1999), which conceptualizes emotions as a cognitive-evaluative process and breaks it down into five steps. These steps are (1) prereflective reaction, (2) awareness of affective response, (3) labeling and interpretation of response, (4) evaluation of response as acceptable, and (5) perceived social context for expression. Wong and Rochlen applied those steps to men and explored how and when the emotion process, which would either lead to non-expression or expression of emotions, could be

disrupted. They found that difficulty identifying feelings (i.e., alexithymia) and negative attitudes about emotional expression were positively related to restrictive emotionality. This means that men who were high in the masculine norm of restrictive emotionality struggled with emotions more so than men who were lower in restrictive emotionality.

Men's struggle with emotions can also spread outward to affect their relationships with others. Being able to understand and express emotions has been linked to being able to interact with others, making it a powerful resource with which to build interpersonal connections (Bruch, 2002; Holmes; 2015; Ritchie, 1999). Men who score high in NMA have been found to struggle to relate to their partners' emotions, display less relationship satisfaction, and be less likely to communicate effectively within these relationships (Karakis & Levant, 2012). Unfortunately, literature is lacking on how NMA might further impact men and their ability to operate in an interpersonally competent world. Consequently, this study seeks to examine whether NMA might impact men's ability to disclose (e.g., communicate) their problems to others, which, in turn, may predict self-stigma to seek psychological help.

Disclosure and Interpersonal Competency

Interpersonal competency is considered a multifaceted construct and is defined as one's ability to interact effectively in relationships with others (Buhrmester et al., 1988). In this case, multifaceted means that one can be competent in some areas but less competent in others. According to Buhrmester and colleagues (1988), interpersonal competency is made up of five facets: Initiation, Negative Assertion, Disclosure, Emotional Support, and Conflict Management. For the purposes of this study, the facet of

Disclosure is the most salient. Disclosure is defined by Buhrmester et al. (1988) as being able to talk about one's problems to others (e.g., friends, family, mental health professionals, partners). These authors found that disclosure competency was positively associated with emotional sensitivity and emotional expressivity; men typically scored lower in this area than women. Later research found that men who scored higher on some traditionally considered, "feminine" traits, were better able to disclose their problems to their partners than men who reported themselves as only holding masculine traits (Lamke et al., 1994). More current research has provided further evidence of this relationship such that masculine norms were typically associated with difficulty expressing emotions and lower disclosure to same sex peers (Bruch, 2002), romantic partners (Holmes, 2015), or people in general (Pederson & Vogel, 2007). Importantly, recent research has discovered that alexithymia is linked to attachment avoidance (i.e., avoiding connection and attachment to others) and distress disclosure (O'Loughlin et al., 2018).

Research in the area of disclosure competency in men has also included the construct of shame. Such research has found that both disclosure competency and shame were important barriers to men seeking help professionally (Clement et al., 2015) and in their romantic relationships (Kõlves et al., 2011). In particular, feelings of inadequacy and deficiency, a type of internalized shame, has been negatively associated with interpersonal competence (Gao et al., 2020). This study seeks to understand how Disclosure might predict men's feelings of inadequacy and deficiency in the context of Self-Stigma Associated with Seeking Psychological Help.

Shame: Inadequacy and Deficiency

Shame is a topic that has been understudied in masculinity literature. It is conceptualized as internalized negative feelings about the self in comparison to others (Lewis, 1971). Lewis discusses shame alongside the term guilt, which, in contrast to shame, consists of negative feelings about a behavior that someone has done rather than who they are as a person. In past literature, shame has been continuously measured alongside guilt, meaning that the same measure assessed for both guilt and shame (Bannister et al., 2019; Crocker et al., 2016; McDermott et al., 2017, Rice et al., 2019; Tangney et al., 1992). Consequently, it is important that research provide adequate attention and resources to assessing the impacts of shame as separate from guilt.

Research looking at masculinity and shame have identified that shame is associated with increased verbal aggression and the risk for posttraumatic stress disorder (PTSD; Bannister et al., 2019; Crocker et al., 2016; Wood et al., 2017). Shame was also positively related to mental illness stigma and was speculated to be one reason why men do not seek help (Wood et al., 2017). In addition, shame has been found to predict psychological distress (Rice et al., 2020). Other studies have indicated that shame is negatively associated with self-compassion and positively associated with CMN and depression (Reilly et al., 2014; Rice et al., 2016). Shame has also been found to be associated with conformity to the masculine norms of Self-Reliance and Emotional Control, primarily in veterans who saw combat. Importantly, men who experienced internalized general shame were more likely to experience shame specifically from their masculinity being threatened than men with lower internalized general shame (Gebhard

et al., 2019). I will now discuss the concept of Threatened Masculinity-Related Shame (TMRS), which is another concept of interest for the current study.

Threatened Masculinity-Related Shame

The term *threatened masculinity* is a newer term in masculinity literature but originates from the concept of Masculine Gender Role Stress (MGRS; Eisler & Skidmore, 1987), a measure of discrepancy strain. MGRS states that men will feel stress in the face of situations that might appear to others as unmanly (e.g., when a personality test states that one has more feminine traits than masculine traits) or when they cannot cope with the demands of the masculine role (e.g., when they cry). MGRS has been associated with physical aggression toward partners (Baugher & Gazmararian, 2015). Similarly, threatened masculinity describes the experience that one might not be as masculine as one appears to be or that one's identity as a man is being attacked. It aligns itself well with O'Neil's (1981) GRC theory in which the core of masculinity is the fear of femininity. Indeed, one's masculinity is often threatened by being caught showing more "feminine" traits, such as emotional expression or behaviors that go against self-reliance (e.g., asking for help or being vulnerable; Baugher & Gazmararian, 2015; Gebhard et al., 2019; Vandello & Bosson, 2013). It also applies to Pleck's (1981, 1995) discrepancy strain in which men feel as if they cannot measure up to the standards of masculinity, which causes significant distress. Threatened masculinity has been found to be associated with increased physical aggression toward partners (Gebhard et al., 2019), which is consistent with earlier findings related to the MGRS by Baugher and Gazmararian (2015). It also has roots with the theory of precarious manhood (Vandello &

Bosson, 2013), which states that masculinity is hard won, easily lost, and threats to masculinity are distressing. This will be discussed in the coming chapter.

Current Study

The current study sought to examine what variables might be implicated in the development of high levels of Self-Stigma associated with seeking psychological help (Self-Stigma) in a diverse sample of men. These variables consisted of conformity to the masculinity norms of Emotional Control and Self-Reliance, NMA, Disclosure, Shame (specifically Inadequacy and Deficiency), and Threatened Masculinity-Related Shame (TMRS). This study aimed to address limitations in previous research through a foundation on emotion theory (in addition to masculinity theory) and the use of shame-exclusive measures. Additionally, this study sought to better understand these relationships among racially diverse groups of men, which has been understudied in the literature. Specifically, I analyzed models using path analysis in which I hypothesized that, for all men, Emotional Control and Self-Reliance would be negatively related to Disclosure and positively related to NMA and TMRS. In turn, Disclosure was predicted to be negatively related to Inadequacy and Deficiency. NMA and TMRS, by, contrast were expected to be positively related to Inadequacy and Deficiency. Finally, Inadequacy and Deficiency was hypothesized to be positively associated with Self-Stigma.

Importance to the Field of Counseling Psychology

The relationship between aggression and masculinity has been well documented in the literature, with much of the violence being directed at female intimate partners (Cohen et al., 2010; Levant & Pryor, 2020; Tager et al., 2010). A central tenant of

counseling psychology is enhancing the welfare of others (Packard, 2009). This study sought to understand the nuanced factors that might be influencing men's dysfunction in relationships and their unwillingness to seek help. If these can be studied and documented, we may be able to help change the lives of abused women and the men who are caught in a cycle of anger and violence with no solutions in sight.

This study also sought to conduct inclusive and thorough research by collecting a racially diverse sample of participants. Counseling psychology prides itself on its dedication to diversity and fighting for the welfare of others (Packard, 2009). The current study applied models related to help-seeking self-stigma to understudied populations in hopes of increasing knowledge that could aid the well-being of men of color. The popular conceptualization of masculinity is heteronormative in nature and blind to the impact of diverse identities in the construction of masculinity. However, the majority of literature discussed is largely within that framework; consequently alternative, more diversity inclusive forms of masculinity may get lost. Therefore, a detailed discussion about hegemonic masculinity and intersectionality will be presented at the end of Chapter II in order to give it focused attention, in accordance with counseling psychology values (Grzanka et al., 2017).

The final way that this study espoused the values of counseling psychology was through advocacy (Packard, 2009). So far, research has identified traditional masculinity to be a major barrier for men who may need psychological help (Berger et al., 2005; O'Neil, 2008; Pederson & Vogel, 2007). This study sought to understand the barriers related to men being unable to seek help and use those findings to advocate and empower

men to rise against harmful aspects of traditional masculinity to find a healthier way of life

CHAPTER II

REVIEW OF THE LITERATURE

The purpose of the first chapter was to introduce the concepts and rationale for this study. By contrast, the present chapter seeks to critically review the literature and examine the processes of how conformity to traits of masculine norms relates to both normative alexithymia in men and their ability to disclose to others. This chapter will explore how NMA, disclosure, and shame related to feeling that one's masculinity is threatened can influence feelings of inadequacy and deficiency, which serve to impact men's self-stigma associated with seeking psychological help. I will begin by discussing the main issue concerning men, mental health, and help-seeking before introducing the predictor variables for the current study, Emotional Control and Self-Reliance (both aspects of Conformity to Masculine Norms [CMN]) and describe help-seeking literature through that lens. After I explore CMN, I will discuss the main help-seeking variable in this study, men's self-stigma associated with seeking psychological help. I will follow that with two important theories related to masculinity and their connection to emotional expression. I will also provide a discussion of different racial conceptualizations on masculinity through an intersectional lens. I will then discuss the concept of NMA with the support of emotion theory and men's issues with disclosing their feelings to peers and loved ones. I will next discuss roles of threatened masculinity-related shame and

inadequacy and deficiency. Finally, I will present a summary of my study and the related hypotheses.

Men's Mental Health and Help-Seeking

There is a documented struggle between men and mental illness. Men are typically found to have lower rates of mental illness than women (NIMH, 2019), as well as be more likely than women to complete suicide (Hedegaard et al., 2018). Although suicide will not be discussed in the current study, this statistic indicates that mental illness is a major problem for men with rates being largely undercounted. Help-seeking rates might help explain this phenomena. For instance, national statistics indicated that women are more likely than men to seek out any mental health treatment (e.g., medication, talk therapy), with White adults being more likely to seek mental health treatment than Black or Hispanic adults (Terlizzi & Zablotsky, 2020). In fact, a national report found that, in men who were struggling with daily feelings of anxiety and depression, only 4 in 10 of them sought medication or talk therapy (Blumberg et al., 2015). The same report indicated that Hispanic and Black men were 30% less likely than White men to seek out either form of treatment. These statistics provide some explanation for men's high rates of suicide, as they are likely not getting the treatment needed to prevent it.

Research has continued to examine gender differences in mental disorders, and many have found evidence for a much narrower gender gap. For example, national samples within the U.S and large cross-sectional studies in Europe have found that gender differences were largely non-existent when disorders were combined (Boyd et al.,

2015; Eaton et al., 2012). However, in both studies, when disorders were categorized as either internalizing or externalizing, gender differences began to appear. Eaton et al. (2012) analyzed data from 43,093 mostly White (56.9%) participants, with 19.3% being Hispanic or Latino, 19.1% African American, 3.1% Asian/Native Hawaiian/Pacific Islander, and 1.6% American Indian/Alaska Native. Approximately 57% of participants were women and 43% were men. They found that women showed higher rates than men for all internalizing disorders consisting of depression, generalized anxiety, panic disorder, social phobia, and dysthymia. The reverse was found for externalizing disorders in which men exhibited higher rates of antisocial personality and dependence on alcohol, nicotine, marijuana, and drugs not otherwise specified.

Findings by Eaton and colleagues (2012) were identical to findings from a later population-based study across European countries (Boyd et al., 2015). Boyd et al. (2015) obtained data from 37,289 respondents from Romania, Spain, Belgium, France, Germany, the Netherlands, Northern Ireland, Bulgaria, Italy, and Portugal. No racial demographics were given. They found that mental health differences were non-existent between genders when mental disorders were combined. However, like Eaton et al. (2012), once disorders were separated into internalizing and externalizing disorders, they found women to have higher rates of internalizing disorders, such as depression, posttraumatic stress, and anxiety disorders. In contrast, men were again high in externalizing disorders, such as attention deficit disorder, drug and alcohol disorders, and conduct disorders. The identical results across two large studies are striking and indicate that gender-related patterns of disorders are largely consistent in Western countries.

As mentioned above, men are less likely than women to seek treatment (Terlizzi & Zablotsky, 2020). Research has determined several attitudinal and structural barriers that might prevent men from seeking help. For example, Seidler et al. (2020) sampled 778 men who reported experiencing a mental health issue. Most were White (70%), and 30% reported some kind of problematic alcohol or drug use. Participants were given measures assessing barriers to mental health treatment and general psychological distress. They found that men in more distress were more likely to seek treatment compared to men who were in less distress. The most common structural barrier was not knowing how to find a counselor. Most common attitudinal barriers were the need to solve their problems on their own and feeling that it was hard for them to admit when they needed help. These barriers allowed Seidler and colleagues to briefly draw a connection from men's attitudes about help-seeking to masculinity characteristics. This is consistent with masculinity literature, which states that high levels of masculine norms typically result in negative attitudes about help-seeking for both White men (Berger et al., 2005; Levant et al., 2009; Levant et al., 2013; Ramaeker & Petrie, 2019) and Black men (Scott et al., 2015).

Despite the advancement in knowledge related to gender and mental illness, more research is needed to understand the various factors associated with men's help-seeking behaviors across racial groups. Although much of the research has focused on masculinity and attitudes toward seeking psychological help, there is a growing need to examine how masculinity might influence self-stigma associated with seeking psychological help. One important masculinity construct to discuss is CMN, particularly its aspects of Emotional Control and Self-Reliance.

Conformity to Masculine Norms (CMN)

CMN is based on Mahalik's (2000) gender norms model, which describes gender role expectations as being sociocultural influences laid down by the most dominant or powerful groups in society (i.e., White, cisgender, heterosexual, Christian, male). These expectations are then communicated to others through specific and cohesive norms. Group and individual factors such as SES, racial identity, sexual orientation, and characteristics of relationships with same-sex others influence how an individual experiences gender role norms. These individual and group factors influence whether the individual conforms or does not conform to certain gender norms.

The Conformity to Masculine Norms Inventory (CMNI) was created in 2003 by Mahalik and colleagues to measure men's conformity to certain masculine norms. Its consists of 11 factors: Winning (e.g., "I will do anything to win"), Emotional Control (e.g., "I try to keep my emotions hidden"), Risk-Taking (e.g., "Taking risks helps me to prove myself"), Violence (e.g., "I am willing to get into a physical fight if it is necessary"), Dominance (e.g., "I should be in charge"), Playboy (e.g., "I don't want to get tied down to dating just one person"), Self-Reliance (e.g., "If I asked for help it would be a sign of failure"), Primacy of Work (e.g., "I tend to prioritize my work over other things"), Power Over Women (e.g., "Things tend to be better when men are in charge"), Disdain for Sexual Minorities (e.g., "It is important to me that people think I am heterosexual"), and Pursuit of Status (e.g., "It feels good to be important"). The items were designed to fall on a continuum from extreme conformity to extreme non-

conformity (Mahalik et al., 2003). This design allowed for precision in determining an individual's levels of conformity to various norms.

Due to the large number of items in the original CMNI, which consisted of 94 items, a much shorter scale 30-item inventory was recently developed to reduce participant fatigue and provide a measure of masculinity with stronger psychometric properties (CMNI-30; Levant et al., 2020). The CMNI-30 retained all original factors of the original CMNI, except for the subscale Dominance, which was removed for low loadings. Unfortunately, a total score cannot be used in the CMNI-30 (Levant et al., 2020). Instead, the CMNI-30 allows us to measure various types of masculine norms using only 3 items per subscale, making it equally efficient and effective.

Men, Help-Seeking, and the CMNI

There has been a significant amount of literature about men's psychological help-seeking and the CMNI, which has been well summarized by a meta-analysis on this topic. Wong and colleagues (2017) analyzed 74 studies and found that CMN was significantly and negatively related to positive mental health and significantly and positively related to negative mental health. Although the effect sizes for these findings were small, they still indicate that conforming to masculine norms has some relationship with men's mental health. As expected, Wong et al. also found that CMN was negatively related to attitudes toward seeking psychological help, which had a medium effect size. This is consistent with both previous and current literature (Mahalik et al., 2003; Ramaeker & Petrie, 2019), with the relationship between traditional masculinity and issues with seeking

psychological help being consistent even in the earliest literature (Good et al., 1989; Wisch et al., 1995).

Wong et al. (2017) also analyzed the relationship between help-seeking and mental health separately for two types of populations (i.e., college samples and mixed college and community samples). They found that, in the college only samples, the negative relationship between negative mental health and CMN and the negative relationship between CMN and help-seeking were retained with small effect sizes. However, there was no significant relationship between CMN and positive mental health. For the mixed college and community samples, they found that all three relationships were significant, with CMN being positively related to negative mental health and negatively related to positive mental health. Both relationships obtained small effect sizes. The mixed college and community sample also found that CMN was negatively related to psychological help-seeking and in contrast to the college only sample, this finding had a medium effect size.

Additionally, Wong et al. (2017) did not find significant moderating effects for gender, race, sexual orientation, or age. However, in Wong's meta-analysis, there were 45 separate samples of predominantly White samples in contrast to only nine predominantly African American samples, nine Asian American samples, and no samples for other racial or ethnic groups. Unfortunately, this is representative of the literature on these topics. More diverse samples (e.g., age, race, SES) are needed to understand the full impact of CMN on different factors associated with mental health and help-seeking.

Importantly, Wong et al. (2017) also found evidence for the negative effects of CMN on interpersonal concerns. They found that CMN was more strongly related to negative social functioning than to any other psychological indicators of mental health. Even though the effect size was small, this suggests that a lack of social functioning might relate more strongly to negative mental health than other factors. Unfortunately, this finding was not elaborated on, although Wong and colleagues speculated that it was understandable, as most of the CMNI subscales were related more to interpersonal concerns (e.g., Winning, Violence, Playboy, Power Over Women, Self-Reliance, and Disdain for Sexual Minorities) rather than intrapersonal concerns. Although the present study did not assess social functioning, the study examined interpersonal competency (i.e., Disclosure). This finding provides some rationale for the impact of masculinity on successfully operating in interpersonal spaces, which may influence men's ability to disclose their problems to others.

Wong et al. (2017) next probed the relationships between the CMNI subscales and negative mental health, positive mental health, and psychological help-seeking to determine which dimensions might be responsible for the relationship. They found that nine of the eleven CMNI dimensions were positively associated with negative mental health, specifically Winning, Emotional Control, Risk-Taking, Violence, Dominance, Playboy, Self-Reliance, Power Over Women, and Pursuit of Status. The dimensions Primacy of Work and Disdain for Sexual Minorities were not significantly related to negative mental health. Four of the eleven dimensions were negatively related to positive mental health: Emotional Control, Playboy, Self-Reliance, and Power Over Women. Risk-Taking was found to be positively related to positive mental health, and the

dimensions Winning, Violence, Primacy of Work, Disdain for Sexual Minorities, Dominance, and Pursuit of Status were not significantly related to positive mental health. It is possible that Risk-Taking could be positively related to positive mental health through non-measured variables such as the personality trait openness to experience, which includes taking some risks (Ferguson & Bibby, 2012). Finally, seven of the eleven dimensions were negatively related to psychological help-seeking: Winning, Emotional Control, Violence, Playboy, Self-Reliance, Power Over Women, and Disdain for Sexual Minorities. The dimensions Risk-Taking, Dominance, Pursuit of Status, and Primacy of Work were not significant. All relationships had small effect sizes except for the relationship between Emotional Control and psychological help seeking, which had a medium effect size.

Apart from the Wong et al. (2017) meta-analysis, research has shown that, not only do men have difficulty seeking help, but they are also likely to engage in behaviors that could harm their physical and mental health. For instance, Levant and colleagues (2009) examined a sample of 135 mostly White (86.1%) men in college who participated in an online survey that used self-report measures about masculinity, attitudes about psychological help-seeking, and risky health behaviors. They found that men who scored high on the CMNI also scored high on health risk behaviors (e.g., smoking, drinking, not going to the doctor). The norms involved in these negative relationships were Winning, Emotional Control, Playboy, Self-Reliance, Primacy of Work, Disdain for Sexual Minorities, and Power Over Women.

The finding of Levant and colleagues (2009) is consistent with other studies. For example, in the article detailing the construction and internal consistency of the CMNI, Mahalik and colleagues (2003) sampled 450 mostly White (81%) men in college who answered questions about CMN and health behaviors. They found that men who endorsed using tobacco scored higher on Risk-Taking and Playboy than men who did not endorse tobacco usage. They also found that men who responded "yes" to drinking so much that they could not remember what they did scored higher on Risk-Taking, Playboy, Violence, and the CMNI total score than men who answered "no." The relationship between the CMNI dimensions of Risk-Taking and Violence with alcohol use was also found in a population of college athletes (Ramaeker & Petrie, 2019). Ramaeker and Petrie sampled 220 mostly White (54.5%) and African American (35.9%) men. They gave the participants several questionnaires asking about masculinity, help-seeking, alcohol use, and depression. They found that higher levels of alcohol use were associated with the CMNI dimensions of Violence and Risk-Taking. Using structural equation modeling, they also found that the CMNI total score was significantly and negatively related to attitudes toward seeking help. These findings indicate that male athletes who were high on CMN were more likely to have fewer positive attitudes about seeking psychological help. Importantly, attitudes about seeking help were positively related to intentions to seek help, a construct which evaluates whether one plans to make an appointment for psychological services or seek out therapy. This would mean that men who have negative attitudes about seeking help could be less likely to intend to seek help.

Finally, Mahalik et al. (2003) conducted another study to explore which dimensions of the CMNI were implicated in attitudes toward seeking help. The

researchers sampled 269 mostly White (83%) college men and gave them the CMNI and other scales of masculinity, as well as measures of psychological distress, attitudes toward seeking psychological help, and social desirability. They found that the total score of the CMNI and the dimensions Emotional Control, Self-Reliance, Winning, Violence, Power Over Women, and Disdain for Sexual Minorities were significantly and negatively related to attitudes toward seeking psychological help. As we have seen, these findings continued to be observed in literature over a decade later (Wong et al., 2017; Herbst et al., 2014; McDermott et al., 2018).

Additional research regarding the relationship between masculinity and men's intentions to seek help has indicated that, of the CMNI dimensions, Emotional Control and Self-Reliance produced the most robust associations. For example, McDermott et al. (2018) evaluated a sample of 2,504 mostly White (68%) university men (n = 1,249) and women (n = 1,176). Participants were given several self-report questionnaires assessing intentions to seek psychological help and CMN. Within the construct of intentions to seek help, the researchers measured both formal (e.g., seeking professional psychological services) and informal (e.g., peers, family, friends) forms of help-seeking. Using structural equation modeling (SEM), they found that, out of all the CMNI subscales, men who were higher in Emotional Control and Self-Reliance were significantly less likely to seek help, both formally and informally. Most recently, a study by Mahalik and Di Bianca (2020) also found associations between help-seeking, Emotional Control and Self-Reliance. A sample of 258 mostly White (84.2%) men completed measures of depression, self-stigma for seeking psychological help, CMN, and help-seeking intentions. Using structural equation modeling, they found that Emotional Control and

Self-Reliance predicted greater self-stigma. Emotional Control, Self-Reliance, and self-stigma were related to low levels of help-seeking. These studies provide strong evidence for the use of these subscales to examine men's help-seeking.

Consistent with McDermott et al (2018), Herbst et al. (2014) sampled 136 cowboys from rodeo associations and administered surveys examining CMN and the likelihood of engaging in help-seeking behaviors (e.g., confiding in others, talking to a doctor or mental health professional) within the context of depression vignettes for which they were asked to imagine themselves in various depression-related scenarios. Using canonical correlation and the CMNI norms of Emotional Control, Power Over Women, and Self-Reliance, Herbst et al. (2014) found that men with high levels of Emotional Control and Power Over Women were significantly less likely to confide in their best friends or a mental health professional, even if they were experiencing a depressive episode, than men with lower levels of these norms. The associations between the two norms and help-seeking were moderate and accounted for 37% of the variance in men's unwillingness to seek help. Interestingly, Self-Reliance was not found to be a significant factor, which deviated from several other research studies (McDermott et al., 2018; Wong et al., 2017; Mahalik et al., 2003).

Unfortunately, most of the literature examining the CMNI in relation to help-seeking sampled mostly White men and occasionally women. Exploratory analyses on racial differences in masculinity and help-seeking included in those studies were often inconclusive, likely due to a lack of power due to sample size (McDermott et al., 2018); however, there are exceptions. For instance, a study which sampled 4,773 mostly White

(72.7%) men also had enough participants from diverse populations to include them in separate analyses (Vogel et al., 2011). These authors sampled 479 Asian Americans, 348 Latino Americans, 226 African Americans, and 192 Americans who identified as multiracial. Unfortunately, they did not specify the specific racial identities of those identifying as multiracial. The researchers administered scales which measured CMN, attitudes toward seeking psychological help, self-stigma, and depression. They found that, across all samples, self-stigma mediated the relationship between CMN and help-seeking attitudes. In other words, men who were high in CMN were high in self-stigma, which led to more negative attitudes toward seeking psychological help.

Significant results with more diverse and vulnerable populations were also found when examining help-seeking attitudes in relation to several CMN dimensions. For instance, Scott et al. (2015) conducted a study that examined Black men who had histories of being in foster care, a population that has been known to be at risk for mental health illnesses (Pecora et al., 2009a, 2009b). Scott et al. (2015) sampled 55 adult Black men who were participating in one of two larger studies. They were given measures of help-seeking and were interviewed. Using chi-square tests, the researchers found that Emotional Control was associated with likelihood to seek help such that as Emotional Control increased, the likelihood of seeking help decreased.

The remaining literature on masculinity and help-seeking examined the relationships between masculinity and the type of help that was being (or not being) sought out (Berger et al., 2013; Herbst et al., 2014). This is crucial to understanding whether certain types of help were more or less likely to be rejected by men. For instance,

research has examined which type of psychological help-seeking might be most negatively impacted by CMN (Berger et al., 2013). Berger and colleagues (2013) sampled 85 mostly White (84.3%) men from the community. The men were interviewed and given measures related to CMN, depression, anxiety, help-seeking behaviors, and perceived problems in living. When interviewed, they were asked questions about their characterization of the problem, coping methods, whether they sought informal (e.g., friends, family, lovers) or formal (e.g., counselors, doctors) help, and their thoughts about medication. They found that medication was the mostly strongly rejected form of treatment among the men. Interestingly, psychotherapy was found to be the most accepted form of treatment. However, both psychotherapy and medication were negatively related to CMN. They also found that confiding in friends and family were also negatively associated with CMN, which is consistent with other literature (Herbst et al., 2014; McDermott et al., 2018; Scott et al., 2015).

Berger et al. (2013) also examined which specific masculinity norms were involved in these relationships. They found that Violence and Self-Reliance were both negatively related to medication treatment, and Playboy was negatively associated with psychotherapy treatment. Men who believed they could solve problems on their own (Self-Reliance) were less willing to seek help and had more negative attitudes about doing so; this finding is consistent with other literature (Heath et al., 2017). Outside of Self-Reliance, there is not much explanation in the literature regarding the other norms that were negatively associated with seeking help (Violence and Playboy).

This section sought to discuss and evaluate the literature associated with help-seeking issues for men as it related to masculinity. The research has shown that masculine norms may be partially responsible for creating barriers to seeking professional help (Berger et al., 2013; Heath et al., 2017), influencing mental illness (Gerdes et al., 2018; Wong et al., 2017), and hindering men from even disclosing problems with loved ones (Herbst et al., 2014; McDermott et al., 2018; Scott et al., 2015). This section also highlighted the large amount of related research which used the CMNI. The CMNI offers insight into norms, particularly Emotional Control and Self-Reliance, which have been consistently found to be negatively related to help-seeking (Johnson et al., 2012; Mahalik & Di Bianca, 2021; McDermott et al., 2017; McDermott et al., 2018; Pattyn et al., 2015; Wong et al., 2017) and are the variables of interest in the present study. This abundance of research allows for deeper exploration into this topic, such as exploring specific types of treatment and norms associated with attitudes toward those types (Berger et al., 2013). Finally, the CMNI measures specific behaviors and feelings which men conform to (e.g., "I never share my feelings"). The approach that the CMNI takes allows us to understand the individual traits and tendencies of a person rather than an overarching set of beliefs.

This study aims to understand how masculine norms influence a specific aspect of help-seeking, help-seeking self-stigma, as well as how other variables such as NMA, Disclosure, Inadequacy and Deficiency (a form of shame), and Threatened Masculinity-Related Shame may contribute to an environment for men to have higher levels of self-stigma, creating a major barrier on the path to treatment. I will now discuss the literature on men's self-stigma and its relationship with help-seeking.

Men's Self-Stigma and Help-Seeking

The current study examined men's self-stigma toward seeking psychological help. The literature delineates help-seeking into several related but distinct concepts, one of which is self-stigma; others consist of attitudes toward seeking psychological help and intentions to seek psychological help. Even though the present study intended to only examine self-stigma with seeking help, self-stigma has been found, both conceptually and quantitatively, to be a valuable factor in determining one's attitudes and intentions to seek help (Corrigan, 2004; Levant et al., 2013; Mahalik & Di Bianca, 2021; Pederson & Vogel, 2007; Vogel et al., 2006; Vogel et al., 2011; Wood et al., 2017). Therefore, each concept will be discussed in order to provide a more thorough review of the help-seeking literature and a deeper understanding of the cognitive processes that occur along the journey to obtaining psychological help. I will start with self-stigma.

As mentioned in Chapter I, there are two relevant types of stigmas. The first is self-stigma associated with seeking psychological help, which reflects one's feelings about themselves if they were to seek help (e.g., "I am weak if I go to a therapist"). The second is a separate but related concept called public stigma, which delineates how others view or think about the person who is seeking help (e.g., "That person sleeping on the bench must be mentally ill"; Corrigan, 2004). Self-stigma about seeking help differentiates itself from attitudes and intentions to seek help in that it is concerned with internal conflicts about the self. Attitudes, by contrast, are more about a person's beliefs about seeking help separate from, but related to, their own self-concept. Intentions are the likelihood that a person will seek help, which is more of an indicator of behavior than

anything related to who they are as a person (Ajzen, 2006). Corrigan (2004) discussed the process of self-stigma as occurring through four factors: cues, stereotypes, prejudice, and discrimination. Cues are signs that allegedly tell a person that someone might be mentally ill (e.g., eccentric behavior, appearance, social behavior). In regard to self-stigma, a man might feel as if they cannot seem to be emotional enough for their partner, which might be a cue that there is something "wrong" with him. However, public stigma cues about men state that men should not be emotional or else they appear feminine, and so the cues in their interpersonal relationships conflict with those of society.

These rivaling cues elicit multiple, potentially contradictory stereotypes or specific ideas about a group of people (e.g., "emotional men are weak and feminine" and/or "non-emotional men make inefficient partners"). Stereotypes, in turn, lead into the prejudice phase in which one internalizes a negative view of themselves based on the stereotype (e.g., "I can get emotional sometimes; therefore, I am a weak man" and/or "I can't seem to be vulnerable with my partner; I am defective"). Finally, those prejudicial statements one makes to themselves influence behaviors (e.g., "I won't seek help because then I will look even weaker" and/or "Therapy could never make a real difference in my life because I am so defective"). Theoretically, it is through this process that men obtain high levels of self-stigma associated with seeking psychological help.

Research has sought to examine the impact that stigma has on mental help-seeking. One important study is a systemic review of such an impact. Clement et al. (2015) reviewed 144 qualitative and quantitative studies from 1980 – 2011. Most studies originated in the United States and Canada (69%). Twenty studies were from Europe, ten

from Australia and New Zealand, eight from Asia, and one from South America. No overall racial or gender demographics were noted. The researchers categorized the studies into association studies, which examined the association between stigma and help-seeking, and barrier studies, which examined stigma-related barriers to help-seeking. The association studies yielded a medium effect size and negative association between stigma and help-seeking attitudes and intentions (d = - 0.52). This association was small for African Americans (n = 570; d = -.025) and large for Arabic students (n = 297; d = -1.21) and Asian Americans (n = 898; d = -1.20). No association was found for Latino, Cuban, or Puerto Rican Americans (n = 328).

The barriers studies often used mixed male/female samples (69.8%). Some were female only samples (30.1%), and only one study used an all-male sample (N = 35; Clement et al., 2015). For these analyses, the studies were categorized into five stigma-related barriers: shame/embarrassment, negative social judgement, disclosure/concerns with confidentiality, employment-related discrimination, and general stigma/other stigma-related barriers (e.g., bringing shame to one's family, being weak). The authors found that disclosure concerns were the most prominent type of stigma barrier, followed by shame/embarrassment. Men were found to have more trouble disclosing to professionals than did women, the latter of whom reported less stigma-related barriers overall. Among racial and ethnic minorities, African Americans and Arabic Americans were disproportionately affected by the disclosure barrier and stigma for the family.

Past studies reflect the findings of Clement et al. (2015). For example, self-stigma has been found to be related to attitudes toward seeking psychological help (Bathje &

Pryor, 2011). Bathje and Pryor (2011) sampled 211 mostly White (86%) male (48%) and female (52%) college students. Participants completed self-report measures associated with public stigma, self-stigma for seeking help, attitudes toward seeking help, and intentions to seek counseling. Attitudes toward seeking help were found to fully mediate the relationship between self-stigma and intentions to seek counseling. In other words, when attitudes were entered into the model, self-stigma was no longer related to intentions to seek counseling in favor of being related to attitudes toward seeking help, which, in turn, was related to intentions. Additionally, men have been shown to be more susceptible to the effects of self-stigma for seeking help than women (Hackler et al., 2010). Hackler and colleagues sampled 145 mostly White (88.1%) female (85.5%) and male (14.5%) college students who scored in the range for an eating disorder. The sample was given measures of self-stigma about seeking psychological help, attitudes toward seeking counseling, and risks and benefits associated with talking to a professional. They found that there was a significant negative relationship between self-stigma and attitudes toward seeking counseling in men but not in women. This study suggests that there are gender differences in self-stigma associated with seeking help.

Research has begun to examine the role that masculinity might play in men's self-stigma regarding seeking help. For example, it was found that self-stigma associated with seeking psychological help partially mediated the relationship between Traditional Masculinity Ideology (TMI) and help-seeking attitudes and fully mediated the relationship between gender role conflict (GRC) and attitudes (Levant et al., 2013). In other words, TMI was associated with self-stigma, which was, in turn, negatively associated with attitudes toward seeking help. Men who were high in both TMI and self-

stigma were likely to have negative attitudes about seeking help. The same was found using another measure of masculinity, the Gender Role Conflict Scale (GRCS; O'Neil et al., 1986). This study highlights the importance of self-stigma in seeking psychological help, especially as related to masculinity, and is consistent with previous literature. For instance, Pederson and Vogel (2007) sampled 575 mostly White (90.4%) undergraduate men and gave them questionnaires asking about GRC, self-stigma, self-disclosure, and attitudes to seek counseling. Using mediation analysis, they found that men with high GRC also had higher self-stigma when it came to seeking help and were less likely to disclose distressing emotions to others; this, in turn, led to negative attitudes about seeking counseling.

Taken together, research examining self-stigma, masculinity, and help-seeking has shown mixed results, depending on the measure of masculinity that was used. For instance, it was discussed earlier that self-stigma explained help-seeking attitudes more than GRC (Levant et al., 2013), yet other research found that GRC was positively related to self-stigma, which reduced disclosure rates (Pederson & Vogel, 2007). Further research is needed to determine the degree to which self-stigma contributes to the relationship between masculinity and help-seeking attitudes.

Using more diverse samples than much of the research cited here, Vogel et al. (2011) found that the strength of the mediated relationship between CMN, self-stigma, and help-seeking attitudes was different for each racial group. For instance, whereas African Americans (4.7% of the overall sample) showed the highest relationship between CMN and attitudes, the relationship between CMN and stigma was weaker for them than

it was for European Americans (72.7%). Latino Americans (7.3%) were found to have the same relationship strength between CMN, stigma, and help-seeking attitudes as European Americans. Most interestingly, there was no significant relationship between CMN and help-seeking attitudes at all for Asian Americans (10.0%). In conclusion, except for Asian Americans, stigma significantly mediated the relationship between CMN and help-seeking attitudes, regardless of racial identity, which indicates a common theme occurring in which masculinity and self-stigma might be key variables (Vogel et al., 2011). However, more research will need to be dedicated to using diverse samples to tease apart the contributions that masculinity has in help-seeking attitudes.

Although racially and ethnically diverse samples have not been used in this context, research has begun to look at what specific norms play a role in self-stigma using primarily White samples. Using the National Comorbidity Survey Replication, a study in 2011 asked 5962 presumed mostly White respondents with common DSM-IV diagnoses (e.g., anxiety, depression, substance use, impulse control, and childhood disorders) about their perceived need for treatment and if they had any barriers (structural or attitudinal) to treatment (Mojtabai et al., 2011). No specific demographics were given. They found that a large percentage of their sample reported a need to handle the problem on their own versus any other barrier (72.6%; e.g., stigma, perceived ineffectiveness). Although only 9.1% of the sample reported not seeking treatment due to the stigma, it is possible that wanting to handle problems on one's own originates from internal stigma not recognized as such by the individual, as it can sometimes operate outside of one's awareness (Corrigan, 2004). However, wanting to solve the problem alone was also the main reason participants dropped out of treatment (42.2%), with stigma being the reason for 21.2% of

the sample. Men in particular were more likely than women to report less of a need for treatment.

The concept about wanting to handle something on one's own links to the masculinity norm Self-Reliance, which has been used in many studies. For instance, Heath and colleagues (2017) sampled 284 mostly White (80.3%) undergraduate men who completed measures examining CMN, self-compassion, perceived risks in self-disclosing emotions to a counselor, and self-stigma. Using structural equation modeling, they found that men high in CMN were lower in self-compassion and higher in perceived risks to disclose and self-stigma over men who were lower in CMN. They also found that the norm Self-Reliance predicted high levels of self-stigma, and Emotional Control predicted both high self-stigma and higher perceived risks to disclose. This study showed that CMN, especially the norms Self-Reliance and Emotional Control, were barriers to disclosing to a mental health professional and were partially responsible for low self-compassion and higher self-stigma. In a more recent study, similar findings were found for Self-Reliance and Emotional Control such that they both significantly and positively predicted self-stigma of seeking psychological help (Mahalik & Di Bianca, 2021).

This section aimed to introduce the concept of self-stigma associated with seeking psychological help, its negative relationship to psychological help-seeking, and how masculinity, particularly the norms of Emotional Control and Self-Reliance, might play a key role in higher levels of self-stigma. Much of the research concerning self-stigma and masculinity is in its early stages, although there is a wealth of literature looking at the broader concepts of men's help-seeking attitudes and intentions.

Masculinity and Help-Seeking Attitudes and Intentions

As mentioned in Chapter I, research from the *Center for Disease Control and Prevention* and in the field of psychology indicates that men are more likely to complete suicide in comparison to women (Hedegaard et al., 2021; Coleman et al., 2020). Despite the disparaging statistic, men are still less likely to seek psychological help (Yousaf et al., 2015). This section aims to discuss men's negative relationship with help-seeking as a function of masculinity through two commonly used measures, the Male Role Norms Inventory (MRNI; Levant & Fischer, 1998) and the Gender Role Conflict Scale (GRCS; O'Neil et al., 1986). Although CMN and self-stigma associated with seeking psychological help are the variables of interest in the current study, this discussion provides a more thorough review of the broader literature on masculinity and help-seeking behaviors.

The MRNI measures an adherence to traditional masculinity ideology (TMI). TMI is the result of the socialization process all men experience and consists of beliefs, attitudes, and values associated with being a man (e.g., men should not cry, boys should not play with dolls, a woman should not be president). The MRNI has gone through many revisions over the years, but one of the most recent versions measures several masculine norms: Restrictive Emotionality (e.g., "A man should never admit when others hurt his feelings"), Self-Reliance through Mechanical Skills (e.g., "Men should have home improvement skills"), Dominance (e.g., "Men should be the leader of any group"), Negativity toward Sexual Minorities (e.g., "Sexual minorities should never marry"), Importance of Sex (e.g., "Men should always like to have sex"), Toughness (e.g., "It is

important for a man to take risks, even if he might get hurt"), and Avoidance of Femininity (e.g., "A man should prefer watching action movies to reading romantic novels"; Levant et al., 2013).

Relatedly, the GRCS (O'Neil et al., 1986) conceptualizes masculine gender roles as stemming from men's socialization and their fear of femininity (e.g., being perceived as feminine or associating with feminine characteristics). The masculine norms used in one of the most recent versions of the GRCS, the GRCS-SF, are Restrictive Emotionality (e.g., "I have difficulty expressing my emotional needs to my partner"), Conflict Between Work and Family Relations (e.g., "My needs to work or study keep me from my family or leisure more than I would like"), Success/Power/Competition (e.g., " Being smarter or physically stronger than other men is important to me"), and Restricted Affectionate Behavior Between Men (e.g., "Men who touch other men make me uncomfortable"; Hammer et al., 2018). The GRCS measures gender role conflict (GRC), which manifests in four dimensions: (1) cognitions (e.g., the way one thinks about aspects of masculinity and femininity), (2) affective experience (e.g., the way one feels about gender roles), (3) behaviors (e.g., the way one behaves in the context of their gender roles), and (4) unconscious experience (e.g., gender roles that manifest outside of our awareness or are repressed).

Research has found that men who are high in TMI and GRC are less willing to seek psychological help. For instance, Berger and colleagues (2005) recruited a sample of 155 mostly White men (85%) who were between the ages of 18 and 88 years old. Participants were administered several self-report scales which asked about adherence to

TMI, GRC, alexithymia, and attitudes about seeking psychological help. They found that all the subscales of the MRNI were associated with negative attitudes toward seeking psychological help. In particular, the norm Negativity toward Sexual Minorities predicted negative attitudes to seeking psychological help more than the other norms. This indicated that seeking help might be perceived as "gay" and, according to masculine norms, must be avoided.

It is important to note that, due to the majority of masculinity literature focusing on heterosexual males, the idea of a gay man being masculine is not often considered, making it seem as if gay men cannot be masculine and masculine men cannot be gay. However, in accordance with the theory of intersectionality, this is false. For example, Simonsen et al. (2000) recruited 650 mostly White (87%) gay men and collected data from several self-report inventories which measured GRC, attitudes toward seeking psychological help, and depression. They found that men who were more open to expressing emotions and sharing affection were less likely to be depressed and more open to seeking help than men who resisted expressing emotions and adhered to the subscale Restrictive Affectionate Behavior Between Men (RAB). This lends support to the idea that emotions, specifically how one deals with their emotions, may be key to understanding why men might be less likely to seek help over their female counterparts and experience increased depression. For gay men, it may be particularly difficult to cope when levels of RAB are high as that would not just restrict them from affection with friends but also with their intimate partner.

Importantly, it was found that older men had more positive attitudes about seeking help than younger men, indicating that masculine norms may decrease over time. Indeed, this was found in an older study in which older men endorsed less TMI than younger men (Levant & Fischer, 1998). Interestingly, in the Berger et al. (2005) study, only one subscale of the GRCS was found to be negatively and significantly associated with negative attitudes toward seeking psychological help, and that was Restrictive Affectionate Behavior Between Men. It is possible that men who feel uncomfortable with sharing affection would be less likely to pursue psychological help, as mental health treatment often requires self-affection.

Berger et al.'s (2005) finding that MRNI was related to negative attitudes about seeking help is also consistent with more recent literature. For example, Gerdes et al. (2018) found similar patterns in their content analysis of the MRNI. The researchers reviewed 84 studies which utilized the MRNI and found that, although most of the studies addressed multiple topics (n = 67), mental health concerns occurred most often in frequency (32.9%), followed by emotions (31.9%) and physical health (23.1%). They also found that the MRNI was consistently associated with negative attitudes toward seeking psychological help. Additionally, Yousaf et al. (2015) sampled 124 men (n = 73) and women (n = 51) from the London, Britain area. Participants were given several self-report measures which asked about attitudes toward seeking psychological help and TMI. They found that men's attitudes toward seeking help were largely due to their adherence to TMI in which higher levels of TMI led to more negative attitudes toward help-seeking.

TMI was also found to be a better predictor of men's help-seeking attitudes than other factors such as self-stigma (Levant et al., 2013). Levant and colleagues sampled 654 mostly European American (80%) college and community men and administered a self-report survey that asked questions about TMI, GRC, self-stigma about seeking help, attitudes toward seeking psychological help, self-efficacy, and depression. They found that depression moderated the relationship between TMI and attitudes about seeking help. In other words, men who had high depression and high TMI had more positive attitudes about seeking help than men who were low on depression and high on TMI. These findings suggest that a certain amount of suffering may have to occur for men to seek help. This assertion was supported by a qualitative study by Johnson et al. (2012) who interviewed 38 men between the ages of 24 to 50 with diagnoses of depression. (No other demographic information was provided.) They found five themes that were associated with men's help-seeking: (1) manly self-reliance, (2) treatment seeking as responsible and independent action, (3) guarded vulnerability, (4) desperation, and (5) genuine concern. In congruence with Levant et al. (2013), the men were more likely to seek help when they became desperate. In other words, they sought help when there was no other option, such as in a "do or die" situation (Johnson et al., 2012, p. 354).

This section discussed the literature on men's attitudes and intentions to seek help that used two very popular measures of masculinity. Overall, regardless of the masculinity measure used, the results posit that masculine norms have a negative relationship with help-seeking (Berger et al., 2005; Gerdes et al., 2018; Levant et al., 2013). These findings are largely consistent with those of the CMNI and help-seeking discussed previously (Herbst et al., 2014; McDermott et al., 2017; McDermott et al.,

2018; Vogel et al., 2011; Wong et al., 2017). In addition to help-seeking, masculinity has been found to impact men's emotional expression (Berke et al., 2018; Bruch, 2002; Cleary, 2012; Jakupcak et al., 2005; Levant et al., 2014; Levant & Parent, 2019). This provides additional information on the impact that masculinity has on the lives of men. In order to understand those impactions more fully, I will now provide a review of the relevant masculinity theories that provide the foundation for this project, as well as introduce the role of emotions.

Masculinity Theory and Emotional Expression

Gender Role Strain Paradigm

One of the most popular and widely accepted theories of masculinity is the Gender Role Strain Paradigm (GRSP; Pleck 1981, 1995). The GRSP posits that gender roles are socially constructed and are a detriment to psychological health. According to the GRSP, society puts pressure on individuals to abide by these gender roles for fear of social condemnation, and this causes strain and negative consequences. In men, the pressure to be masculine creates three different types of strain: dysfunction strain, trauma strain, and discrepancy strain (Pleck, 1995). First, dysfunction strain states that adhering to male role norms causes negative side effects because the norms themselves are inherently negative (e.g., Restrictive Emotionality, Toughness). Dysfunction strain indicates that, because these norms are inherently negative, they will almost always create negative side effects, no matter the individual differences across men. Sobiraj et al. (2015) gathered 213 men from female-dominated occupations (e.g., nursing, early school teaching, childcare services) and administered self-report scales measuring masculinity

ideology, social stressors at work, and psychological strain (e.g., depressed mood, emotional irritation). Using structural equation modeling, they found a partially mediated model between masculinity ideology, social stressors, and psychological strain. In other words, masculinity ideology led to increased social stressors, which led to increased psychological strain. In fact, masculinity ideology was found to be directly related to psychological strain. Congruent with Pleck's (1995) dysfunction strain, men who were high in masculinity ideology suffered from increased social stressors at work and increased psychological strain.

Second, trauma strain posits that the socialization process needed to become an acceptable man is inherently traumatic, as men are taught to forgo normal human experiences like vulnerable emotions in favor of appearing stoic and strong. Indeed, research has indicated that boys and men are punished for expressing emotions like sadness, guilt, and fear (O'Neil, 2008). For example, Cassano et al. (2007) sampled 53 fathers, the majority of whom came from White (95%) and middle (47.2%) to upper class (40.6%) settings, who completed various questionnaires relating to the fathers' perceptions, responses, and levels of acceptance of their children's emotions. Cassano and colleagues found that the fathers were more likely to minimize their sons' expression of their emotions (e.g., "Don't be such a baby"), which sets up boys to become men who are disconnected from their emotions. The socialization process continues as boys age and begin to interact with their peers. It has been found that peers play a role in policing boys' displays of emotions. For instance, boys displaying caring, hurt, or worry emotions often experience misogynistic (e.g., "You are such a girl!") and homophobic (e.g., "Don't

be gay") insults (Reigeluth & Addis, 2016). Through this process, boys learn that, in order to be masculine, vulnerable emotions must be avoided (Pleck 1981, 1995).

Finally, discrepancy strain is felt when men fail to uphold the standard of masculinity upheld by society and, as a result, they experience feelings of inadequacy (Pleck, 1995). In other words, their sense of who they think they should be is not aligned with who they actually are, and this causes negative side effects, such as low self-esteem. According to Pleck (1995), experiencing discrepancy strain can cause men to overconform to masculine norms and behaviorally express aggression. Research on this topic has been congruent with this idea, which will be discussed below (Berke et al., 2017, 2019).

This tendency to overconform is thought to originate from a need to avoid negative social consequences (e.g., ridicule) that are often associated with not being traditionally masculine (Addis, 2011). Research has also found that this occurs when men feel that their masculinity is being threatened. For instance, an experimental study by Berke et al. (2017) was conducted wherein 212 mostly White (66.4%) male college students were split into a threat group and a control group; both groups took a "gender knowledge test" in private. The men in the threat group were given a score ranked "near the average woman's score," and men in the control group were given a score ranked "near the average men's score." Both groups were then given measures of gender discrepancy and cognitive processing (i.e., a word-completion task), as well as a pain tolerance activity which used a rubber tip probe on a muscle in the arm to apply pressure until the participant did not want to go further. It was found that men who were given the

gender discrepant score exhibited higher levels of gender discrepancy, reported more aggressive-related words in the word-completion task, and endured more painful pressure than men who were given the gender congruent score (Berke et al., 2017). This indicates that, when men feel that they are not traditionally masculine, they are more likely to reassert their masculinity by expressing more aggressive emotions and even enduring more pain. According to the GRSP, this is due to a deep feeling of inadequacy and represents a way of restoring the masculinity that they feel they lost (Pleck, 1995).

Other studies have applied discrepancy strain to perpetration of violence. For example, in research which looked at difficulties in regulating emotions and intimate partner violence (IPV), it was found that these difficulties with emotions were related to discrepancy strain (Berke et al., 2019). Berke and colleagues sampled 357 community men, mostly White (73%), who had been in an intimate relationship in the past 12 months. Participants completed questionnaires aimed to measure masculine discrepancy, engagement in aggressive relationship behavior (e.g., physical assault and sexual coercion), and emotion regulation difficulties. Mediation analyses indicated that higher levels of discrepancy stress were related to greater difficulties in emotion regulation which, in turn, were related to increased physical assault. In other words, when these men felt they were not upholding the standards of masculinity, they experienced significant distress, which predicted increased outward expressions of anger and aggression; they were also unable to regulate these emotions and, thus, increased their risk for physical IPV perpetration.

This section aimed to discuss the GRSP and its connection with emotion expression. Through the three types of gender role strain, there is a systemic building of the masculine identity from childhood into adulthood (Pleck, 1981, 1995). Trauma strain, for instance, demonstrates that the early process of learning to be a man, in which boys are not provided with the necessary nurturing of emotions often provided to young girls, is damaging. Boys begin to learn at a young age from both fathers and their peers that vulnerable emotions are not allowed (Cassano et al., 2007). Discrepancy strain has been linked to increased aggression, difficulties with emotion regulation, and even a lack of acceptance and acknowledgement of negative emotions (Berke et al., 2019). It is here that men chase after an idea of masculinity while never quite feeling as if they "measure up". Finally, dysfunction strain posits that, because masculine norms are negative by nature, they will always cause negative effects (Pleck, 1995).

Regarding age group, research typically suggests that rates of adherence and conformity to traditional masculinity typically decreases with age (Levant & Fischer, 1998). This could be because younger men (aged 18-29) are just coming out of adolescence and have likely been required to strictly adhere to gender norms as mentioned through peer policing and mentoring from their parents (Cassano et al., 2007; Reigeluth & Addis, 2016). As expected, younger men in this age group are also less likely to seek help over their older counterparts (Berger et al., 2005). For men aged 18-29, the risk for developing depression in the first year of college is much higher than the final year of college (Jackson & Finney, 2002), and the masculinity norms that they ascribe to can have lasting impacts on their mental health (Iwamoto et al., 2018). For example, Jackson and Finney (2002) surveyed 380 men and 480 women at various stages

in college. This included 20.4% freshman, 28.9% sophomores, 29.1% juniors, and 20.7% seniors. Of those respondents, 49.8% of them were White and 42.6% were African American. Surveys measuring life events (e.g., failing a test, family problems, sexual assault, deviance, race relations) psychological distress, anxiety, and anger/hostility were administered. They found that freshman exhibited more depression and were more vulnerable to life events than their older counterparts. No significant findings for race relations were found.

A more recent study examined how psychological distress may be related to masculinity norms (Iwamoto et al., 2018). Iwamoto et al. (2018) conducted a longitudinal study that followed a mostly White (57%) sample of 322 adult freshman men between the ages of 18 and 20. The first wave of data occurred at the beginning of their freshman year, and the second wave occurred six months later. Participants were given measures assessing conformity to masculinity norms and depression. They found that the norms Playboy and Self-Reliance endorsed in wave 1 were positively associated with depression in wave 2. Although this is a smaller scale longitudinal study, it suggests a pattern wherein conformity to masculine norms may lead to negative mental health characteristics later on. This reinforces the need to identify struggling young men and administer mental health treatment to potentially curb some of these long-term effects. Taken together, GRSP provides a foundation for the Gender Role Conflict Theory and Normative Male Alexithymia hypothesis, both of which are relevant to the current study and will be discussed next.

Gender Role Conflict Theory

The next theory to be discussed is the Gender Role Conflict theory (GRC; O'Neil, 1981a, 1981b). The GRC is based on the GRSP and depicts gender role socialization as an interaction between biological factors and environments that promote masculine values. The GRC and GRSP are similar in stating that gender norms are socially constructed; however, the GRC offers a better understanding of how gender roles might operate in dynamic situations, such as gender role transitions (e.g., getting married, becoming a father), intrapersonal role conflict (e.g., negative emotions and thoughts), interpersonal role conflict (e.g., devaluing, restricting, or violating others), and role conflict from others (e.g., others devalue, restrict, or violate the individual). In short, the GRC represents concrete outcomes of Pleck's (1995) gender role strain that can be understood and measured. Consequently, researchers have been able to evaluate how gender roles and specific situations might affect emotions and emotional expression in men (O'Neil, 1981; Watts & Borders, 2005).

GRC has been found to influence men and their ability to express emotions, starting as young as adolescence (Watts & Borders, 2005). In one qualitative study, 11 mostly White (81%) high school boys between the ages of 14 and 18 were interviewed individually and in small groups. Questions were designed to measure gender role conflict, and each interview and small group was taped for transcription and coding. The boys reported feeling that expressing emotions, save for anger or rage, was inappropriate because it could be perceived as "unmanly" (p. 271). The notion that it is "unmanly" to express emotions is rooted in boys' and men's expectations to avoid and devalue

femininity. Emotional expressiveness is viewed as a feminine characteristic and, therefore, boys should feel conflicted about integrating this into their roles as men if they do not want to appear feminine (O'Neil, 1981). Relatedly, Watts and Borders (2005) found that it was extremely difficult for the boys to express vulnerable emotions; they seldom cried or showed affection or happiness. Even in situations which would warrant the expression of vulnerable emotions, like that of a death in the family, grief was never shown for fear of ridicule. The GRC theory (O'Neil, 1981) suggests that gender role conflict from others as well as from a transition (losing someone close to you) was felt by these boys who, as a result of feeling that conflict, defaulted to the most appropriate reaction for men by not showing emotion. By doing this, they were able to reduce that conflict within themselves.

Although the GRSP and GRC theories discuss the negative consequences of socializing boys and men to abide by masculine norms, they do not include adequate consideration of how masculinity might be conceptualized in men of color, namely Black/African American, Latino/Hispanic, and Asian American men. The next section will discuss a brief examination of how masculinity might be conceptualized based on culture and experiences of oppression for men of color.

Hegemonic Masculinity and Intersectionality

We have discussed several theories of masculinity and how masculinity is related to help-seeking attitudes and stigma, emotional expression, alexithymia, disclosure, and shame. The current study sought to collect data from a diverse sample of men. Masculinity theory and literature have been criticized for its heteronormative lens and

lack of focus on intragroup differences within men (Connell & Messerschmidt, 2005). It has long been argued that focusing solely on sex and gender and neglecting intersecting identities such as race is to underrepresent, and therefore perpetuate injustice against, diverse members of the group (Davis, 1983). Theories such as the GRSP (Pleck, 1981, 1995) and the GRC (O'Neil, 1981) were based on White men. Therefore, they are not representative of the experiences faced by men of Color. Mahalik's (2000) gender norms model provides more emphasis on intersecting identities and the importance of culture but was written by a member of the dominant group and is not currently considered a theory of masculinity. However, one popular masculinity construct that brings societal power dynamics to the forefront is *hegemonic masculinity*.

Hegemonic masculinity originated in 1982 (Kessler et al., 1982) and has been a prominent and hotly debated term in masculinity research ever since. The word *hegemony* was coined by Antonio Gramsci in his concept of cultural hegemony – the dominance of one culture over another (Lears, 1985). Relatedly, the idea of hegemonic masculinity was used to describe the culturally ideal model of a man (e.g., White, able-bodied, heterosexual, Christian; Connell, 1995) and its dominance over women and other men.

The concept of masculinity as a "dominant" identity over that of its feminine counterpart has been discussed in previous literature, with ideals of masculinity (e.g., power over women, resistance to emotional expression, aggression/toughness) upholding patriarchal values that serve to oppress women (Liu, 2005; Prasad et al., 2020). This same system is present for White men more so than men of color and straight men more so

than LGBTQ+ men, as White, straight men are socialized to regard sexually diverse men and men of color with negativity, skepticism, and hostility (Crowell, 2011; Liu, 2005). However, it is not just White men who strive to uphold a hegemonic system. Research has also examined Black men's negative treatment of women, especially Black women, and the LGBTQ+ community as they seek to reach the ideals of the hegemonic group in a quest for privileges of their own (Crowell, 2011). This is a representation of a toxic dynamic in which the very system created by men is the same system that harms them, as they are influenced to forgo aspects of their humanity in exchange for privilege.

As seen in the previous section, systems of privilege and oppression are housed within the contexts of multiple intersecting identities. The term hegemonic masculinity became an issue, as the concept was not inclusive to understanding the dynamics of diverse identities. In 2005, Connell and Messerschmidt proposed a reformation of the term hegemonic masculinity to incorporate a more thorough gender hierarchy, specifically to encompass the complex dynamics between different ways of defining masculinity rather than just focusing on the "dominant" group (p. 848). These different conceptualizations of masculinity consist of nonhegemonic masculinities and other unique formations based on diverse social identities such as disability status, sexual orientation, class, nationality, race, and ethnicity. In order to understand these conceptualizations more fully, we need to discuss the role of intersectionality.

Intersectionality is defined as, "an analytic tool … [that] views categories of race, class, gender, sexuality, nation, ability, ethnicity, and age – among others – as interrelated and mutually shaping one another" (Collins & Bilge, 2020, p. 2). According to this

concept, a single person can have multiple oppressed and privileged identities; the unique combination of these identities shape that person's experience and how masculinity might develop and manifest. As mentioned previously, masculinity was originally largely considered to be simply about sex – gender relations and men's domination over women (Connell, 1995; Lears, 1085). However, recent literature has called for the concept of masculinity to be called *masculinities* so as to transcend simply discussing gender relations and to incorporate intersecting identities (Messerschmidt, 2019). Since then, the study of masculinities has expanded to seek to understand how diverse identities impact how masculinity is expressed and conceptualized. For example, in contrast to White men, men of Color have to contend with backlash related to their racial identity, which is an oppressed identity in Western culture. This will be a main theme in the coming sections as I describe in more detail the specific dynamics involved in being a man and also being part of an oppressed racial group.

Unfortunately, there are no comprehensive theories of masculinity for specific racial groups. However, literature that centers on specific racial identities points to cultural and contextual themes (e.g., history of oppression) that describe how masculinity is conceptualized and performed (Acosta et al., 2020; Payne, 2006; Shek, 2006; Spencer et al., 2004). The following section will be dedicated to discussing masculinity as it relates to being African American/Black, Latino/Hispanic, and Asian in America.

Masculinities in Racially Diverse Populations

African American/Black Masculinities

Black men have been portrayed in American media as violent criminals for centuries, while simultaneously being held as heroes for their performance in sports where they serve as entertainment and are under control by Whites (Leonard, 2004; Ferber, 2007). In the last decade and a half, the long history of crimes perpetuated by police against Black men, such as Treyvon Martin, Eric Gardner, Michael Brown, Walter Scott, Alton Sterling, Philando Castile, and Tamir Rice, have spurred more recent literature to examine how Black masculinities are constructed and perceived in a White supremacist nation (Allen, 2017). In the years after Allen's (2017) article, several other Black men and women were murdered by police, including, but not limited to, Stephon Clark, Breonna Taylor, George Floyd, and Daunte Wright (BBC, 2021).

Ferber (2007) states that, in a White dominated society, there is a dichotomy between the 'good' and 'bad' Black men wherein the good Black men are "tamed" (p. 22) by White society and "know their place," such as being controlled by White coaches on sports teams. By contrast, the 'bad' Black men are ones who are considered to be untamed and susceptible to bouts of aggression, violence, and hypersexuality. Adolescent Black boys are exposed to media representations of Black men as hypermasculine (e.g., sexual prowess, athleticism, violence and aggression, flamboyance) and know that is what is expected of them (Roberts-Douglass & Curtis-Boles, 2013). This deficit model has existed for decades in which the communal and matriarchal nature of many Black families, the antithesis of Western culture, was considered to be the reason for Black boys

behaving as delinquents (Frazier, 1939; Moynihan, 1965). This lens through which Black masculinities are viewed in White society reinforces harmful stereotypes that encourage prejudice against Black men. The way that the dominant society treats Black boys and men influences how they see their masculine identity.

In school, Black boys, who are taught by mostly White middle-class women, often experience increased discipline such as disproportionately high suspension rates (Arcia, 2006; Losen & Martinez, 2013; Gregory et al., 2010) and decreased opportunities for extra educational attainment (Gregory et al., 2010; Allen, 2017). This negative treatment of Black boys often leads them to reject the educational values set down by the dominant society and either act out in ways that appear self-defeating (e.g., getting suspended, dropping out; Canton, 2012; Losen & Martinez, 2013) or become empowered to fight against racism in school while simultaneously using school resources to obtain academic achievement (Allen, 2017). For example, Allen (2017) interviewed ten Black male youth at a high school in the U.S. and completed over 300 hours of field observations in various school spaces (e.g., hallway, classrooms, lunchrooms). In the interviews, the boys discussed their experiences with microaggressions from their teachers, who used stereotypes of Black boys to guide their behavior. The students described that they were watched more, singled out in class, and received less help on schoolwork. According to Allen (2017), the school system reinforced cultural stereotypes of Black masculinity as being, "hypermasculine, hyperphysical, hypersexual … undisciplined, and intellectually deficient" (p. 276), and limited the young boys' understanding about masculinity and who they could be outside of those stereotypes.

In the previous section, it was discussed that Black masculinity can be understood through the lens of the dominant society (e.g., hypersexual, deviant, hypermasculine); however, this view is very different from how masculinity is seen in the Black community. Within the Black community, masculinity consists of values related to taking responsibility for one's own actions and being a provider for the family (Rogers-Douglass & Curtis-Boles, 2013). As with the deficit model, this more positive view of Black masculinity has also been around for decades (Cazenave, 1979, 1984). The lack of public knowledge around the existence of these traits associated with Black masculinity reinforces the notion that there is a widespread racist rhetoric which prevails White Western society, concealing the truth. In the coming paragraphs, the impact of experiences of racism and other childhood adversities (e.g., poverty, abuse) on the construction of Black masculinities will be discussed.

Young Black boys' response to racism has been to adapt certain coping strategies such as the *cool pose* and *playing the dozens*, which, in turn, provide strength, pride, and survival (Majors & Billson, 1992). Theoretical research has examined two different types of masculinity ideologies for Black men: *respect-based* masculinity (which consisted of valuing hard work, fidelity, and education) and *reputation-based* masculinity (which was associated with sexual prowess, toughness, and a rejection of authority; Whitehead, 1997). Recent research has examined these masculinities in a sample of 504 Black American men aged 19-22 who completed surveys measuring masculinity ideology, childhood adversity (i.e., poverty, emotional, physical, sexual abuse or neglect), and socioeconomic instability (Curtis et al., 2021). Participants completed the survey in three waves, 18 months apart from each other, over a three-year period. They found that

childhood adversity and high socioeconomic instability were associated with increased reputation-based masculinity and decreased respect-based masculinity. It is thought that reputation-based masculinity is adopted by men with backgrounds of childhood adversity in order to protect themselves and prevent further victimization (Payne, 2006; Spencer et al., 2004). Although this research examined important contextual factors that impacted identity development, they did not directly study the effects that racism might have on developing a masculine identity.

To examine the impact of racism on masculinity ideology development, Rogers et al. (2015) interviewed 17 Black/African American men about what it meant to be a man and how they would define masculinity. They were later asked similar questions about what it meant to be an African American or Black man. When asked the general masculinity questions, many answered in terms of Western masculine norms (e.g., toughness, leadership, heterosexuality). When responding to questions about what it meant to be an African American or Black man, they responded with similar masculinity traits, but they were embedded with systemic struggles related to race. Rogers et al. termed this phenomenon Racist Gender Role Strain (RGRS; Rogers et al., 2015).

As a result of RGRS, Black men develop specific techniques and concepts to cope with systemic barriers and obstacles that set unique characteristics and values specifically related to their culture and experiences. Techniques and concepts consist of (1) leadership (e.g., being a good role model, provider, and protector), (2) structural oppression (e.g., systemic barriers and racism), (3) African American values (e.g., religion/spirituality, education, historical knowledge), (4) traditional masculinity (e.g., mental toughness,

physical strength/control of one's body), (5) familial relationships (e.g., fatherhood, relationships with women), and (6) self-definition (e.g., autonomy and effects of absent fathers). Rogers' (2015) findings reflect those of previous research in that being a provider, playing sports, and academic achievement were valued as expressions of masculinity and that role models such as father figures, male teachers, and peers of similar racial and ethnic backgrounds were important in developing a healthy masculine identity (Rogers-Douglass & Curtis-Boles, 2013).

This section examined the contextual factors specific to Black men's masculinity development. The next section will examine masculinity within the Hispanic/Latino population.

Hispanic/Latino Masculinities

To begin this section, it is important to define the difference between *Hispanic* and *Latino*. Hispanic refers to someone with a heritage from a Spanish-speaking country, which includes Latin America as well as Spain (Martínez & Gonzales, 2021). Latino represents someone from Latin America, whether Spanish speaking or not, and excludes individuals from Spain (Hayes-Bautista & Chapa, 1987). Much of this section will be discussing masculinity through the lens of individuals from Latin American countries, as the research is more prominent, but research from Spain, France, and Portugal will also be presented.

Latino masculinity is defined by Abalos (2005) as serving a role as protector and provider of the family, with this role being rooted in control and patriarchy. Abalos describes the four faces of Latino men. The first face is one of unconscious control and

repression over the self in which emotions and actions not considered manly are pushed down and any threat to one's masculinity is considered feminine and weak. It is a dedication to the concept of *machismo*, a central gender role influence for men, which describes one who is emotionally invulnerable, dominant, and aggressive (Goldwert, 1983). Those who seek to sway from this way of life are called *Viejas*, or old women who do not measure up (Abalos, 2005; p. 161). This face follows the way of the fathers before them and never seeks alternative ways of being a man.

The second face according to Abalos (2005) describes someone who is out to gain power and may use the neighborhood, or *barrio*, they came from to further their agenda. Vulnerable emotions are suppressed as they live in a world of competition and those emotions can bring them harm from other competitors seeking power and status.

The third face exists in the shadow of racism as Latino men experience hatred from others for where they come from (Abalos, 2005). As they immigrate to the U.S, they struggle to find work, as they often cannot compete with White men. They experience frustration as their children learn English and behave in ways consistent with the dominant American culture but disrespectful to their Latin culture. Abalos describes this process as a collapsing of their masculine identity, their roles and way of life being altered in their new life in America. In response, these men either lash out at their families or *los Gringos* (White people), or engage in illegal activity like gang membership and drug trafficking. Another response they might have to these hardships is to be a provider but be withdrawn and unavailable at home. Such a person is described as

a wonderfully engaged man out in the community but then changes into one of disengagement and emptiness at home.

The final face of Latino masculinity, according to Abalos (2005), is one in which a person's sense of self comes from within where they are free to construct their own way of being rather than follow a set of rules laid down by others. This face asks questions to understand previous motivations to appear masculine and discover a new way of living to fight against injustice and form a better environment for their communities.

Abalos (2005) ends his narrative with a statement hinting at a more positive side of machismo: "Machismo in times of peril demand that men be prepared to fight together with women to protect our humanity by building schools, clinics, and infrastructure; protecting children; and preserving the environment" (p. 166). Despite some considerations that machismo could be used in a positive light, the concept of machismo has largely been referred to as a negative construct (Arciniega, et al., 2008; Pérez-Martínez et al., 2021). For instance, Pérez-Martínez and colleagues (2021) sampled 922 girls and 614 boys aged 13-16 from Spain, Italy, Romania, Portugal, Poland, and the UK. Participants completed self-report questionnaires on acceptance of violence and machismo, social support, SES characteristics, and bullying. For boys, bullying, suffering physical or sexual abuse, and perceiving less support from teachers were associated with higher machismo scores. A history of child abuse, along with higher machismo, were also associated with a higher acceptance for violence.

Seeking to understand how Latino masculinity might be both positive and negative, research began to explore whether additional concepts of Latino masculinity

might be discoverable. In a multi-study project on the development of a machismo scale, it was found that machismo is a two-dimensional construct (Arciniega et al., 2008). Arciniega et al. (2008) collected a sample of 154 men with a Mexican heritage who completed self-report measures on machismo, emotional connectedness, antisocial behavior, masculinity-femininity, interpersonal capabilities, and satisfaction with life. They discovered that the concept of machismo was made up of two factors, *traditional machismo* and *caballerismo*. The former was associated with interpersonal dominance, power, aggressive attitudes, control, and a strict adherence to specific gender roles, whereas the latter consisted of a focus on interpersonal and emotional connection, codes of ethics, nurturance, honor, and importance of family or *familismo*.

To understand more about traditional machismo and caballerismo, Arciniega et al. (2008) collected an additional sample of 477 Latino American men who were given self-report questionnaires measuring machismo, ethnic identity, antisocial behaviors, alexithymia, and ways of coping. Traditional machismo was associated with increased arrests, fights, and alcohol use, whereas caballerismo was not. Caballerismo, by contrast, was associated with greater problem solving, an increased ethnic identity, and other group orientation. Traditional machismo was associated with less ethnic identity and other group orientation. The relationship between machismo and lack of emotional connection is echoed by previous research, which examined 113 Mexican American men using measures that assessed machismo, GRC, acculturation, depression, and stress (Fragoso & Kashubeck, 2000). The researchers found that high levels of machismo and restrictive emotionality were positively related to stress and depression, suggesting that

machismo and facets of GRC (i.e., restrictive emotionality) can be harmful for the well-being of Latino men.

Stressors such as perceived racism and threat of deportation have also been recognized as contributing factors to Latino masculinity (Acosta et al., 2020; Arellano-Morales et al., 2020; Liang et al., 2011). For example, in a study of 159 Latino day workers, it was found that perceived racism was positively associated with GRC and negatively associated with life satisfaction (Arellano-Morales et al., 2016). Participants completed questionnaires measuring perceived racism, GRC, and life satisfaction. GRC was negatively associated with life satisfaction only when there were high levels of perceived racism. When there were low levels of perceived racism, GRC was no longer associated with life satisfaction. Consistent with GRC theory, this finding indicates that, due to systemic barriers related to race, Latino men who were unable to provide for their family (e.g., get jobs, make enough money) suffered negative impacts to their life satisfaction, as they were unable to fulfill their roles as men.

The findings by Arellano-Morales et al. (2016) are consistent with previous research in which perceived racism moderated the relationship between machismo ideology and GRC as well as the relationship between caballerismo ideology and GRC (Liang et al., 2011). Liang and colleagues collected a sample of 148 Latino men aged 18-60 who were given measures examining machismo and caballerismo, GRC, perceived stress, and perceived racism. They found that machismo was positively associated with GRC, restricted affectionate behavior between men, and restricted emotions. Caballerismo, by contrast, was not found to be associated with any dimension of GRC.

Perceived racism in academic settings was found to positively moderate the relationships between caballerismo and success, power, and competition conflict (a dimension of the GRCS). This is understandable, as a major facet of caballerismo is responsibility to provide for one's family, and perceived racism is a major stressor and barrier.

A systemic barrier specific to Latino men is the threat of deportation. When examining fear of deportation and perceived racism under a GRSP lens, it was found that fear of deportation was positively related to higher levels of machismo as well as depression (Acosta et al., 2020). Acosta (2020) and colleagues collected a sample of 241 Mexican migrant farmworkers and gave them measures assessing machismo, adverse childhood experiences, migrant farmworker stress, depression, anxiety, experiences of discrimination, and fear of deportation. In addition to fear of deportation, experiences of discrimination were also positively associated with depression and higher levels of machismo. Using the GRSP as a framework, the researchers speculated that higher levels of machismo would increase the impact of stressors such as discrimination and fear of deportation. This was found to be true, as experiences of discrimination and fear of deportation contradict machismo ideological notions of dominance. In addition, stressors that did not conflict with machismo, such as harsh working conditions and poverty, were not affected by one's level of machismo. Although poverty and harsh working conditions were found to be positively associated with depression, this relationship was not altered or influenced by machismo. These findings indicate, in congruence with the GRSP, that high levels of machismo increase the negative effects of stressors that conflict with its values.

So far, this section has examined masculinity theory and constructs within Black/African American and Hispanic/Latino American populations. The final subsection that will be discussed is masculinity within Asian American communities.

Asian American Masculinities

Literature on Asian American masculinities has largely examined the impact of stereotypes and myths surrounding Asian men (Keo & Noguera, 2018). Such fallacies have led to Asian American men being categorized as much lower in the masculinity hierarchy than other men, and research has examined how this negatively impacts Asian American men's well-being and influences their identity development as men (Lu & Wong, 2013). Early literature on Asian masculinities were examined through European masculinity theories such as the GRC (Liu, 2002; Shek, 2006). More recent literature has begun exploring Asian masculinities using the experiences of Asian men themselves to construct a more accurate understanding of Asian masculinity ideologies (Kyler-Yano & Mankowski, 2020).

Kyler-Yano and Mankowski (2020) recruited a sample of 89 Asian American college men who completed questionnaires measuring masculinity beliefs, IPV, and emotions. Before taking any masculinity measures, participants were asked the open-ended question, "What does it mean to be a real man?". The researchers first examined participants' responses to the normative masculinity questions and found that they ascribed to the theme of aggression, dominance, and self-reliance. However, the researchers were largely interested in the qualitative question. They found 10 themes. The most occurring theme was responsibility (33%), followed by respectfulness (26%), taking

care of others (22%), having a moral code (19%), rigidity (18%), never harming women (11%), being cognitively disciplined (10%), identifying many forms of masculinity (9%), being a gentleman (5%), and being successful (3%). This study indicates that many of the masculine norms endorsed by Asian men had to do with responsibility, respect, and taking care of others.

As with Black/African American men and Latino/Hispanic American men, Asian American men exist in a predominantly White Western cultural context wherein they are judged by the dominant parties. In a review of the literature, Shek (2006) discusses Asian American men being dubbed "effeminate" and "asexual" while simultaneously being considered a "model minority." From a GRSP lens, discrepancy strain would likely be felt as they struggle to measure up to the White normative ideals about masculinity. This was echoed by a study sampling 76 Asian American men (Lu & Wong, 2013). Participants were asked to complete "As a man…" statements ten times, providing ten different responses to the statement. They were then asked to state which of the experiences they listed was most stressful for them and why. A major theme to emerge was "trying to live up to the masculine ideal." In this theme, participants discussed the stress of trying to appear masculine based on the normative concept of masculinity, but ultimately feeling as if they failed based on others' perceptions of Asian men. One participant described being unable to meet both the demands of being Asian and of being an American man. Other participants echoed this statement, as many attempted to be tough and confident but felt as if that was ingenuine to who they truly were, particularly as some considered themselves to be more reserved or tended to shy away from conflict.

Body image was another stressor for participants, as Asian men are often depicted in American society as having small penises and being small and hairless. Other stressors consisted of restricting emotions while also not being allowed to ask for emotional support, exhibiting heterosexual activity such as dating and success with women, and various work-related identities in which they are expected to achieve and provide for their families. Having money was seen as an important aspect of masculinity. In addition, many of the men worried about working so much that they would be unable to have adequate family time.

As mentioned above, Asian men have the unique experience among men from minority groups in the U.S. of being considered a "model minority" (Kyler-Yano & Mankowski, 2020; Lu & Wong, 2013; Shek, 2006). Many of the issues surrounding the use of positive stereotypes, such as the model minority stereotype, are related to the silencing of Asian Americans who may be struggling. One study used census data, data from the American Community Survey (ACS), and empirical articles to debunk many of these myths (Keo & Noguera, 2018). The researchers found within the 2010 ACS that around 30% – 35% of Southeastern Asian American men (e.g., Cambodian, Hmong, Laotian, and Vietnamese) had very low high school graduation rates and suffered from increased rates of poverty, contrary to the stereotype that all Asian men are good in school and are high achievers.

The literature presented in this section suggests that, for Asian men, concerns exist regarding the intersectionality of their racial and gender identities and how they are perceived by Western society. The current literature on Asian masculinities is small;

indeed, only a handful of recent articles discuss the topic, with much of the literature occurring in the 1990s and early 2000s. More research needs to be completed to understand Asian American men and masculinities.

We have discussed several major theories of masculinity, including the GRSP, the GRC, and masculinities for men of Color. However, none of the literature discussed thus far has adequately and explicitly addressed men's emotions. I will now discuss a hypothesis that is central to understanding masculinity concerns and men's difficulty with emotional expression.

Normative Male Alexithymia Hypothesis

The Normative Male Alexithymia hypothesis (NMA; Levant, 1992, 1995) offers valuable information for understanding how masculinity and men's emotional expression is interrelated. The term alexithymia was coined in 1967 by Sifneos and translates to *without words for emotions*. The term originated in psychosomatic research and neurology as a way to explain difficulty with identifying emotions within PTSD and substance use disorder populations. The NMA hypothesis was created to account for a socialized pattern of restrictive emotionality in Levant's non-clinical clients (i.e., clients without clinically significant mental illness who were there for parent education) during the Boston University Fatherhood Project and provides a normative framework to encompass a wider population of men (Levant, 1992). It also serves as a foundation for the Normative Male Alexithymia Scale-Brief Form (NMAS-BF; Levant & Parent, 2019), which will be used in the current study. The NMA hypothesis posits that men's alexithymia severity depends on how strong their gender socialization is, with men

falling anywhere on a continuum from mild to severe levels of normative alexithymia (Levant, 1992; 1995).

Levant's (1992) framework for the socialization process in this hypothesis is rooted in the GRSP such that men may be experiencing any of the three strains mentioned earlier. Levant stated that many men have significant difficulty finding words for vulnerable emotions (e.g., disappointment, fear, sadness, guilt) and attachment (e.g., caring, love), yet are able to identify more aggressive or lustful emotions. Levant hypothesized that this was a result of years of socialization, which prohibited boys and men from expressing their emotions and even punishing them for doing so. This caused a deficit in their emotion vocabulary, and only with practice could they begin to develop the language to talk about their emotions. This hypothesis is similar to the GRSP and GRC in that it discusses emotions as prohibited by masculine norms and is a result of the socialization process to become a man, yet it also offers a more emotion-centered approach that the others lack.

In support of the NMA hypothesis, in a multi-study research article, Levant and colleagues (2014) sampled a group of 258 mostly White (79.8%) college men between the ages of 18 to 59. In Study One, participants filled out surveys measuring normative alexithymia, depression, affect, anxiety, social desirability, emotion regulation, emotion expression, and dissociation. It was found that both suppression of emotions and negative affect predicted normative alexithymia. Using the same participants in Study Two, Levant and colleagues split the men into alexithymic and nonalexithymic groups based on their scores on alexithymia measures as indicated by scientifically supported cutoff

scores. The men then completed an emotion word task on a computer. Words were split into two categories: ones that express vulnerability and attachment and ones that expressed aggression and lust. The authors found that the alexithymic men performed less accurately on the words associated with vulnerability and attachment than the nonalexithymic men, indicating that men who scored high on a scale of normative male alexithymia were unable to recognize and label traditionally non-masculine words as emotion words.

In a review of 25 years of masculinity research, O'Neil (2008) highlights other studies that have examined alexithymia and gender role conflict. One such study found that the masculine norm Restrictive Emotionality (i.e., difficulty expressing feelings; O'Neil et al., 1986) was related to difficulty in finding words for emotions (Berger et al., 2005). Berger and colleagues sampled 155, mostly White (85%), community men from Florida who took several questionnaires measuring masculinity, GRC, alexithymia, and attitudes toward seeking psychological help. For the men in this study, restricting their emotions was significantly and positively correlated with alexithymia. This indicates that there is a link between gender role conflict, particularly Restrictive Emotionality, and alexithymia, at least for White men (Levant & Wong, 2013). Other studies have examined this link in men from other racial and ethnic groups. For example, one study found the same link between Restrictive Emotionality and alexithymia in Japanese men (Hayashi, 1999). Another study with samples of 130 Black American men, 160 Latino American men, 146 Asian American men, and 288 White American men found that there was a significant and positive relationship between Restrictive Emotionality and

alexithymia and that this relationship was strongest for Latino Americans and weakest for Asian Americans (Levant et al., 2015).

These findings are somewhat inconsistent, as a previous study which sampled 273 Black American men, 458 Latino/a American men, and 394 White American men found that the relationship between masculine norms and alexithymia was stronger for White men than Latino or Black men (Levant & Wong, 2013). Findings between masculinity measured with a focus on Latino culture has found traditional machismo to be positively related to alexithymia. Arciniega et al. (2008), as mentioned in the previous section, found that there were two factors of machismo, traditional machismo and caballerismo. They found that traditional machismo was related to greater alexithymia and caballerismo was not, suggesting that identities with a focus on aggression and dominance does not lend itself well to building skills based on understanding the emotions of the self and others. This study examined Alexithymia using the Toronto Alexithymia Scale, it would be beneficial to examine if these relationships are similar when using the Normative Male Alexithymia Scale. Consequently, more needs to be done to understand the relationships between alexithymia and masculinity as it manifests in racial and ethnic minority men.

Other research has examined emotional dysregulation rather than alexithymia; although the terminology is different, it represents an outcome of struggling with NMA and should be discussed. Tager and colleagues (2010) recruited 108 European American and African American men through three batterer intervention programs and gave them questionnaires measuring abusive behavior, difficulties in emotion regulation, and conformity to masculine norms. Unfortunately, specific racial demographic information

was not included. It was found that emotion dysregulation was associated with the norms of Emotional Control and Self-Reliance, the former of which is associated with a need to keep emotions in check and is similar to restrictive emotionality mentioned earlier (Tager et al., 2010).

Men who struggle with emotional dysregulation and are also high on Self-Reliance might be less likely to seek help and may attempt to solve problems themselves by attempting to control and restrict their emotions only to find that they explode in fits of aggression and anger, often against their partners. However, some researchers, such as Cohn et al. (2010), who completed an experimental study on 128 mostly White (80.5%), college men found that it was not impulsive behavior which mediated restrictive emotionality and aggression, but men's nonacceptance of their negative emotions. They therefore hypothesized that the association between emotional dysregulation, restrictive emotionality, and aggression is driven more by an inability to tolerate, acknowledge, and accept emotional experiences rather than being unable to self-regulate. Regardless, these associations indicate that masculine norms and difficulties with emotions (e.g., emotional dysregulation, restrictive emotionality) are related to one another, and their effects expand outward to their interpersonal lives.

Although the theories and research presented so far have explained why men might have difficulty with their emotions, they have failed to discuss how this process occurs. As the current masculinity literature base does not address this, we must look to research in other areas to understand emotions at a deeper level. The next section will discuss emotion theory, which describes the cognitive and affective processes that

underlie men's emotional expression and inexpression and can be used in conjunction with the previously discussed theories, particularly the NMA hypothesis, to more holistically understand men's emotional experiences.

Integrating NMA with Emotion Theory

Research on masculinity and emotions has been criticized for not sufficiently integrating emotion science (Boise & Hearn, 2017; Wong & Rochlen, 2005; Wong et al., 2006). In response to this criticism, masculinity researchers have begun applying a popular model of emotional expression and inexpression, the Kennedy-Moore and Watson model (KM-W; 1999). Kennedy-Moore and Watson (1999) conceptualize emotional behavior as consisting of emotional expression or non-expression. Their definition of emotional expression is an observable verbal or nonverbal behavior that symbolizes or indicates an emotional experience. Their model breaks down a cognitive-evaluative process, which explains how an internal emotional experience is translated into an external emotional expression in five steps. It also includes disruptions that might occur at each step, which results in emotional inexpression.

Using the KM-W model, Wong and Rochlen (2005) describe each step and disruption as it applies to men and masculinity. The first step is the prereflective reaction, which occurs when an emotion-provoking stimulus creates an affective response leading to physiological arousal. For example, if a man were to be told that he is about to lose his job, his heart might beat faster, and his stomach might cramp. Men are likely to experience different strengths of emotions in different situations; therefore, emotional thresholds might be higher or lower. A higher threshold means that it would take a more

extreme stimulus to elicit an emotional response (e.g., death of a loved one); anything lower than that threshold would result in less physiological arousal and no emotion or emotion expression. In this example, if the man had a high threshold, the man losing his job might not even register any bodily sensations and the process would stop there. Unfortunately, to my knowledge, there is no research on men's emotional thresholds and how they might apply to emotional expression in men.

The second step is an awareness of an affective response (Wong & Rochlen, 2005). For instance, the man losing his job might recognize, or not recognize, that his heart is beating faster and his stomach is cramped. Since men are encouraged and motivated to repress negative or vulnerable emotions like fear, they might reject the fact that they are experiencing these physiological reactions and, therefore, would not express the emotion. If so, the emotional process would be disrupted.

The third step is labeling and interpreting an affective response (Wong & Rochlen, 2005). If the man who is losing his job is, in fact, cognizant of his physiological responses, he would then label the emotion (e.g., fear or stress). A disruption in this stage would be for him to not give a name for this reaction. This often occurs unconsciously and is a process associated with alexithymia. Men who experience a disruption at this stage struggle to find vocabulary for how they are feeling or may even be unwilling to label the experience as an emotion at all.

Step four is an evaluation of the response as acceptable (Wong & Rochlen, 2005). Once the man who is losing his job labels his experience as fear, he then must evaluate the emotion using his personal beliefs and values to decide if the emotion is acceptable.

Men are often taught that vulnerable emotions are “unmanly” (Watts & Borders, 2005; p. 271), and, therefore, unacceptable. Consequently, if he is high in masculinity, he would theoretically deem the emotion unacceptable and, as a result, would not externally express the emotion.

The final step is a perception of the social context for the expression of the emotion (Wong & Rochlen, 2005). If the man losing his job finds his emotions to be acceptable, he still must evaluate the social consequences of expressing his feelings of fear. According to Wong and Rochlen, it is often considered inappropriate for men to show vulnerable emotions to certain people (e.g., bosses, instructors). In this context, he might not express this emotion to the person firing him but might go home and express it to his partner. However, if he feels that his partner or others will think less of him if he expresses to them that he is scared, he will likely not outwardly express that emotion to others and, therefore, the process would have been disrupted.

Using the KM-W model, Wong and colleagues (2006) wanted to determine in which steps and through what disruptions restrictive emotionality might occur. The researchers obtained a sample of 222 White (52.3%), Asian American/pacific islander (23.4%), Hispanic (13.1%), and African American (6.8%) university men who completed scales measuring restrictive emotionality, anxiety, self-regulation of emotions, alexithymia, and attitudes of emotional expression, as well as a scale of social desirability. Using three scales which reflected the type of emotional disruption in Steps 2 through 5 of the model (i.e., repression of emotion, difficulty identifying feelings, attitudes toward emotional expression), they found that difficulty identifying feelings

(i.e., Step 3) and negative attitudes toward emotional expression, which represented two steps rather than one step of the model (i.e., Steps 4 and 5) was positively associated with restrictive emotionality. Importantly, when negative attitudes toward emotional expression was controlled for, difficulty identifying feelings was no longer associated with restrictive emotionality. This means that negative attitudes toward emotional expression was more strongly associated with men's restriction of emotions than difficulty identifying their feelings. In other words, men who were high in restrictive emotionality struggled to express their emotions more out of an unwillingness to do so due to the negative attitudes rather than an inability. Surprisingly, repression of emotions (i.e., Step 2) was not associated with restrictive emotionality. It is mentioned in the article that previous literature has theorized that the scale used to measure repressed emotions requires a conscious recognition of emotion (Lumley et al., 2002). Therefore, if emotions are repressed, it is likely that this occurs outside of the person's awareness and would not be picked up by the scale.

Men's ability to understand and express their emotions has negative consequences for how they handle interpersonal conflicts. For instance, the study which developed the Interpersonal Competence Questionnaire (ICQ; Buhrmester et al., 1988), which was used in this current study, found that being able to self-disclose to others was related to emotional expressivity. A sample of 220 male (55.9%) and female (44.1%) college students were asked to respond to several questionnaires on assertiveness, dating, emotional experiences, interpersonal activities, and interpersonal competence. Men were found to have lower disclosure competency, emotional support competency, and conflict management than their women counterparts. Recently, a small amount of research has

investigated NMA and interpersonal relationships. For example, Karakis and Levant (2012) sampled 175 mostly White (91.4%) university men who completed a survey which assessed NMA, fear of intimacy, and relationship adjustment and satisfaction in romantic couplings. They found that men who were high in NMA struggled to relate to their intimate partners' emotions, were less likely to communicate effectively with them, and were less satisfied in their relationships.

Part of masculine socialization is learning to restrict one's emotions (Cassano et al., 2007; Reigeluth & Addis, 2016; Watts & Borders, 2005). Numerous studies have determined that masculinity is associated with NMA (Levant et al., 2003; Levant et al., 2014; Levant et al., 2015). Likewise, dysregulation of emotions has been linked to emotional control, as well as self-reliance (Tager et al., 2010), as men prefer to try to deal with their emotions on their own rather than seeking out help for them. In fact, the need to restrict one's emotions and resolve them on one's own likely leads to disruptions in the cognitive-evaluative process that occurs in emotional expression (Wong & Rochlen, 2005; Wong et al., 2006) and may present as NMA (Levant et al., 2003; Levant et al., 2014; Levant et al., 2015; Wong & Rochlen, 2005; Wong et al., 2006).

Consequently, men who were open to expressing their emotions were found to be more likely to seek help than men who were less open to expressing their emotions (Simonsen et al., 2000). The need to control one's emotions and belief that one should have the ability to fix their problems on their own pave the way for high levels of self-stigma associated with seeking psychological help, negative attitudes toward help-seeking, and less intentions to seek help (Hammer et al., 2013; Mahalik & Di Bianca,

2021; Worthley et al., 2017). Unfortunately, few studies outside of Karakis and Levant (2012) have directly studied NMA and interpersonal competence, although those have found that emotions are linked to being able to navigate the interpersonal world (Bruch, 2002; Holmes; 2015; Ritchie, 1999). However, many of these studies examine sex differences rather than gender role differences. Therefore, there is a great need to assess masculinity, NMA, and interpersonal competence together, as it is critical that we understand how and in what way emotions can impact men and their relationships. Although this study is not examining relationships, assessing interpersonal competency allows us to examine the role of relational aspects of seeking help in which one's loved ones might play a major role in influencing help-seeking behavior. I will now discuss the role that masculinity and NMA play in men's interpersonal competency and disclosure.

Men, Disclosure, and Other Facets of Interpersonal Competency

The literature on relationships provides a diverse array of terminology related to interpersonal competency, such as relationship satisfaction (Humphreys et al., 2009; Karakis & Levant, 2012; Lamke et al., 1994) and conflict management (Buhrmester et al., 1986; Lease et al., 2019). Interpersonal competency is a multifaceted construct which assesses one's ability to interact effectively in interpersonal relationships (Buhrmester et al., 1988) as seen above, researchers have operationalized this in different ways. Interpersonal competency has been used to understand a multitude of contexts such as feelings of belonging in college (Gao et al., 2020), sexism at work (Lease et al., 2020), adolescent friendships (Chow et al., 2013), adolescent dating behavior (Paulk et al., 2011), and marital satisfaction (Schneewind & Gerhard, 2002).

This current study assessed one construct of interpersonal competency, disclosure. Disclosure is an area that has been discussed, albeit minimally, in relation to masculinity, especially Emotional Control and Self-Reliance, and self-stigma associated with help-seeking (Heath et al., 2017). Research has also found that difficulties with emotional expression (Bruch, 2002) and, more specifically, NMA are linked to disclosure rates (O'Loughlin et al., 2018). Men who control their emotions and want to solve their problems on their own are likely not going to have the tools for, or interest in, disclosing their problems to others, including a therapist. To provide a thorough review of the literature, I will be discussing other facets of interpersonal competency in addition to disclosure.

There are five domains of interpersonal competency as outlined by Buhrmester et al. (1988). Those are *initiation*, *negative assertion*, *disclosure*, *emotional support*, and *conflict management*. The first is initiation, which addresses facilitating outings, conversations, and being sociable. The second is negative assertion, or the ability to say "no" to something someone does not want to do, standing up for themselves, and communicating when someone makes them angry. Next is disclosure, the ability for someone to let people know the "real them", expressing how much they care for one another, and being vulnerable. Emotional support consists of helping others when they are upset or assisting with solving the problems of others, showing concern or empathy, and listening when others need to "vent" their problems. Finally, conflict management covers one's ability to take another's perspective in an argument, not exploding at others, and admitting when one is wrong.

Buhrmester and colleagues (1988) sampled 123 male and 97 female college students (no other demographics were provided). Disclosure competence was found to be associated with emotional sensitivity and emotional expressivity. Due to men's difficulty expressing their emotions (Levant et al., 2014; Wong & Rochlen, 2005) they are likely at a disadvantage for being able to disclosure their problems to others. Confirming this, in their original analysis of the gender differences in interpersonal competency, it was found that men had lower emotional support competence, negative assertion competence, disclosure competence, and conflict management than women but had higher initiation competence likely attributed to the traditional role of pursuing sexual relationships (Buhrmester et al., 1988).

Research began to examine Buhrmester and colleagues' (1988) findings in its relation to gender. For instance, Lamke et al. (1994) administered questionnaires measuring personal gender attributes (i.e., masculine, feminine traits), interpersonal competence, and relationship satisfaction to 174 male and 174 female college students (no other demographics were given). They found that men who attributed themselves to some feminine traits were better at self-disclosing to their intimate partner than men who only attributed themselves to masculine only traits, confirming the gender differences in disclosure set forth by Buhrmester et al. (1988). In addition, being able to self-disclose was positively associated with relationship satisfaction. Unfortunately, no specific feminine traits were discussed; however, these findings indicate that men who identify with both male and female traits are more likely to self-disclose and reap the benefits in comparison to men who might have mostly masculine traits.

More recent research, which incorporated measures of masculinity, also supported Buhrmester et al. (1988) findings about male differences in interpersonal competence. For example, a study by Lease et al. (2020) sampled 194 mostly White (90%), male, employed community members by providing them with questions about masculine norms, sexism, and interpersonal competence. They found that adherence to traditional masculine norms was negatively related to emotional support and conflict management in the workplace. These findings indicate that masculine norms are negatively associated with men's ability to provide emotional support and appropriately handle conflicts, at least in the context of employee relationships; however, the use of correlations make it impossible to determine causality.

Other research assessed men's competence in their peer relationships with other men. Bruch (2002) sampled 169 mostly White (72.3%) college men and gave them questions on shyness, toughness, emotional expressiveness, and restrictive emotionality. They found that men who reported they were shy and adhered to the masculine norm of Toughness (e.g., demonstrating physical, mental, or emotional strength, confidence, and Self-Reliance; Brannon, 1976) were less likely to self-disclose to their male peers and had an overall difficulty in expressing their emotions than men who did not report that they were shy and reported less adherence to the toughness norm. This finding about self-disclosure is in line with Buhrmester et al.'s (1988) finding. Although the current study did not discuss shyness, it is important to note that the relationship between self-disclosure, masculinity norms, and emotional expression are connected. Indeed, another survey-based study, which sampled 158 mostly White (55%) college men (21%) and women (78%) found a negative relationship between alexithymia and relationship

satisfaction (Humphreys et al., 2009). Although the researchers did not run analyses based on gender, this finding lends support for the study by Karakis and Levant (2012) mentioned above and indicates that being able to express emotions is related to having successful and thriving relationships.

More recent research confirms previous research cited above on men and self-disclosure. For example, Holmes (2015) sampled ten heterosexual men and interviewed them on their ability to discuss their emotions and conflicts with their romantic partners. Holmes found that most men preferred to work out their own problems in their heads and generally saw themselves as "emotional cripple[s]" (p. 183) and "not big talker[s]" (p. 184). However, Holmes also found that, although most men struggled to express themselves verbally, they often expressed closeness through touch (e.g., cuddling). Many of the men also discussed how physical touch was not a way to resolve problems, especially when the couples were not physically in the same space and so being able to communicate in other ways is important.

A recent study has examined alexithymia, disclosure of one's distress to others, and attachment avoidance. O'Loughlin et al. (2018) sampled a relatively equal number of mostly White (77.0%) men (50.6%) and women (49.4%) who completed self-report questionnaires on distress disclosure, experiences in close relationships, and alexithymia. They found that alexithymia partially mediated the relationship between attachment avoidance and distress disclosure and that this relationship was stronger for men than women. Alexithymia in this study was negatively related to distress disclosure in which highly alexithymic men were unable to put their distress into words to seek help. This

study is significant, as it examines alexithymia's role as a mediator in relation to men's disclosure. Unfortunately, this study did not examine masculine norms.

Previously mentioned studies indicated that not being able to effectively communicate or disclose their emotions to intimate partners (i.e., NMA) was related to lower levels of relationship satisfaction (Humphreys et al., 2009; Karakis & Levant, 2012, Lamke et al., 1994). We can thus speculate that men who display lower interpersonal competency (especially in the facets of disclosure, conflict management, and emotional support) would experience less success in relationships. These failed or severely struggling relationships might, in turn, lead to negative effects, such as feelings of shame. For instance, Kōlves et al. (2011) sampled 228 Australian men and 142 Australian women who had been separated from their married partner within the previous 18 months and an additional 174 Australian men who were single or married and not separated. Participants answered questions related to stressors from the failed relationship, the presence of any mood disorders, suicidal ideation, and shame. They found that men in the separated relationships exhibited more internalized shame than men who were not separated or who were single. Importantly, it was found that their internalized shame was also positively related to suicidal ideation and depression. Similarly, a study about dormitory belonging examined 539 college student men (n = 117) and women (n = 422); using survey data, the authors found that depression and feelings of inferiority (a facet of shame) were negatively correlated with interpersonal competence (Gao et al., 2020). These findings indicate that shame and interpersonal competence might predict psychological ailments that would be helped by seeking behavioral health services.

In conclusion, lower rates of disclosure of one's problems to others have been linked to masculine norms (Bruch, 2002), including Emotional Control and Self-Reliance (Heath et al., 2017), difficulty expressing emotions (Bruch, 2002; Buhrmester et al., 1988), alexithymia (O'Loughlin et al., 2018), and high self-stigma associated with seeking help (Clement et al., 2015; Pederson & Vogel, 2007). Shame has also been found to be an important barrier to men's help-seeking (Clement et al., 2015). However, the concept of shame is not adequately represented in masculinity research. There is some evidence, as we have seen, that low emotional expressiveness relates to lower interpersonal competency (Buhrmester et al., 1988; Karakis & Levant, 2012; Lease et al., 2020) and that shame might indirectly result from these constructs (Kõlves et al., 2011). However, research has yet to synthesize specific facets of shame into a broader model with masculinity. This study will be examining shame from two lenses. The first lens will be internalized general shame, specifically inadequacy and deficiency. The second lens is threatened masculinity-related shame, which posits that shame is directly felt when one's masculine image is in danger. The use of these two types of shame will allow for greater precision in understanding how much might be directly related to a threatened identity and how much might be attributed to other factors, such as disclosure and alexithymia.

Internalized General Shame – Inadequacy and Deficiency

The role of shame has been underemphasized in the literature on men and masculinity. Indeed, a search of relevant articles in psychology research databases related to masculinity and shame yields only one hundred and ninety-six articles with most not actually being relevant to shame and masculinity research. Despite the lack of research

studying masculinity and shame, the studies that exist show statistically significant results about the deleterious effects that shame has on men's minds and bodies (Bannister et al., 2019; Crocker et al., 2016; Rice et al., 2016; Wood et al., 2017). The current study examined inadequacy and deficiency, a facet of internalized general shame. This section will discuss the overall concept and consequences of shame. Unfortunately, no research has yet explicitly examined men's feelings of inadequacy and deficiency. However, this is supported in masculinity theory through the GRSP (Pleck, 1995). Inadequacy and deficiency are about not quite measuring up to some invisible standard (Cook et al., 1988), a central tenant of Pleck's discrepancy strain in which men feel as if they can never quite achieve the masculine ideal set forth by society.

The concept of shame was initially discussed through a psychodynamic lens by Lewis (1971) as being a "superego function" (p. 422) and were semi-unconscious, meaning that some aspects of shame might operate outside of conscious awareness. Specifically, Lewis conceptualized shame as being a connection between the self and the superego, one's higher moral compass (Freud, 1923). Shame is a socially based phenomenon in which the self is operating simultaneously in the world as an individual and as part of a societal network. Lewis discussed this network as outside "others" which put their standards and judgements on the self, which can result in shame. According to Lewis, shame is less likely to be recognized as shame and is, instead, described in relation to the self and the "others" (pp. 424-428). For instance, Lewis noticed in their patients that many did not explicitly identify that they felt shame but instead would worry about how others might perceive them. This indicates that the focus on shame is the self as they are perceived by the "others" (pp. 424-428).

Lewis (1971) conceptualized shame as being comprised of several different variants: (1) mortification, (2) humiliation, (3) embarrassment, (4) feeling ridiculous, (5) chagrin, (6) shyness, and (7) modesty. According to Lewis, mortification would entail "wounded pride" (p. 426) and a feeling of distance between the self and the other person involved. Humiliation can be experienced through the eyes of the self or through the perception of the other person; this causes the self to cycle between reacting in passive or active ways. Embarrassment involves a "loss of power" (p. 426) in relation to the other person. Unfortunately, Lewis did not elaborate on the meanings behind the remaining variants. Following the discussion of these variants, Lewis discussed factors related to shame, which make it difficult to alleviate the pain associated with shame. These are: (1) difficulties in accurate assessment of the person being in a state of shame, (2) difficulties in functioning when feeling shame, and (3) difficulties alleviating hostility when feeling shame.

In the first of Lewis's factors, shame is conceptualized as difficult to acknowledge and alleviate because it is often confused with feelings of guilt and/or is coped with by running away or hiding, a term called "by-passing shame" (p. 428). When shame is felt, it is often followed by a distancing maneuver, which can prevent the development of feeling ashamed as the person has acted before any overt affect could be noticed. Utilization of the defense mechanism of denial is also common, especially when the shamed person is hiding or running away. In addition, shame is described as a primitive and wordless reaction, which might yield little cognitive content and, therefore, might be difficult to self-report.

In Lewis's (1971) second factor, functioning of the self is greatly depreciated when experiencing shame, as this entails experiencing condemnation from others and from within one's self. This split causes perceptions of others, situations, and the self to be blurred and unclear. Additionally, feeling shame is a physically painful experience, and the bodily functions associated with shame (e.g., muscle tension, sweating, sleeplessness, body aches and pains) can be split from the cognitive understanding of what is happening (e.g., recognition that shame is being felt). This results in feelings of incongruence, causing deficits in functioning as the shamed person struggles to find a solution. Finally, Lewis stated in the third factor that dealing with hostility associated with shame is the final barrier to alleviating shame. This hostility can be centered on the self or on others. When a shamed person feels hostility towards themselves, it is usually manifested by not living up to the ideals set down by the "others," feeling small, overwhelmed, and not in control. By contrast, when the hostility is aimed at the "others," the shamed person feels enraged at being considered inadequate or undeserving of love. Lewis commented that hostility against the "others" often redirects back to hostility against the self and that this then leads to psychopathology. This is similar to men behaving in overt masculine ways (e.g., not asking for help, aggression, restriction of vulnerable emotions) when faced with criticism against their masculinity (Baugher & Gazmararian, 2015; Funk & Werhun, 2011; Gebhard et al., 2019).

We have already demonstrated that masculinity typically leads to significant mental health deficits (Herbst et al., 2014; Levant et al., 2013; Wong et al., 2017). Coupling men's responses to feelings of inadequacy (e.g., increased masculinity) with significant mental health deficits that often follow, Lewis's (1971) theory about the link

between shame and psychopathology could be applied to men. We will be discussing more about the effects of men's threatened masculinity in the coming section.

In the years that followed Lewis's (1971) article, more research which sought to measure the phenomena of shame emerged. In 1988, Cook designed a measure called the Internalized Shame Scale (ISS), which will be used in the current study. Cook obtained a large sample of 801 mostly White (no percentage provided) male (50.7%) and female (49.3%) undergraduate students and adult community members and administered the ISS and a survey which asked about alcoholism, childhood abuse, and family deaths. Specific participant demographics were not mentioned. Cook discovered that there was not one factor of shame; rather, there were four. Cook called the first factor inadequate and deficient; Cook's ISS described it as internalized feelings which centered around seeing oneself as "small," feeling insecure about the opinions of others, and feeling as if one was not measuring up (p. 203). The second factor was embarrassed and exposed, which entailed self-harshness after making a mistake, striving for perfection, and a fear that one's faults would be visible to others. The third factor, fragile and out of control, was expressed through feeling as if one was not strong enough to overcome negative feelings and a confusion about knowing one's identity.

The final factor was feelings of emptiness and loneliness, which consisted of feeling unfulfilled and as if something were missing. All factors predicted the development of addiction behaviors (e.g., drug use, alcohol use, overeating, sex and gambling addition, shopping addiction, working excessively) and emotional distress (e.g., anxiety, depression, suicidal ideation, phobias, hospitalization) in both men and women

(Cook, 1988). However, the factors *fragile* and *out of control* were found to be particularly potent predictors of addiction in men. Interestingly, the behaviors associated with shame, as shown by Cook (1988), reflect similar externalizing behaviors often seen in men who are suffering from mental illness as discussed previously (Boyd et al., 2015; Eaton et al., 2012). We can therefore speculate that shame might be a silent contributor.

Since the scale's creation, a handful of research articles have explored the impact that shame has on emotional distress, PTSD, and aggression (Bannister et al., 2019; Crocker et al., 2016; Wood et al., 2017). For instance, a diverse sample of 127 all male veterans (36.2% European American, 24.4% Hispanic, 16.5% African American, 11.0% Asian American) were given self-report questionnaires related to verbal and physical aggression, shame, guilt, and PTSD symptoms (Crocker et al., 2016). It was found that shame was associated with verbal aggression and physical aggression toward others. This is consistent with Lewis's (1971) theory about the impact of shame. PTSD symptoms alone did not correlate with either verbal or physical aggression, although higher PTSD symptoms were significantly associated with higher shame. In examining the relationship among PTSD, aggression, and shame further, it was found that shame mediated the relationship between PTSD and verbal aggression, but not between PTSD and physical aggression. The relationship between PTSD and shame was also found in a later article that used a similar sample of 144 mostly White (58%) male veterans and used similar measures of shame, guilt, and PTSD (Bannister et al., 2019).

Shame has also been evaluated with individuals recovering from psychosis related to schizophrenia, schizoaffective disorder, or delusional disorder. Such a sample was seen

in a study of 79 male and female inpatients (Wood et al., 2017). No other demographics were provided. The researchers administered several self-report questionnaires which measured recovery, depression, shame, stigma, self-esteem, and hopelessness. They found that shame was a significant mediator between mental illness stigma and depression, recovery, and hopelessness. In other words, when an individual experiences or perceives stigma and shame due to that stigma, the presence of shame causes an increase in depression and hopelessness, and a decrease in self-perceived recovery. This indicates that shame has a wide-reaching impact on individuals and reinforces the need for shame-focused mental health services. The relationship between shame and stigma might help explain why men might be less likely to seek psychological treatment. Indeed, shame was cited in an article about stigma as being a significant variable associated with avoiding treatment (Corrigan, 2004). This was consistent in a national sample discussed earlier in the chapter, which found that shame was one of the top barriers to men seeking treatment next to disclosure concerns (Clement et al., 2015). To my knowledge, there is no literature which examines the relationship between shame and self-stigma associated with seeking psychological help with masculinity included as a variable. The Wood et al. (2017) study provides more evidence that stigma in general impacts treatment and recovery.

A small number of studies have examined masculinity and shame together. One such study examined the relationship between self-compassion (i.e., being kind to oneself), shame, and masculinity in a mostly White (61.4%) sample of 145 university and community men (Reilly et al., 2014). Participants were given several self-report questionnaires related to self-compassion, conformity to masculine norms, and shame. It

was discovered that high levels of shame were negatively related to self-compassion and conformity to masculinity norms. In examining these finding further, it was found that men who had high shame had lower self-compassion regardless of their levels of conformity to masculine norms, whereas men with low shame typically had low levels of conformity to masculine norms and high levels of self-compassion. Men with lower levels of shame and higher levels of conformity to masculine norms tended to have lower levels of self-compassion. These findings indicate that shame is important to understanding how masculinity might play a role in constructs like self-compassion.

Other studies examined the role of conformity to masculinity norms and shame on depression (Rice et al., 2016). Rice and colleagues collected a sample of 545 Australian men with an average age of 38.9 from metropolitan areas, no racial demographics were included. Participants were administered self-report measures assessing for conformity to masculine norms, depression, and shame. Higher conformity to masculine norms was related to higher levels of shame and depression. Using mediation analysis, the authors found a significant direct and indirect effect such that CMN was positively associated with higher depression and shame mediated that relationship. In other words, masculinity predicted shame, which, in turn, predicted depression. For men with high conformity to masculine norms, the threat of shame at not adequately displaying those norms might exacerbate depression. Interestingly, they also found an association between age, shame, and CMN. Younger men tended to be higher in CMN and shame in comparison to older men. Unfortunately, they did not clarify specific ages for the two categories. No significance for depression was found.

More recently, Rice and colleagues (2020) examined the mediating role of shame on alexithymia and psychological distress. They investigated a sample of 1,000 men from Canada, 53.1% of whom were between the ages of 19-49 and 46.9% of whom were above the age of 50 (no racial demographics were reported). The authors administered scales assessing distress, depression, suicidal behavior, alexithymia, and shame and guilt. They found that the relationship between alexithymia and psychological distress was positively mediated by shame, providing important evidence for shame's role in difficulties in emotional expression and distress.

Research on veterans found significant associations between shame and the CMNI subscales of Emotional Control and Self-Reliance (McDermott et al., 2017). The researchers examined a total of 349 male (63.2%) and female (36.8%) student veterans who either did or did not see combat. The veterans completed a survey examining painful self-conscious emotions (i.e., shame and guilt), Emotional Control and Self-Reliance, and stigma for seeking professional help. Using structural equation modeling, the researchers found significant and positive associations among self-conscious emotions, Emotional Control, Self-Reliance, and stigma for seeking psychological help but only for the veterans who saw combat. This indicates that understanding the context in which men are operating is important. In this case, the trauma of combat was only significantly related to shame, guilt, help-seeking stigma, and Emotional Control in those who did experienced combat. When the authors analyzed shame and guilt as separate constructs, both failed to be associated with Emotional Control and Self-Reliance; therefore, the effects were only significant when guilt and shame were analyzed together. It is possible that this occurred because of the measure that was used to assess shame and guilt, which assessed both

constructs. However, the relationship between Self-Reliance and stigma to seek help was found for both groups, providing additional evidence for CMN and barriers to help-seeking.

This section discussed the theoretical foundations for general shame and how shame is related to masculinity. Masculinity has been found to be related to increased shame, which contributed to psychological disorders such as depression and suicidality (Gebhard et al., 2019; Reilly et al., 2014; Rice et al., 2016). More specifically, shame was found to be related to Emotional Control and Self-Reliance (McDermott et al., 2017) and self-stigma toward seeking help (Clement et al., 2015); shame was also a mediator between the relationship between alexithymia and psychological distress (Rice et al., 2020). The literature on shame in men is quite limited and, unfortunately, no research has yet examined these variables in relation to inadequacy and deficiency. However, we can speculate based on Pleck's (1981, 1995) discrepancy strain that being unable to express one's emotions and disclose problems to others may incite feelings of inadequacy and deficiency as a man for having such limitations. The next session will discuss how a threatened masculine identity can also create feelings of shame.

Threatened Masculinity-Related Shame

After Pleck's (1981) book, The *Myth of Masculinity*, was released, more literature seeking to understand the negative physical and mental effects that masculinity had on men began to emerge. The concept of threatened masculinity was developed from literature about men's body image and the pressure to acquire and maintain a mesomorphic body structure typical of the ideal masculine man (e.g., flat abs, muscular

arms, narrow waist; Mishkind et al., 1986). The term threatened masculinity appeared in the field first before the term precarious manhood. No major distinction between the two have been made in the literature and they are often used interchangeably; for this study, I will use the term threatened masculinity.

In their seminal article, Mishkind and colleagues (1986) hypothesized that the muscular mesomorphic man benefited from advantages in society, such as attractiveness to women and appearing to have mastery over their environment. The authors discuss that this one type of body ideal is dangerous, as it demands a one-size-fits-all approach in a world where bodies, by their very nature, are diverse. They further asserted that to fail to have the ideal body type was a threat to a man's masculine image, which would, therefore, negatively impact the man's psychological and physical health through feelings of body dissatisfaction, depression, anxiety, and low self-esteem. In the 20th century, as women were gaining rights, it was hypothesized that, as men's domains to assert themselves over women decreased, men gained a need to display their masculinity outwardly as if to differentiate themselves from their female counterparts (Mishkind et al., 1986; Mills & D'Alfonso, 2007). Therefore, being unable to physically differentiate men from women, such as through strength or physical prowess, would be a direct threat to masculinity, as common myths about gender suggest that feminine and masculine characteristics cannot exist simultaneously (Pleck, 1995). Indeed, the GRC theory mentioned earlier specified avoidance of femininity as the core of the masculine identity (O'Neil et al., 1986). Researchers soon became interested in what would occur should one's masculinity be threatened. Although the concept of threatened masculinity has been present for a while, an explicit operationalization of threatened masculinity did not

appear in literature until the late 1980s when the scale called Masculine Gender Role Stress (MGRS; Eisler & Skidmore, 1987) appeared.

In developing their measure, Eisler and Skidmore (1987) drew from Pleck's (1981) book, which stated that men received social condemnation when they violated masculine gender roles. Due to this condemnation, Eisler and Skidmore conceptualized MGRS as a "cognitive appraisal of specific situations" (p. 125). This indicates that men will feel stress when they perceive situations as "unmanly" or feminine or when they are not able to cope with the demands of upholding the male role. Eisler and Skidmore administered the MGRS scale to 82 men and 91 women in a university setting. As expected, men scored higher on the MGRS than women, which indicated that men appraised threats to masculinity as more stressful than did women. They also found that men who scored higher on the MGRS reported increased anger and anxiety than men who scored lower, indicating that stress associated with threatened masculinity was related to emotional distress.

By the mid-2000's, the term precarious manhood appeared in the scientific community and, as explained earlier, is now used interchangeably with threatened masculinity. The thesis of precarious manhood can be reduced down to the idea that masculinity is hard won and easily lost and that threats to one's masculinity is distressing (Vandello & Bosson, 2013). Pleck (1981) discussed this same concept in his book *The Myth of Masculinity* when describing masculinity. While Pleck never used the terms threatened masculinity or precarious manhood, he saw masculinity as a "risky, failure-prone process" (Pleck, 1981, p. 20), as not all men achieve it. Vandello and Bosson

(2013) discuss the three tenants of precarious manhood: (1) manhood is an elusive status that must be earned; (2) once obtained, manhood can be lost or taken away; and (3) manhood must be confirmed by others, which requires the need to publicly demonstrate proof. Up to this point, literature did not discuss how shame might play a part in threatened masculinity. In fact, it has only been within the last few years that research about shame and threatened masculinity began to emerge.

The concepts of internalized general shame and threatened masculinity-related shame are somewhat linked. For example, a recent survey-based study sought to validate the Masculinity and Shame Questionnaire (MASQ; Gebhard et al., 2019), which will be used in this study. The researchers sampled 460 heterosexual, mostly European American (71.3%) and Asian American (13.5%) men. Participants were administered several measures which assessed masculine norms, self-reported aggressive behaviors, guilt, general shame, self-efficacy, and thriving. The researchers found that men who were more prone to general shame were also more prone to experiencing shame from threatened masculinity (Gebhard et al., 2019). This provides evidence for the assertation that threatened masculinity-related shame and internalized general shame are two separate constructs. Consequently, research assessing threatened masculinity-related shame as a distinct variable separate from internalized general shame may be valuable in addressing gaps in the literature.

It is well known that masculinity has been associated with increased aggression, especially toward intimate partners and gay men (Baugher & Gazmararian, 2015; Berke et al., 2018; Cohn et al., 2010; Levant & Pryor, 2020; Tangney et al., 1992). For instance,

a meta-analysis analyzing 20 peer reviewed articles on the MGRS and violence found that men who were high in MGRS endorsed IPV (in IPV vignettes and past violent behavior) more often than men low in MGRS. Most importantly, men who were high in MGRS were most likely to endorse IPV when their masculinity was threatened (Baugher & Gazmararian, 2015). The studies that Baugher and Gazmararian (2015) reviewed typically threatened male participants' masculinity by having them respond to situations in which a man did not behave in a traditionally masculine way (e.g., crying or displaying affection toward other men). What is less understood in the literature is *why* masculinity, even when threatened, can lead to aggression and violence. Gebhard and colleagues (2019) suggested that shame might be the underlying construct explaining men's aggression. According to these researchers, aggression might serve as a mechanism to avoid feelings of shame; however, research had not yet created a measure that could explore that idea. Seeking to fill that gap in the literature, the authors mapped measurable masculinity-related threats that might lead to shame. They began by using literature about situations that research considered threatening to one's masculinity, as well as consultation to generate and revise items for their scale, the Masculinity and Shame Questionnaire (MASQ; Gebhard et al., 2019). According to the MASQ, masculinity-related threats include (1) being perceived as feminine (e.g., crying), (2) failing to be masculine enough (e.g., being mugged and having money taken), (3) being perceived as gay (e.g., being asked out by a man), and (4) failing to be heterosexual enough (e.g., lovers state that they were not sexually satisfied).

Based on the threats listed by Gebhard et al. (2019), we can apply the MASQ masculinity threats to Vandello and Bosson's (2013) tenets of precarious manhood. For

instance, according to the MASQ, there are numerous ways that masculinity is elusive (e.g., can be called feminine at any time), must be confirmed by others (e.g., sexual dissatisfaction from lovers, being seen as strong enough to defend oneself), and can be easily lost or taken away (e.g., being called out, experiencing a traumatic event, feeling inadequate). The integration of shame into the thesis of precarious manhood can be speculated to occur throughout Vandello and Bosson's tenants, specifically regarding a failure to provide proof of one's masculinity. According to Gebhard et al. (2019), that failure is the catalyst to men feeling shame, and, consequently, negative psychological effects might be experienced. The MASQ provides several subscales which help us connect the tenants to the measurable constructs in the measure.

The MASQ (Gebhard et al., 2019) is made up of four subscales, which can be unofficially linked to the tenets of Vandello and Bosson's precarious manhood theory. The four subscales are (1) Feel Shame (e.g., having a negative view of self after a scenario), (2) Escape (e.g., avoiding things associated with the threat), (3) Externalize Blame (e.g., blaming someone or something related to the scenario), and (4) Prevent Exposure (e.g., preventing others from finding out about what happened).

In line with Pleck (1995), the subscale Feel Shame can be associated with the tenet that masculinity is elusive and must be earned (Gebhard et al., 2019). Feeling shame as a response to a threatening situation might mean that masculinity was not earned. For example, if a man fails to score a point in a sports game and that causes his team to lose, shame might arise because he failed to be strong and capable. The subscale Externalize Blame can be linked to Vandello and Bosson's tenet that men need to demonstrate public

proof of their masculinity. By blaming the threatening scenario on someone or something else, the onus can be removed from the individual and masculinity can be preserved. The subscales of Escape and Prevent Exposure can be related to the tenet that masculinity can be lost or taken away. For instance, feeling bad about being turned down for a date might lead some to avoid the people or places that were associated with that situation. This puts the control back into the hands of the individual and prevents any further loss of masculinity. Importantly, this reflects Lewis's (1971) idea of "by-passing shame" in which one runs away or avoids a situation to not feel the physical and psychological effects of shame (p. 428). Regarding the subscale Prevent Exposure, if others were to find out that a man was mugged and could not protect himself, he might be perceived as lesser of a man and based on the third tenet (i.e., masculinity must be confirmed by others).

The study by Gebhard et al. (2019) found a link between threatened masculinity-related shame responses and physical aggression. The researchers collected data from mostly European American (71.3%) men (n = 86) and women (n = 181). Participants completed a self-report survey which asked questions about self-conscious affect, masculinity and shame, MGRS, male norms, masculinity contingency, guilt, self-efficacy, thriving, and aggression. First, they found that men's scores on the MASQ were higher for men than for women. Additionally, physical aggression was found to be associated with the subscales Preventing Exposure and Externalizing Blame after masculinity was perceived as being threatened. Finally, in their post hoc analyses, it was found that threatened-masculinity shame-related responses predicted physical aggression above and beyond other masculinity-related constructs alone. These findings indicate that perhaps masculinity alone is not sufficient to extract physically aggressive behaviors;

rather, men who are more prone to feelings of shame in response to threatened masculinity may be more likely to behave as such. It is unclear why some men are more shame prone than others; regardless, it speaks to the need for more research to examine this concept.

This section discussed the role of threatened masculinity-related shame on men. Although the research has found support for the positive relationship between threatened masculinity-related shame and internalized general shame (Gebhard et al., 2019), no studies have examined threatened masculinity-related shame with any other variable. In fact, no published studies have yet to use the MASQ aside from Gebhard et al. (2019). Although supporting research for threatened masculinity-related shame is scarce, the concept applies well to existing masculinity theories, such as the GRSP (Pleck, 1981, 1995) and the precarious manhood theory (Vandello & Bosson, 2013), and provides an opportunity fill an important gap in the literature.

Summary of and Rationale for the Current Study

The research described throughout this paper has shown evidence that gender norms, masculinity in particular, may influence various negative effects. The literature in the field of men and masculinities has examined masculinity in relation to emotional inexpression, self-stigma for help-seeking, and, to a lesser extent, interpersonal incompetency, internalized general shame, and threatened masculinity-related shame. Two prominent theories of masculinity, the GRSP (Pleck, 1981, 1995) and the GRC (O'Neil, 1981) are the foundation for the current study. These theories provide a framework for understanding the harmful process of being socialized to be traditionally

masculine, such as punishment for showing vulnerable emotions by fathers and the policing of emotions by peers (O'Neil, 2008; Reigeluth & Addis, 2016). In addition, the use of emotion theory, such as the KM-W model (Kennedy-Moore & Watson, 1999), provides a valuable foundation for understanding the cognitive-evaluative process of emotional expression and inexpression, especially as it applies to men and masculinity (Wong et al., 2006).

The current study sought to examine masculinity and self-stigma associated with seeking psychological help, hereafter to be called Self-Stigma, among a diverse sample of men. We have seen in previous sections how masculinity is perceived and conceptualized for Black/African American men, Hispanic/Latino men, and Asian men. These masculinities are both similar and largely different from White men. Similarities point to the harmful effects that masculinity can have on men regardless of racial background (Arciniega et al., 2008; Levant et al., 2015; Levant & Wong, 2013; Scott et al., 2015; Terlizzi & Zablotsky, 2020). Research which discusses the additional impacts that accompanies being an oppressed man in America (Acosta et al., 2020; Arellano-Morales et al., 2016; Canton, 2012; Curtis et al., 2021; Lu & Wong, 2013; Whitehead, 1997) reinforces the need for research to work with increasingly diverse samples and for researchers to have a competence about what masculinity looks like for all members for that sample.

As indicated by the discussion of the literature, current research has found relationships between masculinity, relationship satisfaction, shame, emotional inexpression, stigma for help-seeking, and disclosure, but have yet to synthesize those

findings into a comprehensive model. Analyzing a large model which can make connections between years of different research studies could help us more fully understand the association of masculine norms, particularly Emotional Control and Self-Reliance, with various aspects of men's lives (e.g., NMA, Disclosure, Shame, Threatened Masculinity-Related Shame, Self-Stigma).

After an in-depth review of the research, several of the variables in this study's model were found to be linked to masculinity and to each other, which provides a rationale for the current model. For instance, research had found relationships between masculinity and difficulty identifying and expressing emotions, or NMA (Levant et al., 2014; Levant & Parent, 2019). Masculinity and emotional inexpression were, in turn, found to negatively affect men's competency in their relationships, relationship satisfaction (Buhrmester et al., 1988; Karakis & Levant, 2012; Lease et al., 2020), and disclosure of distress (O'Loughlin et al., 2018). Important to the current study, disclosure competence was found to be associated with emotional expressivity (Buhrmester et al., 1988), which provides additional evidence for a similar finding between Disclosure and NMA. In fact, a mediated pathway was found from masculinity through Disclosure and Self-Stigma to help-seeking attitudes. In other words, masculinity positively predicted Self-Stigma which negatively predicted help-seeking attitudes, masculinity also negatively predicted Disclosure which positively predicted attitudes about seeking help (Pederson & Vogel, 2007). In an examination of barriers to seeking help, Clement et al. (2015) found that disclosure concerns were the most prominent type of stigma barrier, followed by shame/embarrassment, which provides additional evidence regarding the potentially important roles of Disclosure and Shame on Self-Stigma. Masculinity was

also found to predict increased feelings of internalized general shame, shame when one's masculinity was threatened (Gebhard et al., 2019; Reilly et al., 2014; Rice et al., 2016), and negative attitudes about seeking psychological help (Berger et al., 2005; Gerdes et al., 2018; Levant et al., 2013). The same finding about help-seeking was found for emotional inexpression. In fact, men who expressed emotions were more likely to seek psychological help over men who restricted their emotions (Simonsen et al., 2000). Based on this finding, it is probable that being able to freely express one's emotions could lead to less self-stigma for seeking help.

Out of all of the CMN subscales, Emotional Control and Self-Reliance provided the most robust associations of men's Self-Stigma and intentions to seek help (Heath et al., 2017; Mahalik & Di Bianca, 2020; McDermott et al., 2018). Similar associations were also found for shame and guilt which were associated with help-seeking stigma, Emotional Control, and Self-Reliance for veterans who saw combat (McDermott et al., 2017). These studies provide a rationale for the use of Emotional Control and Self-Reliance as masculinity variables in the current study. However, McDermott and colleagues (2017) failed to find significance for the role of Emotional Control and Self-Reliance and shame for non-combat veterans when they analyzed shame as a separate construct from guilt. This provides justification for this study's use of a shame-exclusive measure in order to examine whether any of the significant associations between specific aspects of shame (e.g., Inadequacy and Deficiency), Self-Stigma, and Emotional Control can be replicated and even expanded upon. Although there is some literature which has examined these variables using mediation, there is currently no research which explores all of these relationships in a cohesive model.

This study aimed to incorporate two types of shame into a model of masculinity, NMA, Disclosure, and Self-Stigma. These two types of shame were internalized general shame, specifically Inadequacy and Deficiency, and Threatened Masculinity-Related Shame (TMRS). The incorporation of not just one type of shame but two allowed greater precision in examining the role of shame in a way that research has not yet done. The study that developed the Masculinity and Shame Questionnaire (MASQ; Gebhard et al., 2019) found that TMRS was a distinct form of shame separate from more internalized general shame. Most importantly, it was found, in the same study, that men who already had a high level of internalized general shame were more likely to have high TMRS than men who had lower levels of internalized general shame. This suggests that masculinity can have an additional negative influence on men whereby they feel shame on not just a general level but at the core of their gender identities, thus linking these two constructs. By including both internalized general shame and TMRS in the current study, it was possible to examine how these variables relate to one another and the other variables.

Research has indicated that shame is an important variable to explore. For instance, shame has been found to lead to increased verbal and physical aggression (Crocker et al., 2016) which would theoretically impact relationships; unfortunately, shame and interpersonal competency, specifically Disclosure has not been explicitly tested. Shame was also found to play a large role in men's well-being when assessed with masculinity; for instance, Rice et al. (2020) found that shame positively mediated the relationship between CMN and depression. The relationship between shame and mental illness was found in numerous other studies (Bannister et al., 2019; Crocker et al., 2016; Kõlves et al., 2011; Wood et al., 2017). This might play a role in men developing

psychological disorders such as depression, suicidality, and PTSD and not seeking help for them. Shame was also found to mediate the relationship between alexithymia and psychological distress (Rice et al., 2020), providing support for its negative impact on men. The relationship between shame, specifically Inadequacy and Deficiency, and Self-Stigma has not yet been studied, thereby creating a gap in the literature.

This study served an important purpose in exploring these missing links. Not only is it likely that shame and masculinity are related, but they are also connected theoretically, serving as another rationale for a model that utilizes both variables. In Lewis's (1971) article about the theory of shame, they describe the development of a hostility toward the self or others after feeling inadequate, and therefore shameful. This provides a useful explanation for why men who feel inadequate often engage in more violent or aggressive behaviors (Berke et al., 2017; Gebhard et al., 2019; Tager et al., 2010). Upon close inspection, Lewis's ideas are strikingly similar to Pleck's (1995) discrepancy strain. Although Lewis and Pleck created theories that were not intentionally related to one another, their theories are similar in that both of them discuss negative feelings toward the self after failing to achieve expectations handed down by society which leave them feeling inadequate. Researchers even theorize that shame, rather than masculinity, might explain men's aggression (Gebhard et al., 2019), although this has not been explicitly studied.

Although there has been plenty of research about masculinity and emotional expression, very few studies in the field of men and masculinity have actually been conducted with an understanding of emotion theory. This provides an important rationale

for this study as it was conducted on a foundation of emotion research from the field of men and masculinities as well as from emotion science using the KM-W model of emotions (Kennedy & Watson, 1999). By doing this, the current study aimed to further examine the relationship between masculinity and NMA through this lens to provide more details about the effect that masculinity and NMA has on men's ability to disclose their problems in their romantic and peer relationships. By emphasizing emotion research outside of the field of men and masculinities, a deeper understanding of the emotional process of men could be obtained and with-it new research and therapeutic treatment designed for male concerns.

Research in the field of men and masculinities has traditionally used predominantly White samples. The research that does represent men of color have found similar findings between help-seeking, Emotional Control, and masculinity (Levant et al., 2015; Scott et al., 2015; Vogel et al., 2011) with some research suggesting that men of color seek help even less than White men (Terlizzi & Zablotsky, 2020). It is also unclear whether the relationship between masculinity and NMA is the same for men of color as it has been found that there is less of a relationship between the two for men of color than for White men (Levant & Wong, 2013). This study sought to obtain a diverse sample in order to examine whether relationships that existed between the variables are similar for men of color as they are for White men. Additionally, very few research studies in the field of men and masculinities have examined the role that age plays in men's lives (Gerdes et al., 2018; Wong et al., 2017). However, research has indicated that older men typically endorse fewer masculine traits than younger men (Levant & Fischer, 1998) and older men generally have more positive attitudes about help-seeking than younger men

(Berger et al., 2005). More research should examine masculinity and help-seeking in the 18-29 aged population as this is a formative year for building habits and attitudes that have long term effects such as depression (Iwamoto et al., 2018; Jackson & Finney, 2002).

Although the literature has been thorough in examining the role that CMN subscales, and other masculinity and gender norms, play in each of these variables, the literature has yet to put it all together. It is clear that CMN in particular negatively impacts men's ability to feel and express their emotions (Berger et al., 2005; Bruch, 2002; Tager et al., 2010), connect with others to have successful peer and romantic relationships (Humphreys et al., 2009; Karakis & Levant, 2012), and contributes to a sense of shame that may impair their ability to seek help whether from professional resources or simply confiding in loved ones (Clement et al., 2015; Heath et al., 2017; Herbst et al., 2014). This study intended to use structural equation modeling to assemble an explanatory model for men's Self-Stigma through CMN, specifically Emotional Control and Self-Reliance, Disclosure, NMA, Inadequacy and Deficiency, and TMRS.

Research Questions and Hypotheses

This study aimed to fill the gap in the literature for men of different racial identities. As little research has been done on men of color, this study sought to help break that cycle by recruiting a diverse sample of men. This study ultimately sought to draw connections among Emotional Control, Self-Reliance and Self-Stigma transmitted through NMA, Disclosure, Inadequacy and Deficiency, and TMRS. The order of the variables in my model are informed by the theorized idea that men who do not like to talk

about their feelings to others (Emotional Control) are more likely to struggle with expressing their emotions to loved ones (NMA), which, in turn, predict that they would being less likely to disclose their problems to others (Disclosure) and more likely to experience shame when their masculinity is threatened because they would feel vulnerable (TMRS). Due to their difficulty expressing their emotions, disclosing to others, and feeling vulnerable about their masculinity, they will likely feel inadequate and deficient, even if they are not conscious about why they feel that way (Inadequacy and Deficiency). This inadequacy and deficiency may lead to more self-stigma to seek counseling, as it is considered 'unmanly' for men to seek help, especially for emotional concerns.

For men who strongly believe that they should solve their problems by themselves (Self-Reliance), they are more likely to hold their emotions in and not express them to others in an attempt to hide from others their inner problems (NMA) and would, therefore, not self-disclose to others (Disclosure). Like their emotionally controlled counterparts in the previous model, they would feel shame when their masculinity is threatened because they would feel vulnerable and perhaps exposed (TMRS). Disclosure, NMA, and TMRS would all predict feelings of inadequacy and deficiency, which would then predict higher self-stigma for seeking help.

This section describes hypotheses related to preliminary analysis (i.e., correlational and mean testing), the primary (see Figure 1) and alternative (see Figure 2) models, and moderations for exploring racial differences in specific paths. Since path

analysis were used, each section of the model was individually discussed in terms of hypothesized relationships and directions. The research questions and hypotheses were:

Preliminary Testing of Relationships

Research Question 1: Are there significant relationships among Self-Reliance, Emotional Control, Disclosure, NMA, TMRS, Inadequacy and Deficiency, and Self-Stigma? (For all related hypotheses, Psychological Well-being will be included to determine if it has a relationship with any of the hypothesized variables. If so, it will be added as a covariate.)

- H1: There would be a negative association between Self-Reliance and Disclosure and Emotional Control and Disclosure and positive associations between Self-Reliance and NMA, Emotional Control and NMA, Self-Reliance and TMRS, and Emotional Control and TMRS. There would also be a positive association between Emotional Control and Self-Stigma and Self-Reliance and Self-Stigma.
- H2: There would be a negative association between Disclosure and Inadequacy and Deficiency and positive relationships between NMA and Inadequacy and Deficiency, and TMRS and Inadequacy and Deficiency.
- H3: There would be a positive relationship between Inadequacy and Deficiency and Self-Stigma.

Research Question 2: How, if at all, will the relationships specified in Hypotheses 1-3 change when accounting for age or race (i.e., Black/African American, Hispanic/Latino American, Asian/Asian American, and White/European American)?

- H4: I hypothesized that the relationships would be largely identical to the relationships when all participants were used. Based on research which found that

restrictive emotionality was positively related to NMA for Black, Latino, Asian, and White men but was stronger for Latino American men and weakest for Asian American men (Levant et al., 2015), I hypothesized that the relationship between Emotional Control and NMA would be present across all racial groups, but it would be stronger for Hispanic/Latino men than Asian American men. Due to the lack of research between race and the remaining variables in the model, I hypothesized that the relationships between Disclosure, NMA, TMRS, and Inadequacy and Deficiency would remain the same across all groups.

- H5: I hypothesized that there would be some mean differences in the relationships for certain racial groups. Since White adults were found to be more likely to seek-help over Black or Hispanic groups (Terlizzi & Zablotsky, 2020), I hypothesized that White men would have less Self-Stigma than Black, Hispanic/Latino, or Asian American men.

Model Testing

Model 1 (see Figure 1) consisted of paths in which Emotional Control and Self-Reliance would directly and negatively predict Disclosure and directly and positively predict NMA and TMRS, as well as positively and directly predict Self-Stigma. Emotional Control and Self-Reliance were two separate predictors and were analyzed separately with the same hypothesized pathways. Disclosure would directly and negatively predict Inadequacy and Deficiency. NMA and TMRS would directly and positively predict Inadequacy and Deficiency. Inadequacy and deficiency would positively predict Self-Stigma. An alternative model was also posited (see Figure 2),

which is identical to model 1 without the direct path from Emotional Control and Self-Reliance to Self-Stigma.

Research Question 3: Does Emotional Control and Self-Reliance predict Disclosure, NMA, and TMRS?

- H6: I predicted that Emotional Control and Self-Reliance, when separately analyzed, would have a direct effect on Disclosure, NMA, TMRS, and Self-Stigma. Specifically, Emotional Control and Self-Reliance would negatively predict Disclosure and positively predict NMA, TMRS, and Self-Stigma. Regarding the relationship between Emotional Control and TMRS, research had shown that difficulties with emotions (e.g., Emotional Control) and shame (McDermott et al., 2017) were positively associated with one another; this provided some empirical support for the hypothesized relationship.

Research Question 4: Does NMA predict Disclosure and TMRS?

- H7: Research had indicated that men typically had lower disclosure competency in comparison to women (Buhrmester et al., 1988) and even reported being unable to self-disclose to other male peers (Bruch, 2002). In addition, difficulties with emotions have been associated with interpersonal issues such as being able to communicate effectively with others (Holmes, 2015; Karakis & Levant, 2012; Kõlves et al., 2011), which negatively impacted the strength of their intimate relationships. I hypothesized that NMA would have a direct effect on Disclosure and TMRS in which NMA would negatively predict Disclosure and positively

predict TMRS. In other words, high scores on NMA would predict lower scores on Disclosure and higher scores on TMRS.

Research Question 5: Does Disclosure, NMA, and TMRS predict Inadequacy and Deficiency?

- H8: I predicted that Disclosure, NMA, and TMRS would directly predict feelings of Inadequacy and Deficiency such that high scores on Disclosure would be negatively predictive of Inadequacy and Deficiency, and NMA and TMRS would be positively predictive of high scores on Inadequacy and Deficiency. Research on TMRS had indicated that a large part of the shame process hinged on fears of negative perceptions of others (Gebhard et al., 2019; Lewis, 1971). Therefore, men who felt shame related to their masculinity might feel inadequate and deficient as men, which would be consistent with Pleck's (1998) discrepancy strain theory. This applied as support for a negative predictive relationship between Disclosure and Inadequacy and Deficiency, as having problems or feelings that one could not talk about might cause those problems and feelings to be internalized as the self being naturally inadequate and deficient in comparison to others who might appear more high functioning. Despite the finding that men who were prone to internalized general shame were more prone to threatened masculinity-related shame (Gebhard et al., 2019), this model examined the inverse of this relationship. This decision was made because only one study found this relationship, and it is important to examine other possible relationships, especially when one might fit with a specific model better than the other.

Research Question 6: How does Inadequacy and Deficiency relate to Self-Stigma?

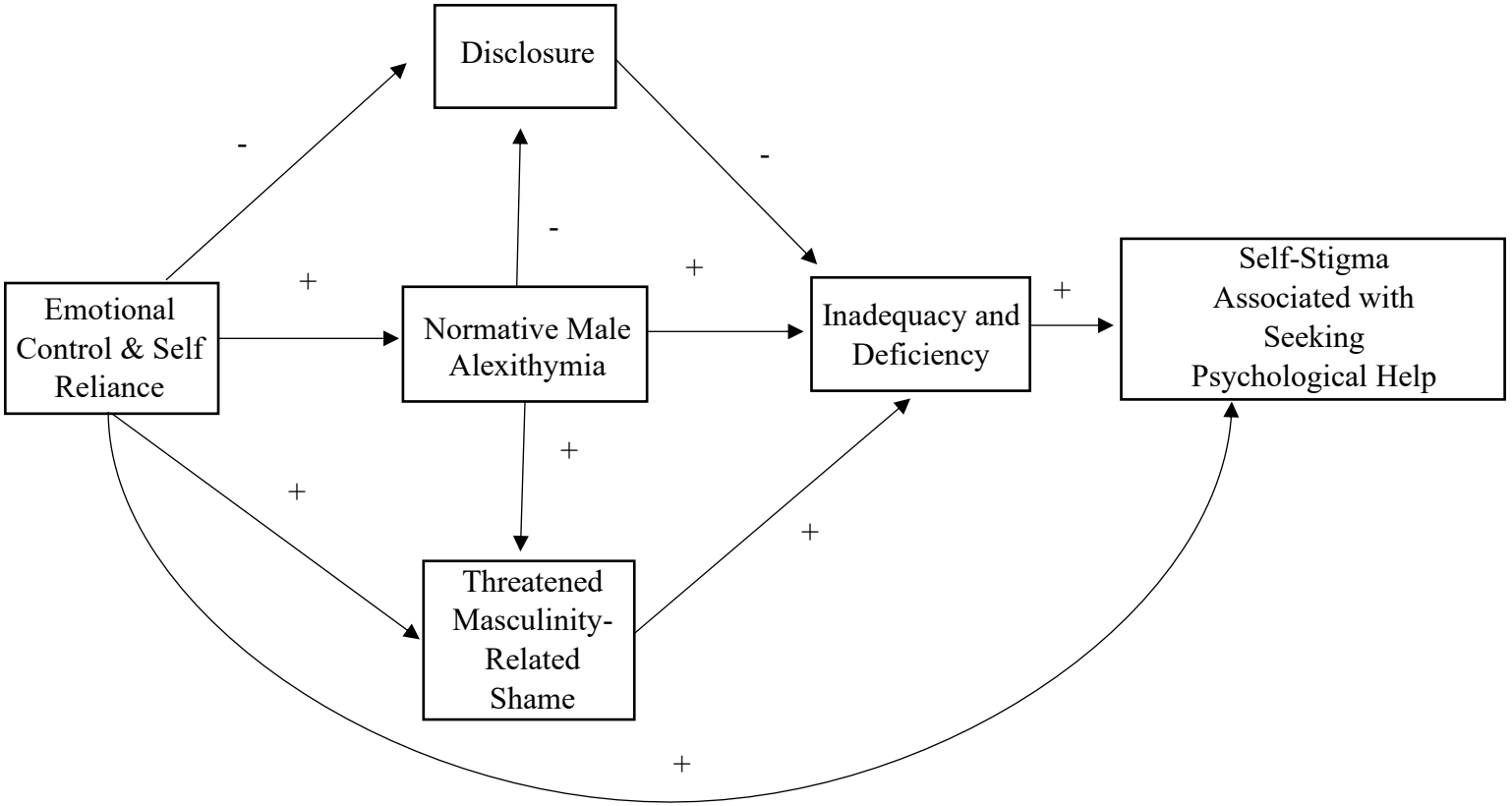
- H9: I predicted that Inadequacy and Deficiency would have a direct effect on Self-Stigma in which Inadequacy and Deficiency would be positively predictive of high Self-Stigma (SSOSH total score). Specifically, men who had determined themselves to be inadequate and deficient would feel a deep sense of shame that they would even need to seek help rather than be able to resolve it on their own.

Research Question 7: Are certain paths in the model conditional upon race/ethnicity?

- H10: I hypothesized that the relationship between Inadequacy and Deficiency and Self-Stigma would be stronger for men of Color than White men.
- H11: Research had also found a stronger association between restrictive emotionality and NMA in Hispanic/Latino men than Asian American men (Levant et al., 2015). Due to this finding, I hypothesized that the relationship between Emotional Control and NMA would be strongest for Hispanic/Latino men and weakest for Asian American men.

Figure 1

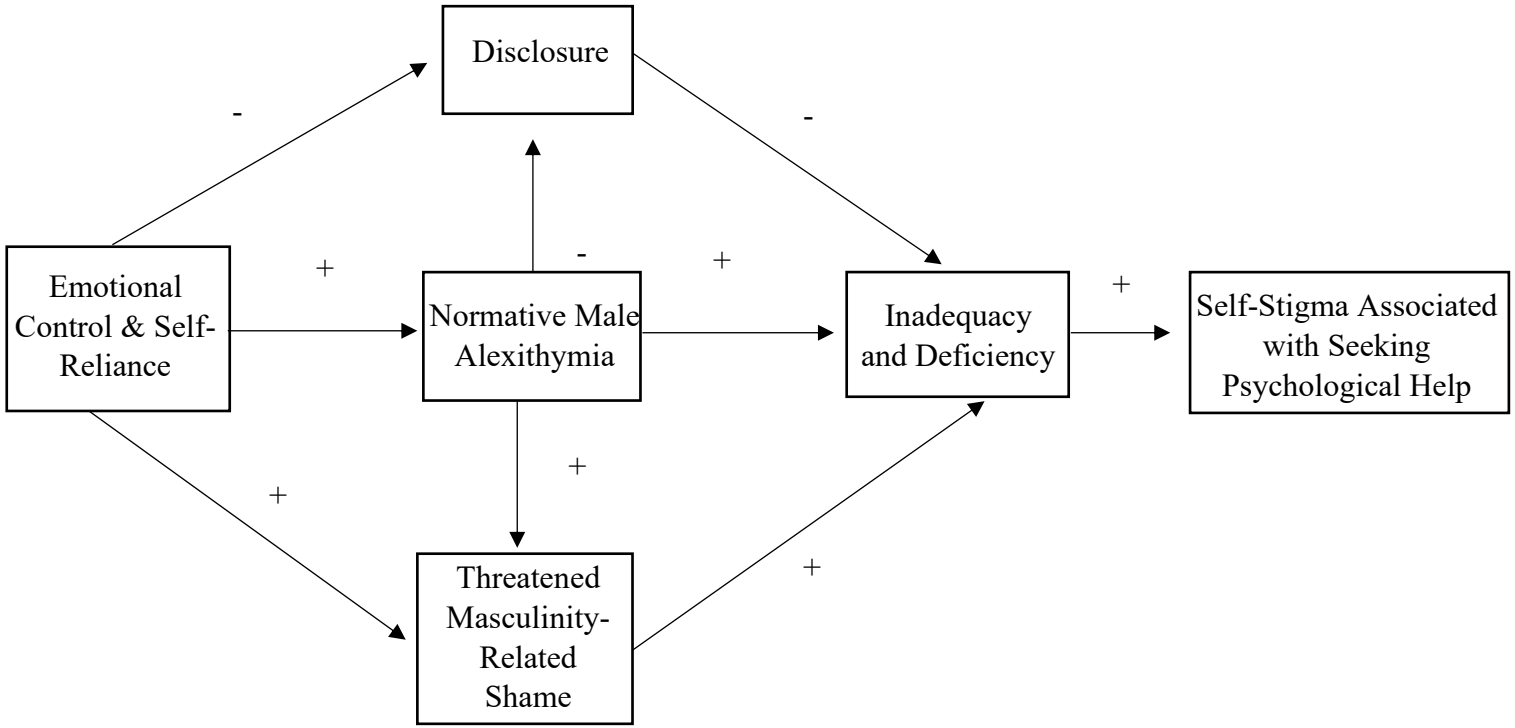
Structural Model Predicting Self-Stigma Associated with Seeking Psychological Help



Note. Model contained two predictors, Emotional Control and Self-Reliance. Each were run separately in separate models with the same hypothesized directions.

Figure 2

Alternative Structural Model Predicting Self-Stigma Associated with Seeking Psychological Help



Note. Model contained two predictors, Emotional Control and Self-Reliance. Each were run separately in separate models with the same hypothesized direction

CHAPTER III

RESEARCH METHOD

The purpose of the current study was to analyze variables in two models that could predict men's self-stigma associated with seeking psychological help. Specifically, I examined whether Emotional Control and Self-Reliance could directly predict Disclosure, NMA, Threatened Masculinity-Related Shame (TMRS), and Self-Stigma Associated with Seeking Psychological Help (Self-Stigma). Additionally, I examined whether NMA, Disclosure, and TMRS would directly predict feelings of inadequacy and deficiency and whether those feelings predicted Self-Stigma. In order to account for general mental health, a possible confounding variable, I measured participant's general psychological functioning to use as a control variable. This chapter serves several purposes. The first will be to provide an overview of the specific steps of the current project including estimated sample size and participant characteristics. The second will be a detailed section about the measures to be used in this study as it aligns with each construct. Third, I will describe the study's procedures, including details about participant recruitment for this study. I will conclude with a list of hypotheses along with statistical analyses used. The chapter will end with a detailed overview of each hypothesis.

Participants

The current study used structural equation modeling (SEM), specifically path analysis. SEM literature typically suggested large sample sizes (Kline, 2016), with many

suggesting at least 300 participants (Comrey & Lee, 2013; Tabachnick & Fidell, 2013). Conducting SEM on a small sample size has been known to result in an increased risk for technical problems during analysis (Kline, 2016). Although suggestions of a 300 participant samples size was a helpful estimate, a one-size-fits-all-method is not a reliable technique for determining sample size in all SEMs (Wolf et al., 2013). In Kline (2016), the author discusses several factors that influence sample size requirements. The first is complexity of the model; typically, models with more parameters need larger samples. Second, models with fewer interactions, mostly linear effects, and variables that are continuous and normally distributed are able to have smaller sample sizes in contrast to models that have many interactive effects or have variables that are non-normally distributed. Third, a larger samples size is needed if measurement reliability is low, as more data will be needed to offset the effects of measurement error or missing data. Finally, specific types of SEMs (e.g., factor analysis) require different sample sizes. The final models were made up of only direct effects, are anticipated to be normally distributed, and used measures with scores that have shown evidence of high reliability and validity. Based on these characteristics, a smaller sample size could be acceptable. However, both models have several observed variables and numerous hypothesized pathways, making them more complex. Unfortunately, there were no sample size calculator available for path analysis; however, there were certain techniques which could aid sample size estimates.

Kline (2016) suggested that, for latent variable models using maximum likelihood estimation methods with continuous and normally distributed outcomes, the N:*q* rule is a guideline to roughly estimate sample sizes. Since this current study meets these

requirements, I used the N:*q* rule to determine a desired sample-size. The N:*q* rule was described by Jackson (2003) to find the minimum sample size needed for the ratio of cases (N) to the number of parameters (*q*). The recommended ratio is 20:1, or one parameter for every 20 participants. In the case of the current study, I estimated that both of my hypothesized models would have at least 9 parameters each. Therefore, my ratio would be 20(9), which would give me an estimated minimum sample size of at least 180 participants. Since sample size varies between model complexity, missing data, and measurement reliability and distribution, I aimed for a maximum of 500 participants. This sample size allowed me to counteract missing data and measurement error (Kline, 2016). Consequently, the present study sought to collect data from 500 men of several racial groups between the ages of 18 and 29. Participants were recruited from throughout the United States using Qualtrics Panels. Qualtrics Panels allows the researcher to specify what characteristics are desired. For this study, I specified the percentage of each racial identity that I wanted to participate in this study. Prior to data cleaning and screening, I obtained a sample size of 502; after two participants were removed for missing half the survey, I was left with my projected sample size of 500, which consisted of 25% White men, 25% Black men, 25% Latino men, and 25% Asian American men (n = 125 per group).

It is important to incorporate more fluid gender identities in research rather than following the dichotomy of male or female. To address this, the demographics form asked about how participants expressed their gender identity (see Appendix A). For non-binary or third gender participants, any who identified as being "mostly masculine," "sometimes masculine," or "sometimes feminine" were accepted into the sample.

Participants who identified as “sometimes feminine” were included as it suggested that some masculine identity would be present, and including participants who encompassed a range of masculine and feminine identities would be valuable for understanding Self-Stigma. Participants who identified as below the age of 18, as women or transwomen, and/or were non-binary or third gender who also had a gender expression of “mostly feminine,” or “neither feminine nor masculine” were not permitted to continue. In addition, because the MASQ was designed only for straight men, men who did not identify as straight were not permitted to continue. This was due to items in the MASQ which used language and examples that assumed the participant completing it was interested in women and avoidant of same-sex relationships. Unfortunately, there was no other measure which assessed shame associated with threatened masculinity that could be used as a replacement. However, self-identified men who stated that they were questioning were permitted to continue as the category ‘questioning,’ according to research, is typically associated with a person who originally assumed they were heterosexual but is now questioning whether they have an attraction to the same sex physically, emotionally, or both (Morgan et al., 2010). This presented a category of participants who were uncertain and therefore would not necessarily be ineligible. By including a mostly diverse sample, I was able to test my model’s efficacy in men from diverse racial groups and gender identities, which has been lacking in the field of men and masculinities research.

After cleaning and screening the data, 28 participants were removed, for a final sample of 474 participants. The majority of the sample identified as cisgender men (98.1%). There were three transgender men (0.6%), five non-binary or third gender

(1.1%), and one who self-described as unisexual (0.2%). Most participants described their gender identity as mostly masculine (81.2%), followed by sometimes masculine (16.5%). Five participants described their identity as sometimes feminine (1.1%), and six participants preferred to self-describe (1.3%). Self-descriptions consisted of identifying as mostly masculine (0.8%), equally masculine and feminine (0.2%), or fluid (0.2%).

Regarding racial identity, it was discovered during data screening that, because race was coded as a multiple response item, many participants selected more than one race (e.g., Black/African American and Hispanic/Latino American). Qualtrics Panels fulfilled the racial quota by prioritizing groups one at a time. Therefore, if a participant selected Black/African American and Hispanic/Latino American, if the priority quota was Hispanic/Latino American, that participant would be counted as Hispanic/Latino American. Following data collection and screening, it became clear that this type of data collection was problematic, as it selected one racial identity for the participant regardless of how the participant might have wanted to be represented. To mitigate this, participants who selected more than one racial identity were coded as biracial (i.e., having two racial identities) and multiracial (i.e., having more than two identities). Since this study did not have hypotheses for biracial and multiracial groups, and choosing the racial identity of the participant would be unacceptable, biracial and multiracial participants were excluded from data analysis involving hypotheses assessing race as a moderator (hypotheses 10 and 11). After exclusion, the racial groups were no longer equal. There were equal numbers of Black/African Americans (23.8%) and Asian Americans (23.8%), followed by White/European Americans (22.6%), Hispanic/Latino Americans (18.4%), biracial Americans (9.7%), and multiracial Americans (1.7%). The mean age was 24 (SD = 3.44).

The majority of the sample identified as heterosexual (97.5%), two participants identified as questioning (0.4%), and 2.1% preferred to self-describe. Additional demographics are provided in Table 1.

Table 1

Sample Demographics

Variable	% of sample	n
Sex		
Male	98.1%	465
Non-binary/third gender	1.1%	5
Transgender man	0.6%	3
Prefer to self-describe	0.2%	1
Gender Identity		
Mostly masculine	81.2%	385
Sometimes masculine	16.5%	78
Prefer to self-describe	1.3%	6
Sometimes feminine	1.0%	5
Racial/Ethnic Identity		
Black/African American	23.8%	113
Asian American	23.8%	113
White/European American	22.6%	107
Hispanic/Latino American	18.4%	87
Biracial	9.7%	46
Multiracial	1.7%	8
Relationship Status		
Single	64.6%	306
In a committed relationship/partnership	10.1%	48
Dating	9.3%	44
Married	8.6%	41
Other	5.7%	27
Engaged	1.1%	5

Separated or divorced	0.4%	2
Cohabitating	0.2%	1
Sexual Orientation		
Straight/heterosexual	97.5%	462
Prefer to self-describe	2.1%	10
Questioning	0.4%	2
Education		
Completed high school/G.E.D	33.3%	158
Completed Bachelor's Degree (e.g., B.A., B.S.)	18.1%	86
Completed some college but no degree	17.9%	85
Currently enrolled in college	8.4%	40
Completed Associate's Degree	8.4%	40
Some high school	6.1%	29
Completed Master's Degree (e.g., M.A., M.S., M.Ed., M.B.A., M.P.H, etc.)	4.9%	23
Completed Doctorate (e.g., Ph.D., Psy.D., Ed.D, M.D., J.D., etc.)	1.7%	8
Prefer to self-describe	0.4%	2
Completed Specialist Degree (e.g., CAGS, Ed.S., Psy.S.)	0.4%	2
Prefer to not say	0.2%	1
Family/Household Income		
$20,001-40,000	23.6%	112
$40,001-60,000	18.4%	87
Under $20,000	17.9%	85
$60,001-80,000	11.6%	55
$80,001-100,000	10.3%	49

$100,001-120,000	7.4%	35
Prefer to not say	3.4%	16
$120,001-140,000	2.1%	10
$140,001-160,000	1.9%	9
$180,000-200,000	1.9%	9
$160,001-180,000	1.1%	5
Prefer to self-describe	0.4%	2
Socioeconomic Status		
Middle Class	51.3%	243
Lower Middle Class	23.0%	109
Upper Middle Class	12.7%	60
Lower Class	9.1%	43
Upper Class	1.7%	8
Prefer to not say	1.9%	9
Prefer to self-describe	0.4%	2
Age		
21	12.0%	57
25	11.0%	52
29	10.8%	51
28	10.1%	48
22	7.6%	36
27	7.6%	36
24	7.4%	35
20	7.4%	35
18	7.2%	34
26	7.2%	34
23	7.0%	33
19	4.9%	23

Note. N = 474. Relationship demographics were coded as multi-select; participants who selected more than one option were coded as “other”.

Measures

Demographic Questionnaire

A brief demographic questionnaire (see Appendix A) was given. Participants provided information about their age, gender, sexual orientation, race, ethnicity, and socioeconomic status.

Self-Reliance and Emotional Control

Conformity to Masculine Norms Inventory Short Form (CMNI-30; Levant et al., 2020)

The CMNI-30 (see Appendix B) is a 30-item short form version of the original CMNI which had 94 items on a six-point Likert scale from 0 (*strongly disagree*) to 5 (*strongly agree*; Mahalik et al., 2003). The original CMNI consisted of 11 subscales which are as follows: (1) Winning (e.g., "In general, I would do anything to win"), (2) Emotional Control (e.g., "I try to keep my emotions hidden"), (3) Primacy of Work (e.g., "I feel good when work is my first priority"), (4) Pursuit of Status (e.g., "It feels good to me to be important"), (5) Heterosexual Self-Preservation (e.g., I would be furious if someone thoughts I was gay"), (6) Playboy (e.g., "I would frequently change sexual partners if I could"), (7) Violence (e.g., "I like getting into fist fights"), (8) Self-Reliance (e.g., "I hate asking for help"), (9) Risk-Taking (e.g., "Taking risks help me prove myself"), (10) Power Over Women (e.g., "I control the women in my life"), (11) Dominance (e.g., "In general, I must get my way").

The original CMNI subscale scores yielded Cronbach's alphas of .72 and .91 and showed evidence of good validity and test-retest reliability (Mahalik et al., 2003). Over the years, attempts have been made to shorten the CMNI such as CMNI-11 (Mahalik et al., 2007), CMNI-22 (Burns & Mahalik, 2008), CMNI-46 (Parent & Moradi, 2009) and

CMNI-29 (Hsu & Iwamoto, 2014), but the psychometrics of these measures proved to be less than ideal. For example, a sample of 1,561 men were recruited from universities and the community (Levant et al., 2020). Participants were given the CMNI, Generalized Anxiety Disorder-7-item scale (GAD-7; Löwe et al., 2008), and the Patient Health Questionnaire-2-Item Scale (PHQ-2; Kroenke et al., 2003). Comparisons between the CMNI-30 and the other CMNI scales indicated that the CMNI-30 was found to have better fit statistics and measurement invariance than most of the previous CMNI measures in the series and at a much shorter length than the original CMNI. The CMNI-30 retained the original six-point Likert scale and ten out of the 11 original subscales, each with three items. The 10 subscales were: (1) Emotional Control, (2) Winning, (3) Playboy, (4) Violence, (5) Heterosexual Self-Preservation, (6) Pursuit of Status, (7) Primacy of Work, (8) Power Over Women, (9) Self-Reliance, and (10) Risk-taking; the original subscale Dominance was no longer included in the scale.

The CMNI-30 evidenced a common factors structure, indicating that it was unable to provide an overall conformity to masculine norms score and is only valid for use of individual subscales (Levant et al., 2020). I will be using the subscales of Self-Reliance and Emotional Control, which displayed Cronbach's alphas of .90 and .78, respectively. The CMNI-30 subscales and GAD-7 were found to be significantly related to one another $F(10, 1550) = 14.88$, $p < .001$, $R^2 = 0.09$. Self-reliance was found to be positively and significantly related to anxiety ($\beta = .278$); emotional control was negatively related to anxiety ($\beta = -.070$). The CMNI-30 and the PHQ-2 were also found to be associated with one another $F(10, 1550) = 15.992$, $p < .001$, $R^2 = 0.090$, providing initial evidence of concurrent validity.

Analyses on measurement invariance determined that race and CMNI-30 did not alter the CMNI-30's ability to predict PHQ-2 scores for men of color ($F(10,1519) = 7.57$, $p < .001$, $R^2 = 0.10$; $\Delta F = 1.09$, $p = .364$). The CMNI-30 with men of color did change the CMNI-30's predictive ability for GAD-7 scores ($F(10, 1521) = 8.13$, $p < .001$, $R^2 = 0.10$; $\Delta F = 2.22$, $p = .015$) but only for the Violence, Playboy, and Primacy of Work subscales, which will not be used in the current study. Partial invariance testing found that 70% of the residuals were invariant and suggested that measurement of CMN was being completed between groups at similar levels of precision. Therefore, the factors of the CMNI-30 appear to hold the same meaning for White men and men of Color, indicating that it is valid for use with more diverse samples. The present study only used the Emotional Control and Self-Reliance subscales, which yielded alphas of .85 and .31 respectively. Due to the low alpha for the Self-Reliance subscale, findings associated with this subscale should be interpreted with caution.

Normative Male Alexithymia

Normative Male Alexithymia Scale-Brief Form (NMAS-BF; Levant & Parent, 2019)

The NMAS-BF is a brief, 6-item version of the original NMAS (Levant et al., 2006), which consisted of 20 items on a 7-point Likert scale from 1 (*strongly disagree*) to 7 (*strongly agree*). The NMAS-BF was designed to be a quick assessment of men's ability to express their vulnerable emotions and feelings to friends and family (e.g., "I don't like to talk with others about my feelings"). The NMAS-BF retained the original 7-point Likert scale of the first NMAS. Factor analysis indicated that the NMAS-BF is a unidimensional scale, which supports the use of a total score.

To measure validity and reliability, 505 mostly White (73.9%) men were recruited and given the NMAS, TAS-20 (Bagby et al., 1994), and the Restrictive Emotionality subscale of the MRNI-SF (Levant et al., 2013). The Cronbach's alpha for the scale's total score was .80, evidencing good reliability. The NMAS was also positively related to the TAS-20 (r = .57, p < .001), indicating good convergent evidence of validity. The results of comparisons between the NMAS-BF and a similar scale of alexithymia, the Toronto Alexithymia Scale (TAS; Bagby et al., 1994), indicated that the NMAS-BF measured alexithymia in a similar way to the TAS-20 and even exhibited larger standardized loadings, which ranged from .81 to .82, in comparison to TAS-20's range of .70 to .85. This establishes evidence of concurrent validity and suggests that the NMAS-BF may be slightly superior to the TAS-20 in measuring alexithymia. Finally, the NMAS-BF uniquely predicted restrictive emotionality over and above the TAS-20 (R^2 = .088, ΔR^2 = .025), providing incremental evidence of validity. Unfortunately, the scale was never validated for use with men of Color. Currently, there is no measure of normative male alexithymia that has specifically been examined in men of Color. For the current study, the alpha for the total score was .56, which suggested poor reliability. Due to its low reliability coefficient, findings involving the NMAS-BF should be interpreted with caution.

Disclosure

Interpersonal Competence Questionnaire (ICQ; Buhrmester et al., 1988)

The ICQ is a 40-item questionnaire which measures levels of competency in peer and romantic relationships on a 5-point Likert scale: 1 (*I am poor at this, I'd feel so uncomfortable and unable to handle this situation, I'd avoid it if possible*), 2 (*I'm only*

fair at this, I'd feel uncomfortable and would have lots of difficulty handling this situation), 3 (*I'm okay at this, I'd feel somewhat uncomfortable and have some difficulty handling this situation*), 4 (*I'm good at this, I'd feel quite comfortable and able to handle this situation),* and 5 (*I'm extremely good at this, I'd feel very comfortable and could handle this situation very well*). The ICQ scale is made up of five dimensions of interpersonal competence: (1) Initiation (e.g., "Asking or suggesting to someone new that you get together and do something"), (2) Negative Assertion (e.g., "Telling a companion you don't like a certain way he or she has been treating you"), (3) Disclosure (e.g., "Telling a close companion about the things that secretly make you feel anxious or afraid"), (4) Emotional Support (e.g., "Helping a close companion cope with family or roommate problems"), and (5) Conflict Management (e.g., "Being able to take a companion's perspective in a fight and really understand his or her point of view").

Based on the initial psychometric tests (Buhrmester et al., 1988), the scale was found to adequately distinguish between different domains of interpersonal competency such as peer and roommate relationships, including same sex and opposite sex peers, and intimate relationships (e.g., lovers, family members). Importantly, the scale was also found to distinguish between more masculine expressions of interpersonal competency (e.g., initiation and assertiveness) and feminine expressions (e.g., emotional support and disclosure). The scale was created with different types of disclosure in mind, specifically in friendship and dating contexts. For this study, I will only be using the Disclosure subscale.

The Disclosure subscale's scores have demonstrated adequate evidence of reliability and validity. Buhrmester and colleagues (1988) compiled three samples from

different universities. The first consisted of 123 male and 97 female undergraduates from Denver. The second was 83 males and 119 female undergraduates from a Los Angeles university. The third was 13 males and 18 females from the University of California. No demographics related to race were reported for any of the samples. Sample three was used only for 4-week test-retest reliability data. Participants were administered the ICQ, Dating and Assertiveness Questionnaire (DAQ; Levenson & Gottman, 1978), a mood checklist (Lebo & Nesselroade, 1978), the Social Skills Inventory (SSI; Riggio, 1986), and the Social Reticence Scale (SRS; Jones & Russell, 1982). The Cronbach's alpha for the subscale Disclosure in the context of friendship was .85, and disclosure in dating was .82 in original reliability testing. Test-retest reliability for Disclosure was $r = .75$. Women reported greater disclosure with friends than did men $F(1, 417) = 28.60$, $p < .001$, but there were no differences in disclosure to romantic partners. Correlations were found between the Disclosure subscale and the DAQ ($r = .44$, $p < .01$; $r = .25$, $p < .01$) and SRS ($r = -.41$, $p < .01$), indicating good concurrent and discriminant validity (Buhrmester et al., 1988).

Unfortunately, the ICQ has never been officially validated for men of Color. However, a study that used the scale on a sample of White and Black men determined that the scale yielded a range of Cronbach's alphas from .72 to .86 (Lease et al., 2010) for Black men. The researchers did not specify the specific alpha for each subscale. Other studies have successfully performed psychometric testing on the ICQ scale and developed it for use in other countries. These studies determined that the ICQ was valid for cross-cultural use (Giromini et al., 2016; Kanning, 2006). This suggests that the scale has some usability with more diverse populations. Although a shorter version of the scale

called the ICQ-15 has been developed for Spanish and German speaking countries (Coroiu et al., 2015; Salavera & Usán, 2018), one has yet to be made for dominant English-speaking cultures, so the original measure will be used in the current study. For the current study, the scale yielded a Cronbach's alpha of .92, which suggested good reliability.

Inadequacy and Deficiency

Internalized Shame Scale (ISS; Cook, 1988)

The ISS is a 35-item scale on a 5-point Likert scale from 0 (*never*) to 4 (*almost always*) that assesses internalized shame. It was developed with college and community populations with both clinical (e.g., chemical dependency, trauma, emotional distress) and non-clinical (e.g., participants who answered "no" to all survey items asking about trauma or abuse history) samples. Factor analysis determined that shame was measured across four dimensions; those dimensions were: (1) Inadequate and Deficient (e.g., "Compared to other people I feel like I somehow never measure up"), (2) Embarrassed and Exposed (e.g., "When I feel embarrassed I wish I could go back in time and avoid that event"), (3) Fragile and Out of Control (e.g., "I feel as if I have lost control over my body functions and feelings"), and (4) Empty and Lonely (e.g., "I always feel like there is something missing"). For this study, I will be using the Inadequate and Deficient subscale.

The ISS's scores showed initial evidence of reliability and validity. Cook (1988) administered the ISS to 603 undergraduate male (55%) and female (45%) students, 198 adults from the community of which 38% were male and 62% were female, and 64 participants (50% male and 50% female) from various clinical settings (e.g., a chemical

dependency treatment program, a battered woman's shelter, and those being supervised by child protection workers for abusing or neglecting their children). The internal consistency reliability estimate for the undergraduate sample was .95 with a test-retest correlation of .81 over the span of 6-8 weeks. Reliability coefficients were .95 and .93 for the adult and clinical population, respectively. The means for the ISS in adult and undergraduate samples did not differ significantly from each other, so they comprised the non-clinical population of the study. The Subscale coefficient for the Inadequate and Deficient subscale's score was .91 for the combined adult and undergraduate sample, indicating good reliability. Some differences between male and female scores on the ISS were noted. Women typically scored higher on shame than men in the undergraduate $F(1, 601) = 24.55$, $p = .000$, adult $F(1,196) = 5.32$, $p = .022$, and clinical samples $F(1, 62) = 11.93$, $p = .001$. Male scores in the undergraduate ($M = 35.1$; $SD = 17.0$), adult ($M = 33.1$; $SD = 21.3$), or clinical ($M = 43.5$; $SD = 17.9$) subgroups did not significantly differ from one another at the .01 level.

More recent psychometric evaluations have been completed on the ISS, and it was determined that the validity and reliability mirror those from the original development (Del Rosario & White, 2006; Rybak & Brown, 1996). Del Rosario and White (2006) sampled 184 undergraduate mostly White (91.3%) students (152 females, 31 males) and administered the ISS and the Self-Esteem Scale (Rosenberg, 1965). Test-retest analyses determined the trait shame to be stable $r = .81$, $p < .01$, and the subscale Inadequate and Deficient showed evidence of internal consistency with a coefficient alpha of .95.

Although the original ISS was developed with a mostly White population (no specific demographics were given), psychometrics for the scale have also been examined

in Portuguese samples (Matos et al., 2012). Although official psychometric testing has not been completed on the ISS with men of Color, a recent study that used the ISS with an African American sample found that the ISS had a Cronbach's alpha of .96, indicating high internal consistency. The current study only the Disclosure subscale, which exhibited good reliability with an alpha coefficient of .92.

Threatened Masculinity-Related Shame

Masculinity and Shame Questionnaire (MASQ; Gebhard et al., 2019)

The MASQ is a 68-item scale that asks participants to respond to 17 different scenarios in which their masculinity would be threatened. Participants are asked to respond to four questions under each scenario that align with the scales' four dimensions of masculinity-related shame. An example of a scenario is, "You take a highly regarded personality test, and the results indicate that your personality is more feminine than masculine." Participants respond to prompts asking them to rate how likely they would feel or behave in that situation. Responses are recorded on a 5-point Likert scale from 1 (*not likely*) to 5 (*very likely*). The 4 dimensions of masculinity-related shame that all scenarios and responses are based on are: (1) Feel Shame (e.g., "You would feel like a loser who doesn't deserve a date"), (2) Escape (e.g., "You would want to just go home"), (3) Externalize Blame (e.g., "You would think, 'this test's definition of "masculine" and "feminine" is bogus'"), and (4) Prevent Exposure (e.g., "You would try to keep other people from finding out about this").

In the initial assessment of psychometric properties, Gebhard and colleagues (2019) collected data from 647 men (71%) and women (27%) who were mostly White (71%). Out of the 647 participants, 267 were recruited from a university and 374 (all

men) were recruited from Amazon Mechanical Turk. Participants were given scales measuring self-conscious affect, masculinity and shame, masculine gender role stress, male role norms, masculinity contingency, guilt, self-efficacy, thriving, and physically aggressive behaviors. The subscale scores for Feel Shame, Escape, Prevent Exposure, and Externalizing Blame was found to have strong internal validity estimates, with alphas ranging from .87 to .93. A total score for this scale was not psychometrically evaluated or recommended. However, thorough analyses were completed on each subscale. In the present study, I will be using the Feel Shame subscale; therefore, only psychometrics for this subscale will be discussed.

The Feel Shame subscale has evidence reported a Cronbach's alpha of .90, indicating good reliability (Gebhard et al., 2019). *T*-tests indicated that male scores on the Feel Shame subscale ($M = 2.32$, $SD = .71$) were higher than women's scores ($M = 1.96$, $SD = .54$), $t(132) = 4.18$, $p < .01$). The Feel Shame subscale was associated with the subscales of another measure of shame, Test of Self-Conscious Affect (TOSCA; Tangney et al., 2008)—TOSCA – Shame (Negative Self) $r = .71$, $p < .01$, TOSCA – Shame (Hide) $r = .75$, $p < .01$, TOSCA – Externalizing Blame $r = .56$, $p < .01$—establishing good convergent validity evidence for measuring shame (Gebhard et al., 2019). To determine if the MASQ would be able to measure masculinity, it was analyzed with several masculinity inventories and was found to be significantly and positively associated with each one: the Masculine Gender Role Stress (MGRSS; Eisler & Skidmore, 1987; $r = .62$, $p < .01$), Male Role norms (MRNS; Thompson & Pleck, 1986; $r = .37$, $p < .01$), and the Masculinity Contingency Scale (MCS; Burkley et al., 2016; $r = .53$, $p < .01$); this provides further evidence of convergent validity (Gebhard et al., 2019). For divergent

validity, the Feel Shame subscale was found to have significantly less association with other scales such as the TOSCA – Guilt (Remorse), $r = .15$, $p < .01$, the General Self-Efficacy Scale (GSES; Schwarzer & Jerusalem, 1995) $r = -.21$, $p < .01$, and the Brief Inventory of Thriving (BIT; Su et al., 2014) $r = -.20$, $p < .01$ (Gebhard et al., 2019).

The MASQ was developed using a primarily White (71.3%) sample, with 13.5% being Asian Americans. This scale is relatively new, and no other research has been published that has used the scale. Therefore, although the initial validation studies included a relevant subsample of Asian Americans, its use with other diverse samples is unknown. In the current sample, only the Feel Shame subscale was used, which demonstrated good reliability with a Cronbach's alpha of .92.

Self-Stigma

Self-Stigma of Seeking Help- Short Form (SSOSH-SF; Vogel et al., 2006)

The SSOSH is a 10-item scale that measures self-stigma associated with seeking psychological help (e.g., "If I went to a therapist, I would be less satisfied with myself"). Higher scores indicate higher concerns that seeking psychological help would negatively impact one's self-regard, self-satisfaction, self-confidence, and overall self-worth. The scale uses 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*).

In the initial validation study, Vogel and colleagues (2006) collected a sample of 470 male (48%) and female (52%) college students. Most of the participants were White (92%), followed by 2% African American, 1% Latino/Latina, 2% Asian American, 1% Multiracial American, and 2% International. The participants were administered several scales associated with attitudes toward help seeking, disclosure, social stigma, and intentions to seek counseling. The SSOSH was found to have a unidimensional factor

structure, indicating that it measures a single construct, and yielded a Cronbach's alpha of .91, indicating good evidence of internal consistency. The SSOSH' score was found to be positively correlated (r = .47, p < .001) with the Anticipated Risks subscale of the Disclosure Expectations Scale (DES; Vogel & Wester, 2003) and the Social Stigma for Seeking Psychological Help (r =.48, p < .001; SSRPH; Komiya et al., 2000), establishing good evidence of construct validity (Vogel et al., 2006). The SSOSH's score was negatively associated with scores on the DES Anticipated Benefits (r = -.45, p < .001), Attitudes Toward Seeking Professional Psychological Help Scale (r = -.63, p <.001; ATSPPHS; Fischer & Farina, 1995), and the Intentions to Seek Counseling Inventory (r = -.38, p < .001; ISCI; Cash et al., 1975), successfully establishing evidence of criterion validity (Vogel et al., 2006). Finally, the SSOSH was found to predict attitudes toward seeking psychological help (β = -.40, p < .001) and help seeking intent (β = -.27, p < .001).

Vogel et al. (2006) ran another study to examine test-retest reliability. A separate sample of 546 male (42%) and female (58%) mostly White (89%) college students were given a measure of social desirability and scales from the previous study. At time one, the SSOSH had an internal consistency of .90. The same students were given the scales again two months later, and an internal consistency for the SSOSH after that length of time was .88. The SSOSH was not associated with the social desirability scale (r = -.13, p > .05). Important to the current study, men were found to have higher rates of self-stigma to seek counseling (M = 29.1, SD = 6.7) than women (M = 26.2, SD = 6.4), $t(266) = 3.65$, p < .001, η^2_P = .05).

In another study with a different sample, Vogel et al. (2006) collected data from 271 male (39%) and female (61%) mostly White (88%) college students. Participants were given scales measuring global self-esteem, Hopkins's symptoms, distress, self-concealment, and use of psychological services, as well as the measures used in the previous study. The SSOSH was found to be unrelated to global self-esteem ($\beta = .07$, $p > .05$) and overall psychological distress ($\beta = .08$, $p > .05$), providing support for discriminant validity. To determine whether the scale could differentiate those who had sought counseling over those who did not, the researchers analyzed the SSOSH with students who had been to counseling and students who had not been to counseling. They found that students who sought psychological help reported less self-stigma toward seeking help ($n = 64$, $M = 28.1$, $SD = 6.2$) than students who did not see psychological help ($n = 202$, $M = 28.1$, $SD = 6.7$), $F(1, 266) = 15.7$, $p < .001$, $\eta^2_P = .05$, providing additional support for predictive validity.

As seen in the psychometric studies, the SSOSH was developed using a mostly White sample (Vogel et al., 2006). Although invariance testing was not included in the original scale development, several articles have used the scale with diverse populations across the world in nations such as Turkey, England, Greece, Israel, and Taiwan (Kaya et al., 2015; Vogel et al., 2013). In the United States, the scale has been used with Nigerian Americans (Meniru & Schwartz, 2018) and Latinos (Ballesteros & Hillard, 2016). The history of the SSOSH suggests that its scores could be valid for men of Color; unfortunately, this has largely not been evaluated. In the current study, the SSOSH yielded an alpha of .68, which indicated marginal reliability.

General Mental Health

Schwartz Outcomes Scale-10 (SOS-10; Blais et al., 1999)

The SOS-10 is a 10-item measure that assesses psychological health and functioning (e.g., "I am hopeful about my future"). High scores on this measure are consistent with higher levels of psychological functioning. The scale asks participants to respond to 10 statements using a 7-point Likert scale from 0 (*Never*) to 6 (*All of the time or nearly all of the time*) to record how they have been generally doing over the last seven days.

The scale was created through interviews with medical staff (i.e., psychologists, psychiatrists, and neurosurgeons) and two patient focus groups (Blais et al., 1999). Medical staff were asked questions such as: "What do you think changes in a person's life when the treatment you provide is successful?" Patients were asked: "What has changed in your life as a result of your treatment?" and "What do you hope will change as a result of your treatment?" A resulting pool of 81 items were created based on common interview themes which was later reduced to 47 items. Those 47 items were administered to 112 patients in a hospital setting (e.g., psychopharmacology clinic, psychotherapy clinic, emergency acute psychiatry, inpatient and emergency room patients). A total of 69 women and 43 men completed the survey with an average age of 37 years. The scale was found to be unifactorial and made up of 10 items. More items were dropped to result in a 20-item scale. The 20-item scale showed evidence of excellent reliability, as indicated by a Cronbach's alpha of .95 and a split-half reliability of .92. There were no differences for sex (men: $M = 64$, $SD = 24$; Women: $M = 66$, $SD =$

24) or age between patients 40 years or younger (M = 66, SD = 27) and patients over 40 years old (M = 65, SD = 24).

Another sample of 24 community health patients and 35 nonpatients were sampled to further examine the 20-item scale (Blais et al., 1999). A total of 39 women and 20 men participated with an average age of 34 years old. Like the 47-item version, the scale was deemed unifactorial. Cronbach's alpha was .96 and split-half reliability was .92. Test-retest reliability over one week for nonpatients was .87. To potentially reduce the scale down further, a third sample of 57 patients and 28 nonpatients was recruited. Patients were given the SOS-20 along with the Beck Hopelessness Scale (Beck et al., 1975), a self-esteem measure (Heatherton & Polivy, 1991), the Positive Affect and Negative Affect Scale (PANAS; Watson et al., 1988), Survey Form-12 (SF-12; Ware et al., 1995), Mental Health Index-5 (MHI-5; Stewart et al., 1992), Functional Status Questionnaire (Jette et al., 1986), the Fatigue Scale from the SF-36 and the Sense of Coherence Scale (Antonovsky, 1979, 1987), Life Satisfaction question (Andrews & Withey, 1976), the Satisfaction with Life Scale (Pavot & Diener, 1993), Psychiatric Symptoms (Blais, 1999), and Desire to Live (Lenderking, 1992).

A Rasch item analysis indicated that a few items showed poor fit, and a 10-item scale was created based on the Rasch characteristics. The final 10-item scale had a Cronbach's alpha of .96 and corrected item-to-scale total correlations ranging from .74 to .90. The scale yielded strong negative correlations with the Psychiatric Symptom Scale (r = -.66), Beck Hopelessness Scale (r = -.64), Fatigue Scale (r = -.75), and negative affect scale (r = -.72), showing good evidence of divergent validity. Good evidence of convergent validity was also shown, as the scale demonstrated strong correlations with

the MIH-5 (r = .86), life satisfaction (r = .78), desire to live (r = .86), self-esteem scale (r = .81), Positive Affect Scale (PANAS; r = .67), the sense of coherence (r = .81), and SF-12 (Mental Health Component Scale; r = .76).

Finally, to test if the scale was sensitive to changes in treatment, the 10-item scale was administered to 20 inpatients in a psychiatric unit at admission and at discharge (Blais et al., 1999). Scores were significantly different across time, $t(19) = -5.23$, $p < .001$ which indicated that the scale was sensitive to treatment changes. In the current sample, the SOS-10 yielded an alpha of .91, which suggested good reliability.

Procedure

The survey was approved by IRB and participants were recruited through Qualtrics Panels. Qualtrics Panels is a professional data collection service that offers access to participants all over the country. The participant pool generated by Qualtrics Panels came from the individuals who signed up to receive monetary compensation for research participation. Each person received a different contract with Qualtrics Panels and an already agreed upon amount of money per research study completed in accordance with Qualtrics policies. The researcher paid Qualtrics Panels a lump sum of money, and then Qualtrics Panels paid participants who completed the survey based on their individual contracts with the company. Therefore, I was not responsible for paying participants directly. My survey consisted of a total of 64 questions. I collected 500 participants who identified as over the age of 18 from the U.S and as male, trans male, or, in the special cases discussed above, non-binary or third gender. To create a diverse sample, I requested that 25% of my participants be White/European American, 25% Black/African American, 25% Hispanic/Latino American, and 25% Asian American. I

have paid a cost estimate from Qualtrics Panels, which was calculated based on the desired sample characteristics (e.g., race, age, gender, number of participants needed, number of survey questions). The cost to collect the data was $2,625. I sought out dissertation funding opportunities through the APA and my graduate program, unfortunately, no funding could be found so the cost came out of pocket. Although this was a large sum of money, I believe that funding research with diverse samples is important and aligns with the field of counseling psychology as mentioned in Chapter 1.

Participants signed up for the survey on Qualtrics Panel's website and followed a link to be taken to the survey hosted by Qualtrics. They were given an informed consent form and completed the demographic questionnaire. Participants who met criteria advanced to the rest of the survey, which included the randomized measures. Finally, participants were given a debriefing form at the end of the study and compensated as agreed upon in their individual contracts.

Analyses

This section will explain the analysis plan for the current study. In my preliminary analyses, I conducted an examination of the relationships between variables using Pearson bivariate correlation and partial correlations across racial groups. Second, I analyzed model 1 on the entire sample with Emotional Control and Self-Reliance being the predictors, run separately. I compared this to a partially mediated model including the same variables. Finally, I ran moderation analyses in PROCESS on specific pathways for each racial group to determine if there were racial differences. This section seeks to deeply discuss the process by which these analyses will occur.

The models in this study were tested using path analysis in Mplus (Muthén & Muthén, 1998-2017). As mentioned above, a minimum of 300 participants is typically used when conducting any kind of SEM (Comrey & Lee, 2013; Tabachnick & Fidell, 2013). Unfortunately, no sample size calculator existed for path analysis, but, according to the *N*:q rule (Jackson, 2003), a sample size of 180 would be sufficient for the nine parameters in both of my models. However, since this study was aiming to capture a highly diverse sample, this study sought to collect a sample of at least 500 in order to have a sizeable number of participants in each racial demographic and help reduce measurement error.

Once the data were collected, they underwent a careful cleaning and screening process which included the detection and removal of outliers, participants who did not meet criteria, and/or participants who missed more than half of a single measure. The data were then evaluated for skewness, kurtosis, and multicollinearity. Fortunately, per Qualtrics Panels' policy, data collected from Qualtrics Panels would only include those who completed the entire survey; therefore, missing data was minimal. To account for missing data, full information maximum likelihood (FIML) was conducted in Mplus and Process to replace any missing data with substituted values rather than use classical techniques such as single-imputation methods, which could incite bias (Vriens & Melton, 2002). Although the chance of bias is always present when dealing with missing data, using more modern methods such as FIML reduces the risk in comparison to more classical methods (Peters & Enders, 2002). Means, standard deviations, and intercorrelations were also examined.

In accordance with best practice guidelines, a baseline measurement model was conducted first before the hypothesized models were examined. This allowed me to test the relationships among variables without them being constrained to a model. Next, I fit the model to specifically hypothesized pathways and used Chi-Square (CMIN) statistics, Root Mean Square Error of Approximation (RMSEA), Comparative Fit Index (CFI), and Standardized Root Mean Square Residual (SRMR) to test for model goodness of fit and examined the relationships between the variables. Alternative a priori models would be conducted should the hypothesized models not be a good fit for the data. The alternative model (see Figure 2) consisted of similar paths as Model 1 but withdrew the additional paths by which Emotional Control and Self-Reliance both directly and positively predicted Self-Stigma Associated with Seeking Psychological Help (Self-Stigma). The core of path analysis is regression and correlation (Kline, 2016); therefore, the analytical plan for most segments of the hypothesized models consisted of multiple and linear regressions. Both models were tested for fit with all participants, regardless of race or ethnicity.

Preliminary Testing of Relationships

Research Question 1: Are there any significant relationships between Self-Reliance, Emotional Control, Disclosure, NMA, TMRS, Inadequacy and Deficiency, and Self-Stigma?

- H1: There would be a negative association between Self-Reliance and Disclosure and Emotional Control and Disclosure and positive associations between Self-Reliance and NMA, Emotional Control and NMA, Self-Reliance and TMRS, and

Emotional Control and TMRS. There would also be a positive association between Emotional Control and Self-Stigma and Self-Reliance and Self-Stigma.

- H2: There would be a negative association between Disclosure and Inadequacy and Deficiency and positive relationships between NMA and Inadequacy and Deficiency, and TMRS and Inadequacy and Deficiency.
- H3: There would be a positive relationship between Inadequacy and Deficiency and Self-Stigma.

Data Analysis Plan: Pearson bivariate correlations were conducted to assess Hypotheses H1 through H3. In addition, I used partial correlations; these would be compared using zero-order correlation coefficients and would determine whether a significant correlation existed when removing the variance associated with a third variable. These would be completed with the entire sample, the variables, and the SOS-10 to determine if psychological functioning was influencing the relationships. If psychological functioning shares variance with the variables, it would be added as a control variable.

Research Question 2: How, if at all, will the relationships specified in Hypotheses 1-3 change when accounting for race (i.e., Black/African American, Hispanic/Latino American, Asian/Asian American, and White/European American)?

- H4: The relationships would be largely identical to the relationships when all participants were used with some differences. Based on research which found that Restrictive Emotionality was positively related to NMA for Black, Latino, Asian, and White men but was stronger for Latino American men and weakest for Asian American men (Levant et al., 2015), I hypothesized that the relationship between

Emotional Control and NMA would be present across all racial groups, but it would be stronger for Hispanic/Latino American men than Asian American men. Due to the lack of research between race and the remaining variables in the model, I hypothesized that the relationships among Disclosure, NMA, TMRS, and Inadequacy and Deficiency would remain the same across all groups.

Data Analysis Plan: Participants would be grouped based on racial identity and dummy coded. Partial correlations would be conducted separately for each racial group. In addition, partial correlations would also be completed with each racial group, the variables, and the SOS-10 to determine if psychological functioning was influencing the relationships. If it did, it would be added as a control variable.

- H5: I hypothesized that there would be some mean differences across variables for certain racial groups. Since White adults were found to be more likely to seek-help over Black or Hispanic groups (Terlizzi & Zablotsky, 2020), I hypothesized that White/European American men would have less Self-Stigma than Black/African American, Hispanic/Latino American, or Asian American men.

Data Analysis Plan: An ANOVA was conducted across all racial groups for the Self-Stigma variable.

Model Testing

Model 1 (see Figure 1) consisted of paths in which Emotional Control and Self-Reliance would directly and negatively predict Disclosure and directly and positively predict NMA, TMRS, and Self-Stigma. Disclosure would directly and negatively predict Inadequacy and Deficiency, and NMA and TMRS would directly and positively predict

Inadequacy and Deficiency. Finally, Inadequacy and Deficiency would directly and positively predict Self-Stigma.

Research Question 3: Do Emotional Control and Self-Reliance predict Disclosure, NMA, TMRS, and Self-Stigma?

- H6: Emotional Control and Self-Reliance would have a direct effect on Disclosure, NMA, Self-Stigma, and TMRS. Specifically, Emotional Control and Self-Reliance would negatively predict Disclosure and positively predict NMA, TMRS, and Self-Stigma.
- Data Analysis Plan: In Mplus, a path analysis was examined in which Emotional Control and Self-Reliance (Emotional Control and Self-Reliance subscales of CMNI-30) would negatively predict Disclosure (Disclosure scores on the ICQ), and positively predict NMA (NMAS scores), TMRS (Feel Shame scores on MASQ), and Self-Stigma (SSOSH scores).

Research Question 4: Does NMA predict Disclosure and TMRS?

- H7: NMA would have a direct effect on Disclosure and TMRS such that NMA would negatively predict Disclosure and positively predict TMRS. In other words, high scores on NMA would predict lower scores on Disclosure and higher scores on TMRS.
- Data Analysis Plan: In Mplus, a path analysis would demonstrate that NMA (total score of the NMAS-BF) would negatively predict Disclosure and positively predict TMRS.

Research Question 5: Do Disclosure, NMA, and TMRS predict Inadequacy and Deficiency?

- H8: Disclosure, NMA, and TMRS would directly predict feelings of Inadequacy and Deficiency such that high scores on Disclosure would be negatively predictive of Inadequacy and Deficiency, and NMA and TMRS would be positively predictive of high scores on Inadequacy and Deficiency.
- Data Analysis Plan: In Mplus, a path analysis would indicate that disclosure would negatively predict Inadequacy and Deficiency and NMA, and TMRS would positively predict Inadequacy and Deficiency.

Research Question 6: How does Inadequacy and Deficiency relate to Self-Stigma?

- H9: Inadequacy and deficiency would have a direct effect on Self-Stigma such that Inadequacy and Deficiency would be positively predictive of high Self-Stigma (SSOSH scores). Specifically, men who had determined themselves to be inadequate and deficient would feel a deep sense of shame that they would need to seek help rather than be able to resolve issues on their own.
- Data Analysis Plan: Using Mplus, a path analysis would indicate that Inadequacy and Deficiency (Inadequate and Deficient subscale of the ISS) would positively predict Self-Stigma.

Research Question 7: Are certain paths in the model conditional upon race/ethnicity?

- H10: I hypothesized that the relationship between Inadequacy and Deficiency and Self-Stigma would be stronger for men of Color than White/European American men.
- H11: Research had also found a stronger association between restrictive emotionality and NMA in Hispanic/Latino men than Asian American men (Levant et al., 2015). Due to this finding, I hypothesized that the relationship between Emotional Control and NMA would be strongest for Hispanic/Latino American men and weakest for Asian American men.
- Data Analysis Plan: For hypothesis 11, the racial variables will be dummy coded and analyzed as moderators to the hypothesized paths in PROCESS using Model

CHAPTER IV

RESULTS

This chapter presents the results of the statistical analyses. It will start with an overview of screening procedures. Second, descriptive statistics will be explored, which include means, standard deviations, and internal consistency statistics for all subscales. This will be followed by tests of hypotheses, beginning with preliminary analyses that consist of bivariate and partial correlations and ending with the testing of final path models and moderation analyses. SPSS v 27 was used for all data cleaning, screening, and preliminary analyses. Path models were run using Mplus. Moderation analyses were analyzed using the PROCESS 4.1 macro for SPSS (Hayes, 2021).

Data Screening

Inclusion criteria for participation in this study consisted of being a cisgender man between the ages of 18 and 29. Due to the sensitive nature of certain questionnaires that might appear offensive to sexual minority men, men who identified as bisexual or gay were not permitted to continue. Participants were required to be either Asian American, Black/African American, White/European American, or Hispanic/Latino American. Biracial and multiracial participants (n = 54) were included in the main path analyses and bivariate correlations as long as at least one of their identities included one of the

races/ethnicities previously mentioned. Biracial and multiracial participants were not included in analyses that had race/ethnicity as a predictor variable (e.g., partial correlations and moderations), as I only wanted specific racial groups.

The initial sample consisted of 502 men. All participants consented to take the study and met the race/ethnicity and sexual orientation criteria. Two participants were removed for missing over half of the survey (<0.1%). A total of 18 participants (0.4%) were removed for being over the age of 29. Six participants (0.1%) were removed for being multivariate outliers. Two participants (<0.1%) were removed for patterned responding (i.e., using one or two numbers for the entire survey). Five attention checks were randomly placed in the survey. Attention checks prompted participants to select a specific response (e.g., "please select *strongly agree*"). During the data collection phase, participants who failed more than three attention checks (i.e., 75% or more) were not included in the final sample. Qualtrics Panels automatically removed participants who did not pass the attention checks; consequently, it is unclear how many were removed during sampling procedures. The final sample consisted of 474 participants (99% of the original sample).

The sample in this study presented very little missing data and, as mentioned above, only two participants were identified as having a pattern of responding. There was a total of 16 missing items scattered throughout the data, with participants only missing one or two items per scale, which was not enough to consider removing them from the sample. This is consistent with recommendations that suggest removing participants missing more than 20% of a scale (Tabachnick & Fidell, 2007). Any missing items were

accounted for by using Available Item Analysis (mean scoring) on all scales (Parent, 2013).

Total scores and subscale scores were calculated using mean scoring. Tests of normality were run on all scales. According to Kim (2013), for sample sizes above 300, an absolute value of > 2.00 for skewness and > 7.00 for kurtosis indicate normality issues. No scales had skew statistics above 2.00, which indicated no issues related to skewness. Similarly, none of the scales yielded kurtosis statistics over 7.00; therefore, no issues related to kurtosis were found. No univariate outliers were found. No correlations fell above .70, indicating no issues with bivariate multicollinearity (Tabachnick & Fidell, 2007). No issues related to multivariate multicollinearity or singularity were found. As for multivariate outliers, ten participants fell at or above the Mahalanobis distance χ^2 = 27.87 cutoff, which was based on the number of variables at a probability of < .001. Cook's distance was also analyzed to determine if the ten participants should be removed from the sample as influential outliers. In line with suggestions by Hoaglin and Welsch (1978), a more rigorous threshold was calculated ($4/(N - k - 1)$ in which N represents the sample size (474) and k is the number of explanatory variables (9). Based on this, participants who fell at or above .00862, in addition to being above the 27.87 Mahalanobis distance cutoff score, were removed from the sample. Out of the thirteen multivariate outliers, six yielded problematic Cook's distance scores and were removed.

Prior to running the main analyses, racial variables were dummy coded. Those who identified as Black/African American were coded as "1," and those who did not identify as Black/African American were coded as "0". This was repeated for

Hispanic/Latino American men and Asian American men. For dummy coding, it is required that I identified a reference group to which the other groups were compared. Previous literature traditionally used mostly White samples, and research which looked at racial comparisons used White men as the constant, with most recommendations being rooted in this way of doing research. Therefore, for the present study, I used White/European American men as the comparison group for the other groups.

Descriptive Statistics

Before hypothesis testing, descriptive statistics were run on all scale and subscale scores (see Table 2). The statistics consisted of means and standard deviations, as well as Cronbach's alpha levels to examine internal reliability. Cronbach's alpha levels were marginal to strong for Disclosure, Inadequacy and Deficiency, SOS-10, SSOSH, Feel Shame, and Emotional Control, falling between .68 and .92. Alpha levels for NMA and Self-Reliance were determined to be poor, with alphas of .56 and .31, respectively. It is unclear why this occurred. To be sure there were no errors in scale coding and calculation, a review of the data was completed, and it was confirmed that the scales were correctly reverse scored where necessary and calculated appropriately. An item analysis was also conducted on the afflicted scales, and it failed to detect any individual item that might be responsible for the low reliability coefficients. It is possible that undetected random responding may be responsible, as these results run contradictory to previous research, which suggested that these scales demonstrated good reliability (Levant & Parent, 2019; Levant et al., 2020). Regardless of the cause, due to the low alphas of these two scales, results pertaining to these measures should be interpreted with caution.

Table 2

Descriptive Statistics for All Main Variables

Variable	M	Possible Range	Observed Range	SD	α
Disclosure	3.04	1.00 - 5.00	1.00 – 5.00	0.80	.85
Inadequacy and Deficiency	1.90	.00 – 4.00	.00 – 4.00	0.91	.92
NMA	4.16	1.00 – 7.00	1.33 – 7.00	0.89	.56
SOS-10	3.98	.00 – 6.00	.30 – 6.00	1.12	.91
SSOSPH	2.80	1.00 – 5.00	1.00 - 4.50	0.59	.68
TMRS	2.94	1.00 – 5.00	1.00 – 5.00	0.89	.92
Emotional Control	2.50	.00 – 5.00	.00 – 5.00	1.24	.85
Self-Reliance	2.54	.00 – 5.00	.00 – 5.00	0.93	.31

Note. NMA = Normative Male Alexithymia; SOS-10 = Schwartz Outcome Scale-10; SSOSPH = Self-Stigma of Seeking Psychological Help; TMRS = Threatened Masculinity-Related Shame, officially known as the Feel Shame subscale of the Masculinity and Shame Questionnaire.

Regarding means and standard deviations, participant responses typically fell in the neutral to dissenting category. As seen in Table 1, the mean for Disclosure subscale from the Interpersonal Competence Questionnaire (Buhrmester et al., 1988) was 3.04 (*SD*

= 0.80), which translates to "*I'm okay at this, I'd feel somewhat uncomfortable and have some difficulty handling this situation*". For Inadequacy and Deficiency, a subscale of the Internalized Shame Scale (Cook, 1988), the mean was 1.90 (*SD* = 0.91), indicating that participants rarely experienced feelings of inadequacy and deficiency. NMA was the total score of the NMAS (Levant & Parent, 2019) and received a mean score of 4.16 (*SD* = 0.89), indicating that participants typically responded in a neutral manner, neither agreeing nor disagreeing. The mean for the SOS-10 (Blais et al., 1999) was 3.98 (*SD* = 1.12), indicating that participants responded in a neutral manner to the questionnaire. The SSOSPH is the total score of the SSOSHS (Vogel et al., 2006) and had a mean of 2.80 (*SD* = 0.59). Participants slightly disagreed with items on this scale. Responses to the TMRS subscale, officially known as the Feel Shame subscale from the Masculinity and Shame Questionnaire (Gebhard et al., 2019), demonstrated a mean of 2.94 (*SD* = 0.89) with participants mostly responding that they were slightly less likely to feel shame in the given scenarios. Finally, Emotional Control (*M* = 2.50, *SD* = 1.24) and Self-Reliance (*M* = 2.54, *SD* = 0.93), two subscales from the CMNI-30 (Levant et al., 2020), indicated that participants typically responded to items with *Somewhat Disagree*.

Hypothesis Testing

Preliminary Analyses

Hypothesis 1

The first hypothesis was examined using bivariate correlations (see Table 3) to examine whether there were relationships among Self-Reliance, Emotional Control, Disclosure, NMA, Threatened Masculinity-Related Shame (TMRS), Inadequacy and Deficiency, and Self-Stigma. Specifically, it was hypothesized that there would be negative associations between Self-Reliance and Disclosure, as well as Emotional Control and Disclosure, and positive associations between Self-Reliance and NMA, as well as Emotional Control and NMA. Positive associations between Self-Reliance and TMRS, as well as Emotional Control and TMRS, were also hypothesized. Finally, it was expected that there would be a positive association between Emotional Control and Self-Stigma, as well as Self-Reliance and Self-Stigma. All bivariate correlations will be interpreted in accordance with Ferguson's (2009) effect size cutoffs, which posit that the recommended minimum effect size for a "practically" (p. 533) significant correlations is .20, moderate effect size is .50, and strong effect size is .80.

Hypothesis 1 was partially supported. Bivariate correlation analyses indicated a significant negative relationship between Emotional Control and Disclosure (r = -.48, p < .01) that was moderate in effect size, but not between Self-Reliance and Disclosure (r = -.09, p = .06). Bivariate correlations supported the next part of Hypothesis 1 in which Self-Reliance and Emotional Control were both meaningfully

and positively related to NMA ($r = .36$, $p < .01$, and $r = .31$, $p < .01$, respectively). The prediction that Self-Reliance and Emotional Control would be positively related to TMRS was partially supported, with Self-Reliance yielding a significant, positive relationship ($r = .16$, $p < .01$) but not Emotional Control ($r = -.08$, $p = .07$). Unfortunately, although the relationship between Self-Reliance and TMRS was statistically significant, it cannot be considered practically significant according to Ferguson (2009). Finally, the hypothesis that there would be positive associations between Emotional Control and Self-Stigma, as well as Self-Reliance and Self-Stigma, was also partially supported. Only Self-Reliance was shown to be positively related to Self-Stigma ($r = .33$, $p < .01$), indicating a practically significant effect size, whereas Emotional Control was not significantly related to Self-Stigma ($r = .05$, $p = .30$).

Table 3

Bivariate Correlations for all Main Variables

Variable	Disclosure	Inadequacy and Deficiency	NMA	Self-Stigma	TMRS	Emotional Control	Self-reliance
Disclosure	-						
Inadequacy and Deficiency	-.08	-					
NMA	-.26**	.33**	-				
Self-Stigma	-.10*	-.25**	.23**	-			
TMRS	-.01	.50**	.20**	-.24**	-		
Emotional Control	-.48**	- .07	.31**	.05	-.08	-	
Self-Reliance	-.09	.26**	.36**	.33**	.16**	.20**	-

Note. N = 471. NMA = Normative Male Alexithymia, TMRS = Threatened Masculinity Shame.

*$p \leq .05$, **$p \leq .01$.

Hypothesis 2

Hypothesis two posited that there would be a negative association between Disclosure and Inadequacy and Deficiency and positive relationships between NMA and Inadequacy and Deficiency, and TMRS and Inadequacy and Deficiency. This hypothesis was partially supported. Contrary to predictions, the relationship between Disclosure and Inadequacy and Deficiency was not statistically significant (r = -.08, p = .08). However, the relationship between NMA and inadequacy and deficiency was positive and statistically significant with a meaningfully significant effect size, supporting this hypothesis (r = .33, p < .01). It was also predicted that there would be a positive relationship between TMRS and Inadequacy and Deficiency. This hypothesis was supported (r = .50, p < .01), indicating that shame felt in relation to one's masculinity (e.g., not measuring up) was directly related, with a moderate-level effect size, to feelings of inadequacy and deficiency.

Hypothesis 3

Hypothesis three predicted that there would be a positive relationship between Inadequacy and Deficiency and Self-Stigma. This hypothesis was supported and practically significant (r = .25, p < .01), indicating that men who are experiencing higher levels of Inadequacy and Deficiency are likely to experience more Self-Stigma.

Hypothesis 4

Hypothesis four stated that the relationship between Emotional Control and NMA would be present across all racial groups, but it would be stronger for Hispanic/Latino

American men than Asian American men. For the remaining variables, it was hypothesized that relationships between Disclosure, NMA, TMRS, and Inadequacy and Deficiency would remain the same across all racial groups. The hypothesis was partially supported. Using partial correlations, the relationship between Emotional Control and NMA were statistically and practically significant as hypothesized for Black/African Americans ($r = .31$, $p < .01$), Hispanic/Latino Americans ($r = .31$, $p < .01$), and Asian Americans ($r = .31$, $p < .01$). However, in comparing partial correlations from each group, the relationship between Emotional Control and NMA was not stronger for Hispanic/Latino Americans than for Asian Americans as was predicted ($\chi^2 = .004$, $p = .946$). For the final part of the hypothesis, it was found that Disclosure, NMA, TMRS, and Inadequacy and Deficiency did indeed remain the same across all racial groups as evidenced by significant chi-square statistics (Table 7). Tables 4-6 provide partial correlations between all variables for each racial group.

Table 4

Partial Correlations for all Main Variables Controlling for Black/African American Men

Variable	Disclosure	Inadequacy and Deficiency	NMA	Self-Stigma	TMRS	Emotional Control	Self-reliance
Disclosure	-						
Inadequacy and Deficiency	-.09	-					
NMA	-.26**	.34**	-				
Self-Stigma	-.10*	-.25**	.24**	-			
TMRS	-.02	.50**	.20**	.24**	-		
Emotional Control	-.48**	-.06	.31**	.05	-.07	-	
Self-Reliance	-.09	.26**	.36**	.33**	.16**	.20**	-

Note. N = 471. NMA = Normative Male Alexithymia, TMRS = Threatened Masculinity Shame.

*$p \leq .05$, **$p \leq .01$.

Table 5

Partial Correlations for all Main Variables Controlling for Hispanic/Latino American Men

Variable	Disclosure	Inadequacy and Deficiency	NMA	Self-Stigma	TMRS	Emotional Control	Self-reliance
Disclosure	-						
Inadequacy and Deficiency	-.08	-					
NMA	-.26**	.33**	-				
Self-Stigma	-.10*	-.25**	.23**	-			
TMRS	-.01	.50**	.20**	.24**	-		
Emotional Control	-.48**	-.07	.31**	.05	-.08	-	
Self-Reliance	-.08	.26**	.36**	.33**	.16**	.20**	-

Note. N = 471. NMA = Normative Male Alexithymia, TMRS = Threatened Masculinity Shame.

*$p \leq .05$, **$p \leq .01$.

Table 6

Partial Correlations for all Main Variables Controlling for Asian American Men

Variable	Disclosure	Inadequacy and Deficiency	NMA	Self-Stigma	TMRS	Emotional Control	Self-reliance
Disclosure	-						
Inadequacy and Deficiency	-.08	-					
NMA	-.25**	.33**	-				
Self-Stigma	-.10*	-.25**	.24**	-			
TMRS	-.02	.50**	.20**	.24**	-		
Emotional Control	-.48**	-.07	.31**	.05	-.08	-	
Self-Reliance	-.10*	.26**	.36**	.33**	.15**	.21**	-

Note. N = 471. NMA = Normative Male Alexithymia, TMRS = Threatened Masculinity Shame.

*$p \leq .05$, **$p \leq .01$.

Table 7

Test for Equality of Correlation Coefficients for All Racial Groups

Variable	χ^2	*p* value
Disclosure/Inad	.031	.984
Disclosure/NMA	.035	.982
NMA/Inad	.039	.980
NMA/TMRS	0	1.00
TMRS/Inad	0	1.00

Note. N = 471. Inad = Inadequacy and Deficiency, TMRS = Threatened Masculinity Shame.

I next examined if the relationships found in the bivariate correlations for the full sample were influenced by Psychological Well-being by conducting partial correlations on allvariables while controlling for well-being for the sample as a whole (Table 8). There was one observed change when the variance associated with Psychological Well-being was partialled out. The relationship between Emotional Control and Inadequacy and Deficiency went from being nonsignificant at $r = -.07$, $p = .14$ to statistically and practically significant at $r = -.21$, $p < .01$. As mentioned previously, according to Ferguson (2009), a coefficient of .20 and above is the minimum to be considered a practically significant correlation. In other words, when variance associated with psychological well-being was removed, high levels of Emotional Control was associated with lower levels of Inadequacy and Deficiency.

To account for this finding, the hypothesized models were run with PsychologicalWell-being as a covariate. There were two other changes in correlations, the first being the relationship between Disclosure and Inadequacy and Deficiency, which went from being non-significant and negative to significant and positive ($r = -.08$, $p = .08$, to $r = .10$, $p = .03$). Although the p value is below .05, a correlation coefficient of .10 is not considered practically significant (Ferguson, 2009). Conversely, the relationship between Disclosure and Self-Stigma went from being significant to not significant ($r = -.10$, $p < .04$ to $r = -.04$, $p = .40$); however, this is not a meaningful change, as correlations were smaller than |.20| (Ferguson, 2009)

Table 8

Partial Correlations for all Main Variables Controlling for Psychological Well-being

Variable	Disclosure	Inadequacy and Deficiency	NMA	Self-Stigma	TMRS	Emotional Control	Self-Reliance
Disclosure	-						
Inadequacy and Deficiency	.10*	-					
NMA	-.21**	.29**	-				
Self-Stigma	-.04	.21**	.21**	-			
TMRS	.03	.51**	.19**	.23**	-		
Emotional Control	-.48**	-.21**	.31**	.01	-.07	-	
Self-Reliance	-.04	.23**	.36**	¤ .32**	.15**	.17**	-

Note. N = 471. NMA = Normative Male Alexithymia, TMRS = Threatened Masculinity Shame.

*$p \leq .05$, **$p \leq .01$.

Hypothesis 5

Hypothesis five predicated that there would be racial differences in Self-Stigma. Specifically, it was hypothesized that White/European American men would have lower levels of Self-Stigma than Black/African American, Hispanic/Latino American, and Asian American men. An ANOVA with Self-Stigma as the outcome and racial identity as the predictor was run with the Games-Howell post hoc test. Games-Howell can be used with uneven sample sizes and in the presence of heterogeneity of variance (Field & Wilcox, 2017). The results of the ANOVA were nonsignificant $F(4, 474) = 0.67$, $p = .62$, $\eta^2_P = .006$. This indicates that there were no significant differences in Self-Stigma across racial groups.

Model Testing

The following hypotheses predicted Self-Stigma using two models, one with Emotional Control as the predictor and the other with Self-Reliance as the predictor. In their respective models, it was thought that Emotional Control and Self-Reliance (Figure 1) would predict Disclosure, NMA, and TMRS. In both models, Disclosure, NMA, and TMRS were hypothesized to, in turn, predict Inadequacy and Deficiency. Finally, Inadequacy and Deficiency was expected to predict to Self-Stigma. One alternative model (Figure 2) for each hypothesized model was run to find the best fitting model for each. The two alternative models were identical to the main models except that the direct paths from Emotional Control and Self-Reliance to Self-Stigma were removed. The two main models and the two alternative models make a total of four models. Mplus version 8.6 (Muthén & Muthén, 1998-2017) was utilized for all models.

The first hypothesized model (Figure 3) consisted of Emotional Control having a direct effect on Disclosure, NMA, TMRS, and Self-Stigma. The fit of the model was marginal to good: robust $\chi^2(5) = 26.43$, $p < .001$; CFI = .94; RMSEA = .095 (95% CI = .061, .132); SRMR = .043. The alternative model (Figure 4) involving Emotional Control was roughly identical in fit to the hypothesized model: robust $\chi^2(6) = 28.63$, $p < .001$; CFI = .94; RMSEA = .089 (CI = .058, .123); SRMR = .047. To determine if one model was a better fit over the other, a Satorra-Bentler chi-square comparison was completed. This analyzes the difference in chi-square statistics between a baseline model and nested model. The model with the least constraints, and, therefore, lower degrees of freedom, is the baseline model, and the model which is more restrictive with more degrees of freedom is the nested model (Bryant & Satorra, 2012). The Satorra-Bentler tests the hypothesis that the nested model has significantly worse model fit. Therefore, according to Bryant and Satorra (2012), a non-significant finding indicates that the nested model is not meaningfully different from the baseline model. A significant result suggests the opposite, that the constraints placed on the baseline model worsen model fit. The statistic was not significant (TRd = 1.92, $p = .166$), indicating that the nested model does not worsen model fit. In cases of nonsignificant fit differences, Weston and Gore (2006) recommend choosing the most parsimonious model; in other words, the model which achieves the desired prediction with the least number of variables. The most parsimonious model would be the model with the most degrees of freedom. In this case, the alternative model (Figure 2) is the most parsimonious and was used for all subsequent analyses.

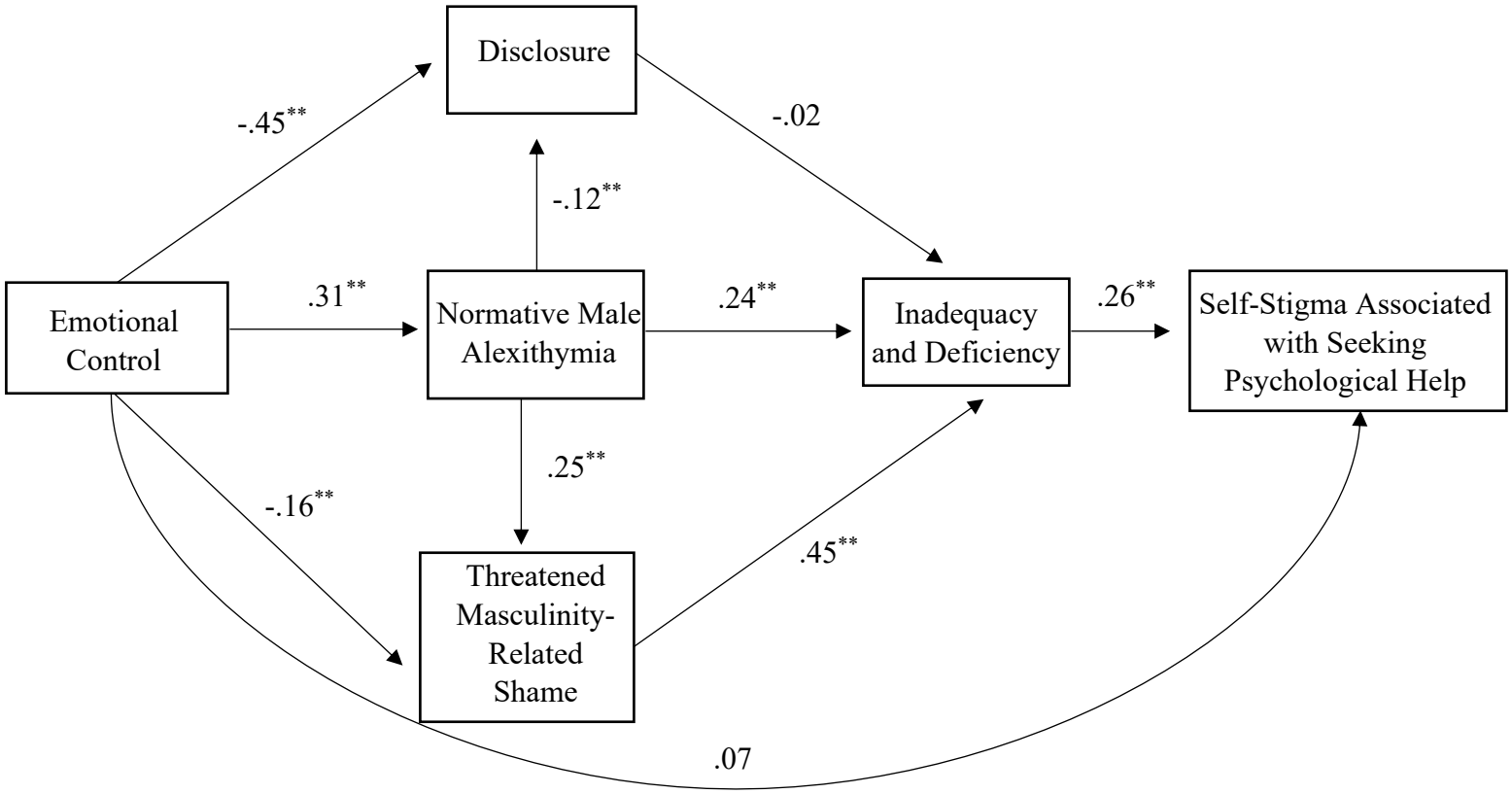
The next part of Hypothesis 6 tests the same hypotheses but with Self-Reliance as the predictor instead of Emotional Control (Figure 5). The hypothesized model was of adequate to good fit: robust $\chi^2(5) = 16.35$, $p < .001$; CFI = .96; RMSEA = .069 (CI = .034, .108); SRMR = .037), whereas the alternative model (Figure 6) was of poor fit: robust $\chi^2(6) = 45.46$, $p < .001$; CFI = .86; RMSEA = .11 (CI = .087, .151); SRMR = .075). The Satorra-Bentler chi-square difference test (TRd = 27.322, $p < .001$) confirmed that the alternative model worsened model fit, indicating that the hypothesized model was the best fitting. Consequently, it was used for all subsequent analyses.

Hypothesis 6

It was hypothesized that Emotional Control and Self-Reliance would have direct effects on Disclosure, NMA, TMRS, and Self-Stigma. Specifically, Emotional Control and Self-Reliance would negatively predict Disclosure and positively predict NMA, TMRS, and Self-Stigma. I will begin by discussing the results of the Emotional Control alternative model, which was shown to be more parsimonious than the main hypothesized model. Hypothesis 6 was partially supported. As predicted, there was a negative significant path from Emotional Control to Disclosure ($\beta = -.45$, $p < .001$), and a positive significant path from Emotional Control to NMA ($\beta = .31$, $p < .001$). Contrary to prediction, the path from Emotional Control to TMRS was negative and significant, rather than positive and significant ($\beta = -.16$, $p = .002$).

Figure 3

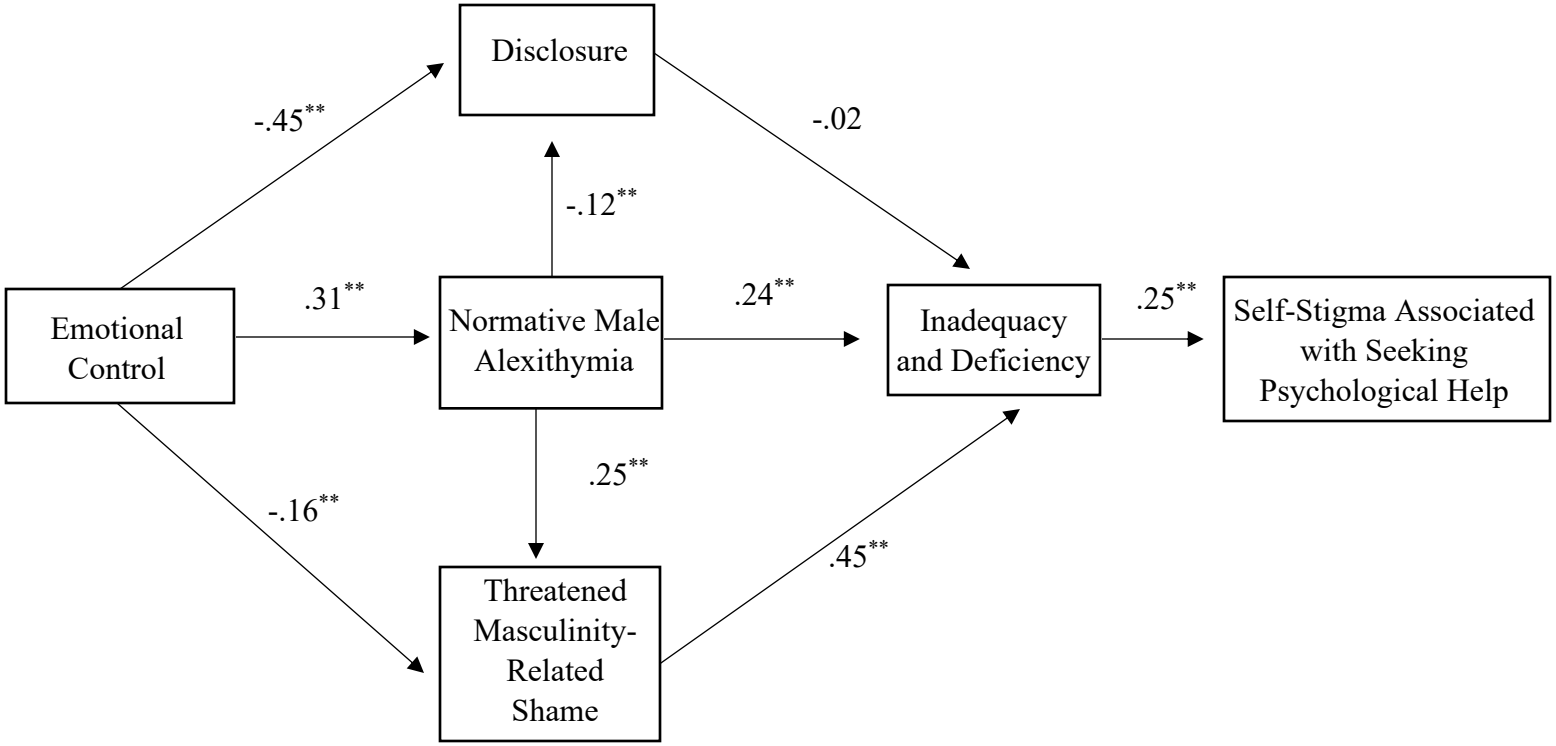
Hypothesized Structural Model with Emotional Control Predicting Self-Stigma Associated with Seeking Psychological Help



Note. *p ≤ .05, **p ≤ .01

Figure 4

Alternative Structural Model with Emotional Control Predicting Self-Stigma Associated with Seeking Psychological Help



Note. $^{*}p \leq .05$, $^{**}p \leq .01$

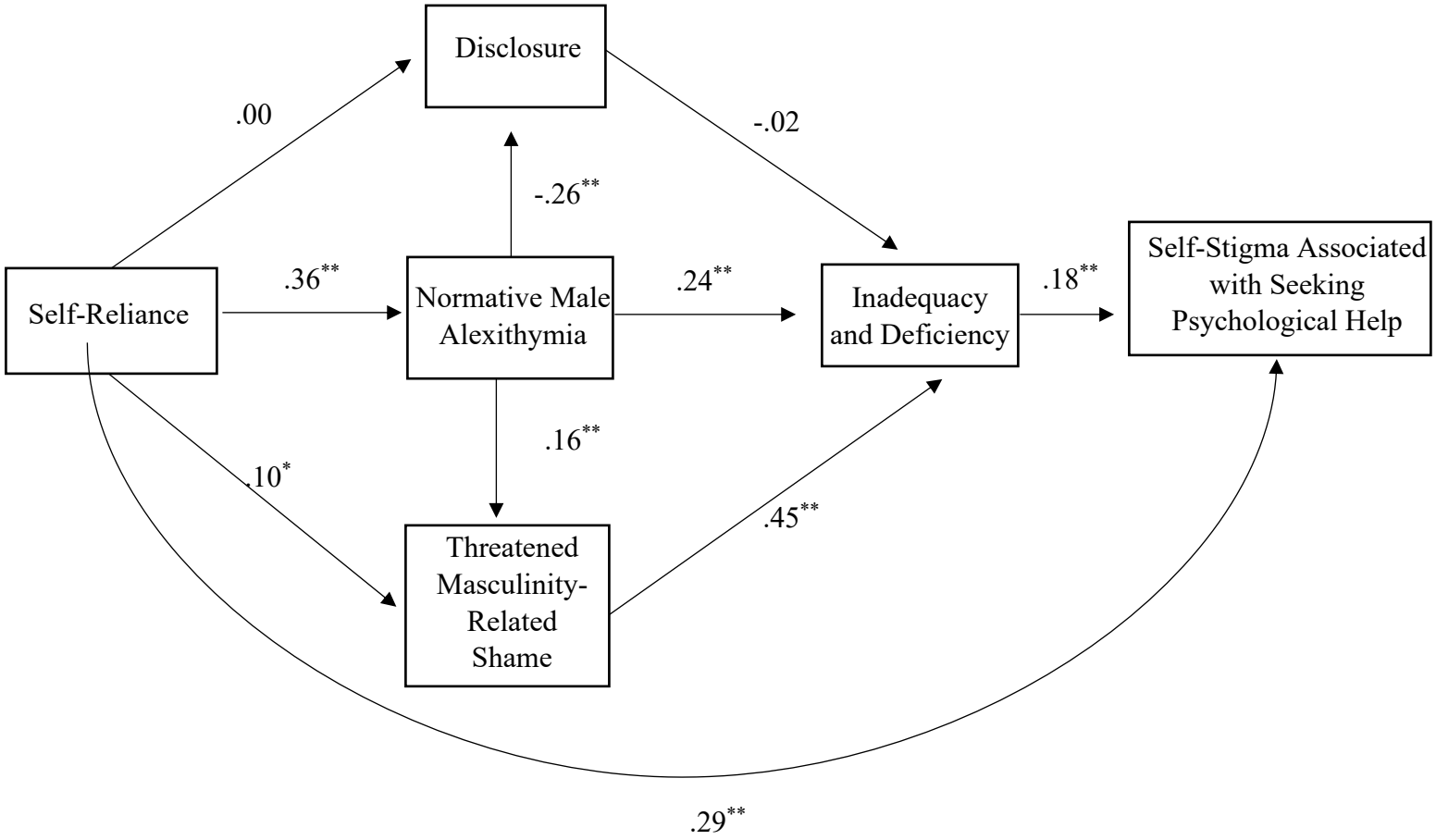
Moving to the Self-Stigma hypothesized model, the path from Self-Reliance and Self-Stigma was significant (β = .29, $p < .001$), as were the paths from Self-Reliance to NMA (β = .36, $p < .001$) and TMRS (β = .10 $p = .05$), supporting the hypothesis. The path from Self-Reliance to Disclosure was not significant (β = .004, $p = .927$), making this hypothesis only partially supported.

Hypothesis 7

Hypothesis seven posited that NMA would have a direct effect on Disclosure and TMRS such that NMA would negatively predict Disclosure and positively predict TMRS in both the Emotional Control and Self-Reliance models. For the Emotional Control model, the hypothesis was supported. There were significant paths between NMA and Disclosure (β = -.12, $p = .005$) and NMA and TMRS (β = .25, $p < .001$). The path between NMA and Disclosure was negative, and the path from NMA to TMRS was positive, also as predicted. Results were similar for the Self-Reliance model, with paths from NMA to Disclosure and NMA to TMRS being significant (β = -.26, $p < .001$, and β = .16, $p < .001$ respectively). The path from NMA to Disclosure was negative, whereas the path from NMA to TMRS was positive, also as hypothesized. Findings from both models indicate that Hypothesis seven was fully supported.

Figure 5

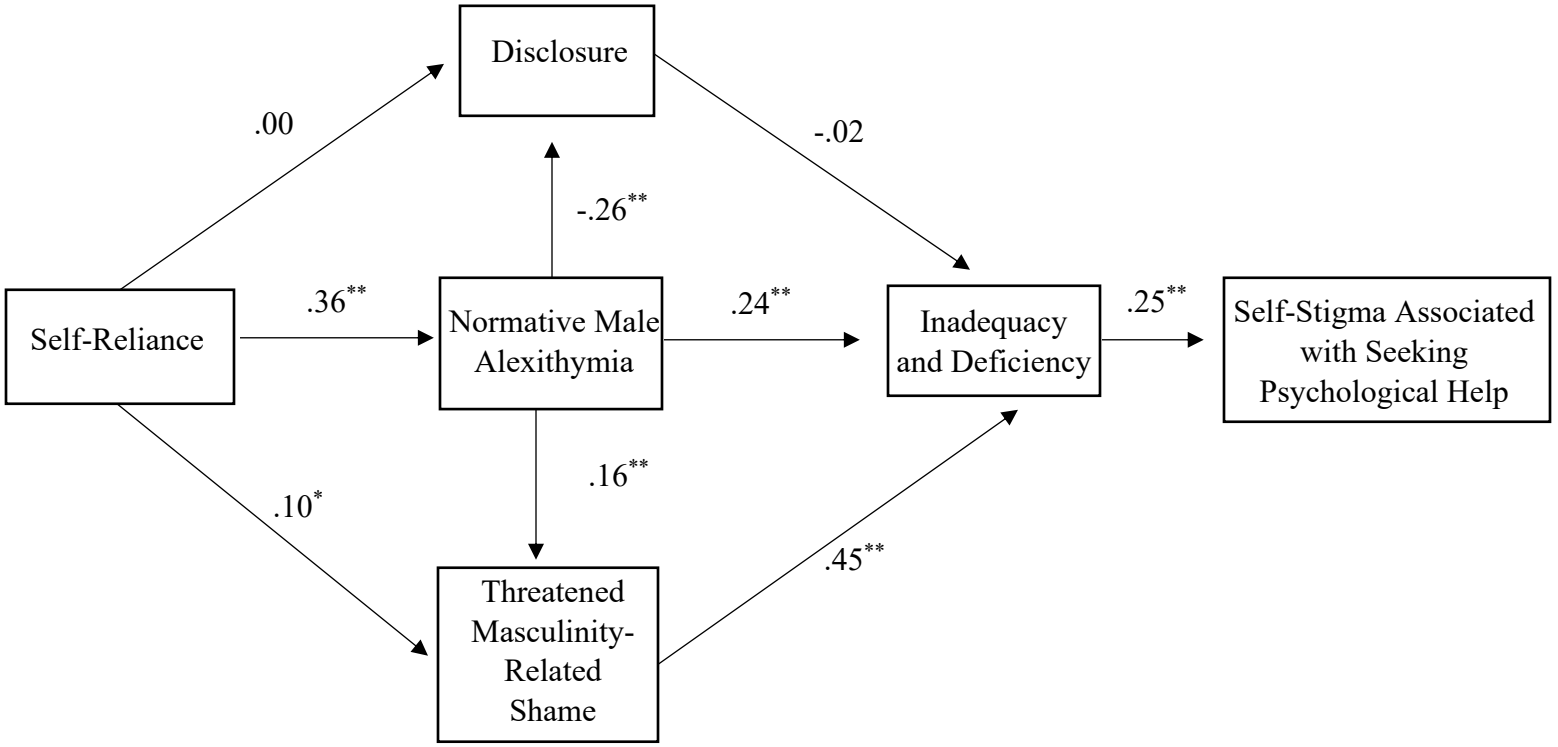
Hypothesized Structural Model with Self-Reliance Predicting Self-Stigma Associated with Seeking Psychological Help



Note. *p ≤ .05, **p ≤ .01

Figure 6

Alternative Structural Model with Self-Reliance Predicting Self-Stigma Associated with Seeking Psychological Help



Note. *p ≤ .05, **p ≤ .01

Hypothesis 8

Hypothesis eight predicted that Disclosure, NMA, and TMRS would directly predict feelings of Inadequacy and Deficiency such that high scores on Disclosure would be negatively predictive of Inadequacy and Deficiency, and NMA and TMRS would be positively predictive of Inadequacy and Deficiency. Beginning with the Emotional Control model, significant paths were found between NMA and Inadequacy and Deficiency ($\beta = .24$, $p < .001$), as well as TMRS and Inadequacy and Deficiency ($\beta = .45$, $p < .001$). However, the path from Disclosure to Inadequacy and Deficiency was not significant ($\beta = -.02$, $p = .741$), making this hypothesis partially supported. The same results were found for the Self-Reliance model, with significant paths between NMA and Inadequacy and Deficiency ($\beta = .24$, $p < .001$) and between TMRS and Inadequacy and Deficiency ($\beta = .45$, $p < .001$). There was also a non-significant path from Disclosure to Inadequacy and Deficiency ($\beta = -.02$, $p = .741$).

Hypothesis 9

Hypothesis nine stated that Inadequacy and Deficiency would have a positive, direct path to Self-Stigma. This hypothesis was supported for both the Emotional Control and Self-Reliance models. For the Emotional Control model, the path from Inadequacy and Deficiency to Self-Stigma was $\beta = .25$, $p < .001$, and in the Self-Reliance model, the path was $\beta = .18$, $p < .001$.

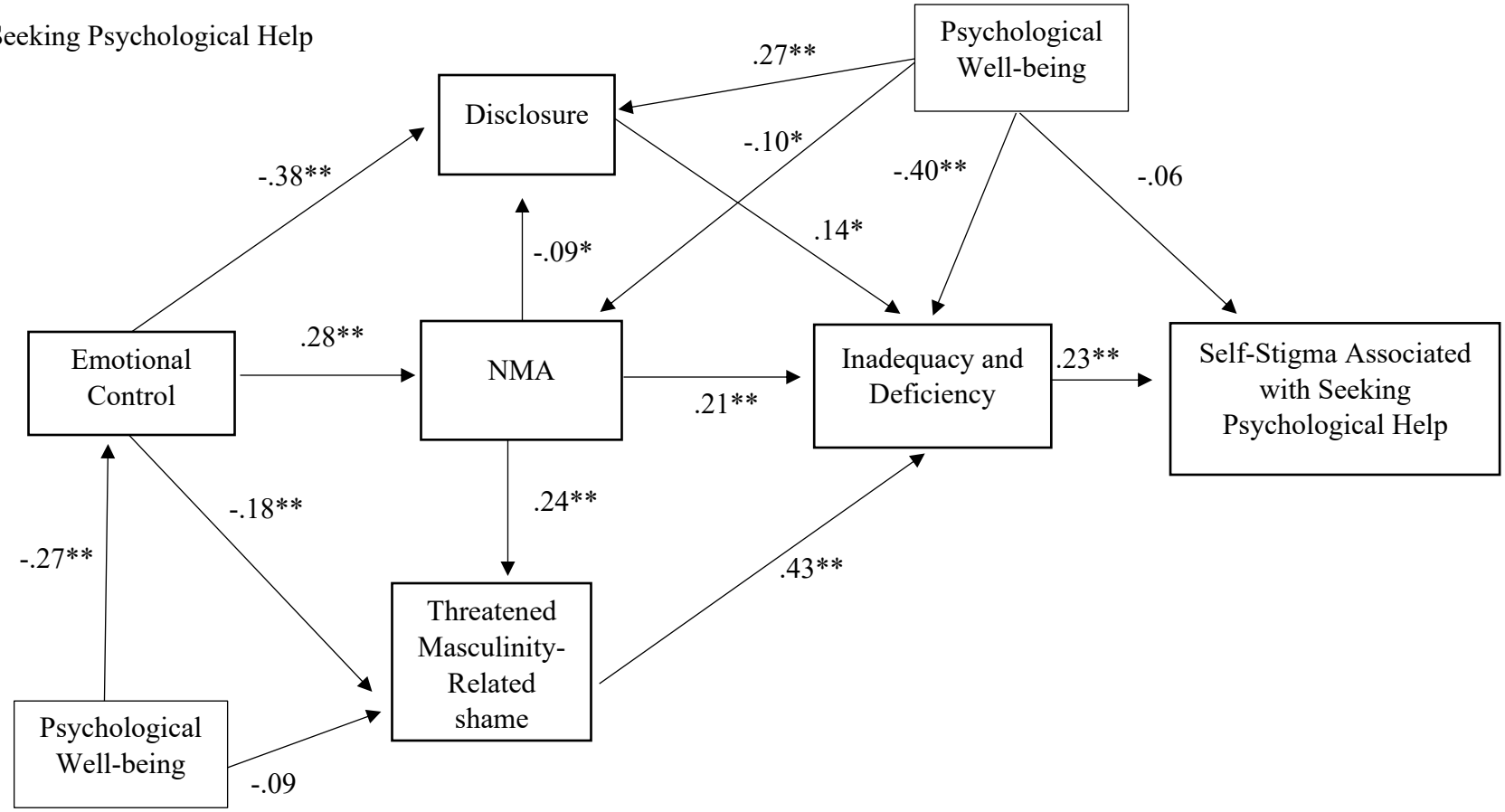
Controlling for Psychological Well-being

To determine if the relationships in the two selected models could be attributed to Psychological Well-being, this construct was added as a covariate to each path on the

model. Beginning with the best-fitting Emotional Control model (Figure 7), the fit ranged from poor to good: robust $\chi^2(6) = 37.81$, $p < .001$; CFI = .94; RMSEA = .106 (95% CI = .075, .139); SRMR = .043. Most paths in this model were consistent with the original alternative model, with the exception of the path from Inadequacy and Deficiency to Disclosure, which was significant and positive in this model (β = .14, p = .002), whereas it was not significant and negative in the original alternative model (β = -.02, p = .741). Paths associated with Psychological Well-being were significant, except for the path from Psychological Well-being to TMRS (β = -.09, p = .090) and the path from Psychological Well-being to Self-Stigma (β = -.06, p = .202).

Figure 7

Psychological Well-being as a Covariate in the Structural Model with Emotional Control predicting Self-Stigma Associated with Seeking Psychological Help

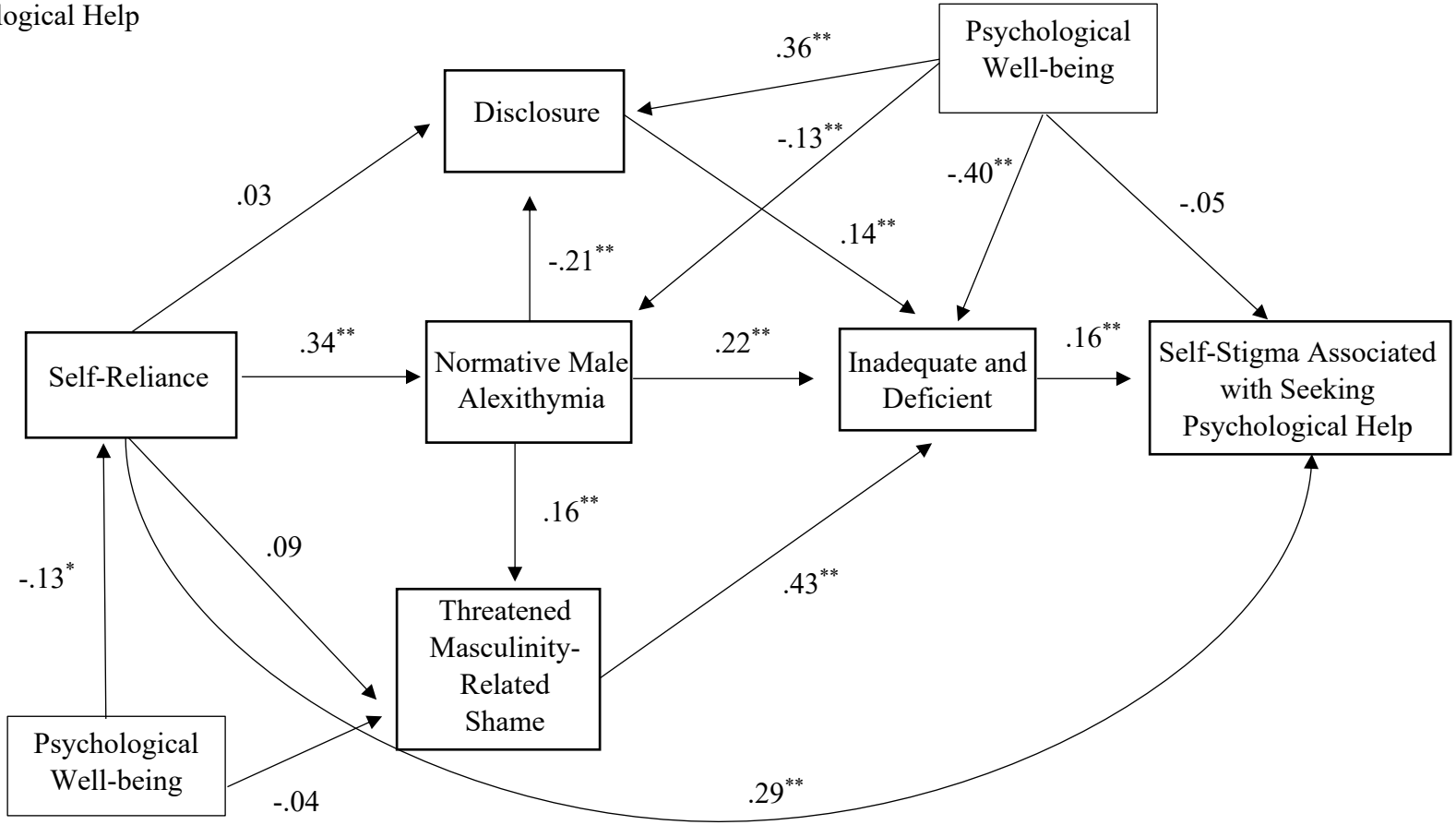


Note. $^{*}p \leq .05$, $^{**}p \leq .01$

Next, I ran the Self-Reliance model with Psychological Well-being as the covariate (Figure 8). The model fit was adequate to good: robust $\chi^2(5) = 16.24$, $p = .006$; CFI = .98; RMSEA = .070 (CI = .033, .108); SRMR = .030. Results of the path analysis were similar to the previous model, except for the path from Self-Reliance to TMRS, which was no longer significant ($\beta = .09$, $p = .056$). However, it should be noted that the original path was barely significant ($\beta = .10$, $p = .048$). Paths involving the covariate, Psychological Well-being, were largely similar to those in the Emotional Control model. All paths were significant, except for paths from Psychological Well-being to TMRS ($\beta = -.04$, $p = .431$) and from Psychological Well-being to Self-Stigma ($\beta = -.05$ $p = .236$).

Figure 8

Psychological Well-being as a Covariate in the Structural Model with Self-Reliance predicting Self-Stigma Associated with Seeking Psychological Help



Note. *p ≤ .05, **p ≤ .01

Hypothesis 10

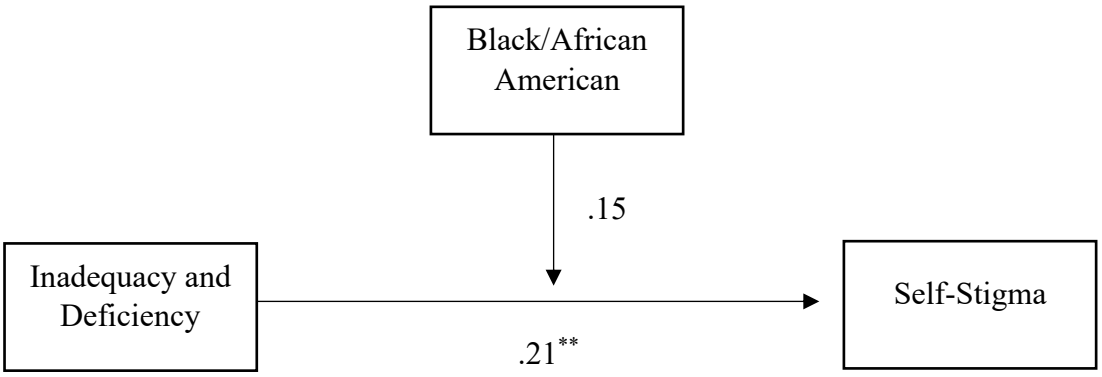
Hypothesis ten sought to examine racial differences in the relation between Inadequacy and Deficiency and Self-Stigma. Specifically, it was hypothesized that the relation would be stronger for men of Color than for White/European American men. To assess this, I used Hayes' Model 1 in PROCESS. I examined three models. In each case, one of the racial demographics was entered as the moderator in the relationship between Inadequacy and Deficiency and Self-Stigma. The interactions were non-significant for all racial groups as evidenced by the presence of zero in the confidence intervals: Black/African American men [B = -.0642, 95% C.I. (-.22, .09), p = .431], Hispanic/Latino American men [B = -.1263, 95% C.I. (-.31, .05), p = .170], and Asian American Men, [B = .0656, 95% C.I. (-.12, .25), p = .491].

For Black/African American men (Figure 9), the path from Inadequacy and Deficiency was significant [B = .2125, 95% C.I. (.09, .32), p < .01]; however, race was not a significant moderator [B = .1482, 95% C.I. (-.20, .50), p = .408]. This indicates that identifying as Black/African American compared to White/European American did not significantly influence the relationship between Inadequacy and Deficiency and Self-Stigma. The result was the same for Hispanic/Latino American men (Figure 10), with the path from Inadequacy and Deficiency being significant [B = .2125, 95% C.I. (.10, .32), p < .01], but not the moderating path [B = .2470, 95% C.I. (-.12, .61), p = .191]. Finally, the same was found for Asian American men (Figure 11). The path from Inadequacy and Deficiency was significant [B = .2125,

95% C.I. (.09, .32), $p < .01$], but the moderating path was not [$B = -.1667$, 95% C.I. (-.55, .22), $p = .403$]. This hypothesis is thus not supported.

Figure 9

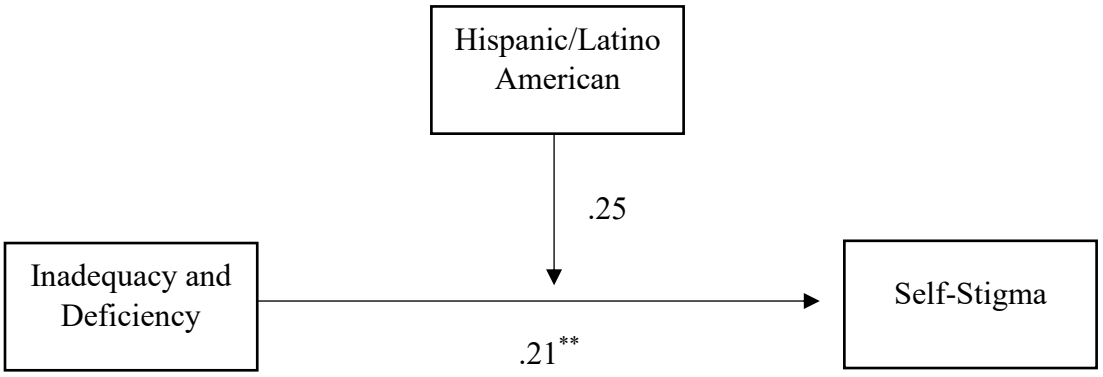
The relationship between Inadequacy and Deficiency and Self-Stigma moderated on by Black/African American racial/ethnic identity.



Note. *p ≤ .05, **p ≤ .01

Figure 10

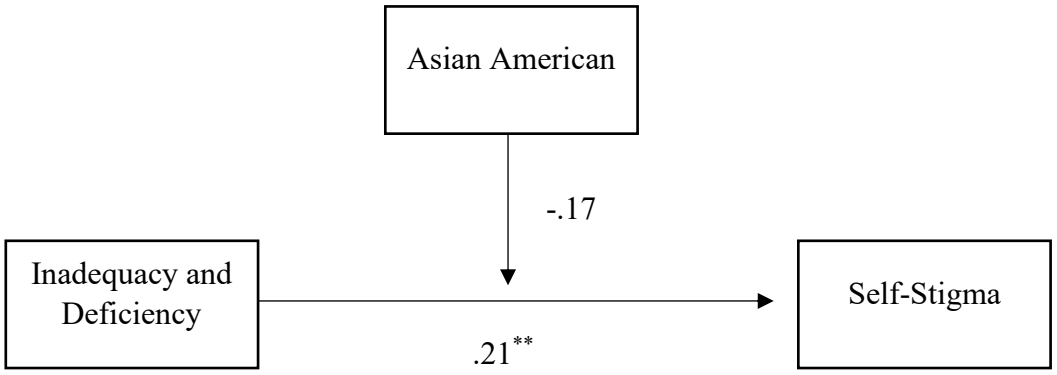
The relationship between Inadequacy and Deficiency and Self-Stigma moderated on by Hispanic/Latino American racial/ethnic identity.



Note. *p ≤ .05, **p ≤ .01

Figure 11

The relationship between Inadequacy and Deficiency and Self-Stigma moderated on by Asian American racial/ethnic identity.



Note. *p ≤ .05, **p ≤ .01

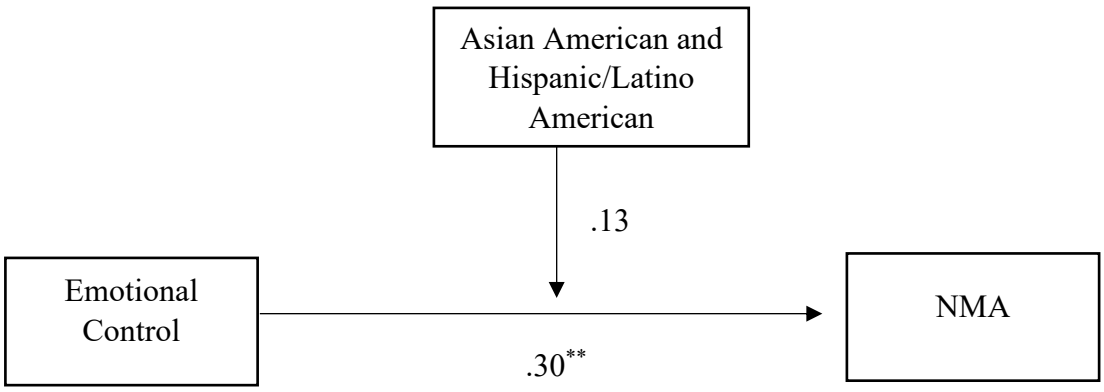
Hypothesis 11

The final hypothesis sought to examine racial effects for Hispanic/Latino American men and Asian American men such that the relation between Emotional Control and NMA was expected to be stronger for Hispanic/Latino American men and weaker for Asian American men. This hypothesis was assessed by using Model 1 in Hayes' PROCESS macro for SPSS. There was a significant relationship between Emotional Control and NMA [B = .3046, 95% C.I. (.17, .43), p < .01] (Figure 12). Unfortunately, there was no significant interaction between having either a Hispanic/Latino American identity or an Asian American identity on the relationship between Emotional Control and NMA [B = -.0862, 95% C.I. (-.27, .10), p = .375]. For this study, an insignificant interaction indicates that having a Hispanic/Latino

American identity or an Asian American identity did not affect the relationship between Emotional Control and NMA. Since the interaction was not significant it could not be probed to determine whether one identity would have a stronger relationship with Emotional Control and NMA than the other. This hypothesis goes unsupported.

Figure 12

The relationship between Emotional Control and NMA moderated on by Hispanic/Latino American racial/ethnic identity.



Note. *p ≤ .05, **p ≤ .01

CHAPTER V

DISCUSSION

This final chapter will review the results of the current study such that each hypothesis will be discussed in the context of past literature. Following an in-depth discussion of this study's findings, implications for practice and research will be reviewed. The chapter will conclude with a section assessing the strengths and limitations of the present study.

Summary of the Hypotheses and Results

The current study supports the idea that masculinity, difficulties with understanding and expressing emotions, and shame are positively associated with one's self-stigma about seeking psychological help regardless of racial identity (i.e., Asian American, Black/African American, Hispanic/Latino American, White/European American). This idea prevailed even after controlling for general psychological well-being. These constructs were assessed using several measures consisting of the Conformity to Masculine Norms Inventory Short Form (CMNI-30; Levant et al., 2020), Normative Male Alexithymia Scale- Brief Form (NMAS-BF; Levant & Parent, 2019), Internalized Shame Scale (ISS; Cook, 1988), Masculinity and Shame Questionnaire (MASQ; Gebhard et al., 2019), Self-Stigma of Seeking Help (SSOSH; Vogel et al., 2006), and the Schwartz Outcomes Scale-10 (SOS-10). Disclosure was also assessed

using the Internalized Shame Scale (ISS; Cook, 1988); however, one's ability to disclose was not significantly related to masculinity or feelings of shame as was hypothesized. This study posited 11 hypotheses. Hypotheses 1-5 assessed relationships using bivariate correlations, partial correlations, and an ANOVA. Hypotheses 6-9 represented the main analyses using a path analysis. Finally, hypotheses 10-11 were assessed using moderation. Tests of these hypotheses yielded a number of results that partially supported, fully supported, or did not support the hypotheses. These are described in more detail below.

Hypothesis 1

The first hypothesis, examined using bivariate correlations, tested whether there would be significant relationships among Self-Reliance, Emotional Control, Disclosure, NMA, TMRS, Inadequacy and Deficiency, and Self-Stigma. It was predicted that there would be negative associations between Self-Reliance and Disclosure, as well as Emotional Control and Disclosure, and positive associations between Self-Reliance and NMA, as well as Emotional Control and NMA. It was also hypothesized that there would be positive associations between Self-Reliance and TMRS, as well as Emotional Control and TMRS. Finally, it was hypothesized that there would be a positive association between Emotional Control and Self-Stigma, as well as Self-Reliance and Self-Stigma.

Hypothesis 1 was partially supported with some unexpected outcomes, particularly with Disclosure and TMRS. Unexpectedly, the relationship between Self-Reliance and Disclosure was not significant. It is unclear why this result occurred; it is possible that the low internal reliability of the Self-Reliance scale could be influencing

this relationship. By contrast, Emotional Control and Disclosure had a significantly and moderately strong negative correlation such that as Emotional Control increased, competency to disclose to others decreased. In other words, men who are high in Emotional Control may simultaneously not be comfortable or feel competent in disclosing their problems to others or being otherwise vulnerable (e.g., exposing their sensitive side to others or revealing something intimate about themselves). Self-Reliance and Emotional Control were both positively related to NMA as expected. This is consistent with previous research, which found that high levels of masculinity norms were associated with higher levels of difficulty understanding and expressing emotions (Levant et al., 2014; Levant & Parent, 2019), at least for European American men. Men who are high on Self-Reliance or Emotional Control often simultaneously struggle to express their feelings to others, even their closest family and friends. This makes sense, as to be self-reliant is to not depend on others and solve problems alone, and men who seek to control their emotions are equally likely to not want to express their emotions to others (Cleary, 2012; Johnson et al., 2012; O'Loughlin et al., 2018).

The second unexpected result was related to TMRS. Interestingly, Self-Reliance positively and significantly related to TMRS, but Emotional Control did not. In fact, the correlation coefficient was trending in the opposite direction (negative) than anticipated. It is possible that men who are very controlled in their emotions may not have the ability to recognize feelings of shame, as shame is a complex emotion that is often avoided (Lewis, 1971). Self-Reliance, by contrast, may be considered a behavioral factor and could, therefore, be easier to recognize when one is not being self-reliant (e.g., asking for help, confiding in others). There is no current literature which evaluates TMRS and

masculinity norms, but it is possible that Self-Reliance may be related to TMRS because not acting in a self-reliant way, which can be easily noticed, may be observed and processed as being less masculine and would, therefore, elicit masculinity-related shame.

Finally, the relationships of Self-Reliance and Emotional Control to Self-Stigma were assessed. Interestingly, only Self-Reliance was shown to be positively related to Self-Stigma, whereas there was no significant relationship between Emotional Control and Self-Stigma. Similar to the previous non-significant relationship involving Emotional Control and TMRS, it is possible that men with a lot of control over their emotions may be unable to recognize feelings of self-stigma. However, this is speculation. By contrast, men who prefer to solve their problems on their own (i.e., through Self-Reliance) may be likely to recognize that to seek help for their problems would be a direct objection to behaving in a self-reliant way, and they could, therefore, internalize stigma commonly associated with seeking help such as to seek help is a weakness. This is mentioned in previous literature which, unfortunately, uses mostly White samples (Herbst et al., 2014; Johnson et al., 2012; Mahalik & DiBianca, 2021; Pederson & Vogel, 2007).

Hypothesis 2

Similar to the first hypothesis, hypothesis 2 utilized bivariate correlations to test whether there would be a negative association between Disclosure and Inadequacy and Deficiency and positive relationships between both NMA and TMRS with Inadequacy and Deficiency. Like hypothesis 1, hypothesis 2 was partially supported, with Disclosure again demonstrating surprising results. Contrary to predictions, Disclosure and Inadequacy and Deficiency were not significantly related to one another. Due to the lack

of research examining Disclosure and Inadequacy and Deficiency, we can only speculate why this might have occurred. It is possible that men may not feel inadequate or deficient from not disclosing to others, as non-disclosure is arguably consistent with traditional norms of masculinity (Bruch, 2002; Cleary, 2012; Clement et al., 2015; Pederson & Vogel, 2007). In fact, not needing to self-disclose could hypothetically create feelings of pride.

As expected, the relationship between NMA and Inadequacy and Deficiency was positive and significant. Men who do not feel comfortable expressing their emotions or who have difficulty expressing their emotions are likely to also feel inadequate and deficient. It is possible that this relationship is occurring because of feedback that men could be receiving from romantic partners who are increasingly requiring more emotional availability from men (Boise & Hearn, 2017). It is possible that men with these difficulties are becoming aware that it is a growing norm to be more emotionally engaged and may feel that they are unable to meet these new standards due to the socialization processes which taught them otherwise (Pleck, 1981, 1995). Finally, TMRS was positively and significantly related to Inadequacy and Deficiency. In other words, men who were high on masculinity shame were also likely feeling inadequate and deficient, supporting this hypothesis. Although no research has examined TMRS and Inadequacy and Deficiency, this finding makes conceptual sense based on Pleck's (1995) discrepancy strain, which posits that it is common for men to feel as if they do not measure up to masculine ideals due to the unachievable nature of traditional masculinity. The shame associated with feeling less masculine than one wishes to be incites feelings of inadequacy. To date, no other research has directly examined masculinity-related shame

and feelings of inadequacy and deficiency, although these findings support Pleck's theory.

Hypothesis 3

Hypothesis 3 examined whether a positive relationship existed between Inadequacy and Deficiency and Self-Stigma using a bivariate correlation. This hypothesis was fully supported and was moderate in strength. Men who endorsed feelings of inadequacy and deficiency were also likely to endorse high feelings of self-stigma regarding seeking psychological help. Like previous hypotheses, research otherwise has yet to examine how Inadequacy and Deficiency specifically relates to Self-Stigma, but this finding supports research showing that shame/embarrassment is a prominent barrier to seeking help (Clement et al., 2015). Conceptually, the result of this hypothesis makes sense given that, if one feels inadequate or deficient, they may be likely to believe that to seek help would be proof that they are so inadequate that they cannot solve their problems on their own. This could be especially likely for men, as they may seek to abide by masculinity norms, which state that asking for help is an indicator of being unmasculine (Berger et al., 2005; Gerdes et al., 2018; Levant et al., 2013).

Hypothesis 4

Hypothesis 4 sought to examine racial differences in the relationship between Emotional Control and NMA using partial correlations. Specifically, it was hypothesized that this positive and significant relationship would be present across all racial groups but would be stronger for Hispanic/Latino American men than Asian American men. For the remaining variables, it was hypothesized that relationships between Disclosure, NMA,

TMRS, and Inadequacy and Deficiency would be similar across all racial groups. This hypothesis was partially supported. For all men, regardless of race, those with high Emotional Control were likely to also have high NMA. Contrary to predictions, this relationship was roughly equal in magnitude across all racial groups. Therefore, the relationship was not stronger for Hispanic/Latino American men than Asian American men, which did not support this part of the hypothesis. This is opposite of previous findings, which suggested that the relationship between Restrictive Emotionality and NMA could be stronger for Hispanic/Latino American men than for Asian American men (Levant et al., 2015). We can only speculate why this occurred. Levant et al. (2015) used different scales measuring emotionality (i.e., Restrictive Emotionality located in the MRNI) and alexithymia (TAS-20); although they measured similar constructs to NMA and Emotional Control, there could be some differences in how these were operationalized, which led to differences in findings. It should also be noted that, due to the gender-focused nature of the study, participants might have been primed to focus on their gender identity rather than their racial or ethnic identity. Additionally, race and ethnicity were measured as distal variables, rather than proximal variables (e.g., racial and ethnic identity). Proximal variables have been shown to be more successful in gathering group differences (Cho et al., 2013; Larson et al., 2012).

For the remaining variables (i.e., Disclosure, NMA, TMRS, and Inadequacy and Deficiency), it was found that all relationships from the previous hypotheses were consistent across racial groups, supporting this part of the hypothesis. This is also consistent with previous research examining outcomes with diverse populations, which found many similarities in how masculinity affects men of all races (Arciniega et al.,

2008; Levant et al., 2015; Levant & Wong, 2013; Scott et al., 2015; Terlizzi & Zablotsky, 2020), although there is also plenty of evidence to suggest that there are racial differences in how masculinity is displayed and observed by others (Abalos, 2005; Allen, 2017; Keo & Noguera, 2018; Rogers et al., 2015). These findings suggest that the relationship of masculinity to emotions, shame, and self-stigma about seeking help may be somewhat generalizable across multiple racial groups, with some limitations to be discussed in coming sections.

To examine if psychological functioning could be influencing the relationships found in hypotheses 1-3, partial correlations were run on the entire sample with Psychological Well-being included. One change was noted, specifically in the relationship between Emotional Control and Inadequacy and Deficiency. Interestingly, the relationship changed from being negative and nonsignificant to negative and significant such that high levels of Emotional Control was related to lower levels of Inadequacy and Deficiency. Due to the lack of literature in this area, we can only speculate as to why this might have occurred. It is possible that higher levels of emotional control could make consciously feeling inadequate and deficient difficult because emotions are not being expressed. Relatedly, lower levels of emotional control might be associated with more feelings of inadequacy and deficiency because emotions are more accessible and potentially distressing. Since psychological well-being was removed, it is possible that this is not due to psychological distress but potentially a third variable, such as gender role stress, as men who are actively struggling with their emotions may feel "unmasculine" and, therefore, might perceive themselves as weak. Due to this influence

of Psychological Well-being on this relationship, Psychological Well-being was added as a covariate in the coming path analyses.

Hypothesis 5

Hypothesis 5 examined additional racial and ethnic differences between variables using an ANOVA. It was predicted that White/European American men would have lower levels of self-stigma about seeking help than Black/African American men, Hispanic/Latino American men, and Asian American men. However, contrary to previous research, which found that racial minority individuals sought help less than White individuals (Terlizzi & Zablotsky, 2020), there were no significant racial differences for self-stigma about seeking help across any of the groups. It is possible that sample size is a factor, as Terlizzi and Zablotsky (2020) used a much larger sample. The construct being measured might be another reason why these results occurred. Terlizzi and Zblotsky did not assess Self-Stigma; rather, they examined the rates at which racial minority individuals sought help in comparison to Whites. It might be that racial minority individuals resist seeking help for a different reason aside from feelings of self-stigma. For instance, it could be distrust of help-seeking systems, which have historically oppressed them, or experiences of discrimination (Martinez de Andino & Weisman de Mamani, 2022; Powell et al., 2016). As mentioned in Hypothesis 4, participants might have been primed to answer questions based on their gender rather than their racial or ethnic identity, and the distal (rather than proximal) measurement of race and ethnicity also likely contributed to a lack of group differences.

Hypothesis 6

Hypothesis 6 examined the direct effects of Emotional Control and Self-Reliance on Disclosure, NMA, TMRS, and Self-Stigma. It was predicted that Emotional Control and Self-Reliance would, independently of one another, negatively predict disclosure and positively predict NMA, TMRS, and Self-Stigma. Thus, Emotional Control and Self-Reliance were analyzed in separate models. After a series of model testing examining the fit of the hypothesized models over the alternative models, it was determined that the alternative Emotional Control model was a better fit than the hypothesized model. The hypothesized and alternative models were largely the same, except the hypothesized models predicated a direct relationship from Emotional Control and Self-Reliance to Self-Stigma, whereas the alternative models did not. The alternative Emotional Control model directly predicted Disclosure, NMA, and TMRS but did not examine a direct relationship from Emotional Control to Self-Stigma. For the Self-Reliance model, the inverse was found, as the hypothesized model was a better fit than the alternative model. In contrast to the alternative Emotional Control model, the Self-Reliance model measured a direct relationship from Self-Reliance to Self-Stigma in addition to its predicted direction relationships to Disclosure, NMA, and TMRS.

For the Emotional Control model, there was a significant and negative relationship between Emotional Control and Disclosure, as expected. This suggests that men who struggle to talk about their emotions are not likely to feel comfortable disclosing them to others. Also, in line with predictions, Emotional Control was positively and significantly associated with NMA, indicating that men who prefer to

control their emotions through not discussing them with others will likely feel more uncomfortable or have significant difficulty with expressing their emotions. This finding is consistent with previous literature, which states that masculinity is related to difficulty identifying and expressing emotions in European Americans (Levant et al., 2014; Levant & Parent, 2019) and in Latino Americans and Black Americans (Archiniega et al., 2008; Levant & Wong, 2013). Regarding the hypothesized relationship that Emotional Control would be significantly and positively related to TMRS, interestingly, the inverse was found. Emotional Control was found to be negatively and significantly related to TMRS. Due to the limited research, it is unclear why this finding occurred, but we can speculate that men with high levels of Emotional Control may not have the emotional self-awareness to consciously perceive complex emotions such as shame as related to their masculinity. The hypothesized relationship between Emotional Control and Self-Stigma cannot be discussed as it was not included in the best fitting model.

For the Self-Reliance model, contrary to expectations, there was not a significant relationship between Self-Reliance and Disclosure. Given the lack of research on masculinity and disclosure, we can only speculate as to why this occurred. It is possible that an unexamined third variable, such as level of self-awareness, is influencing the relationship. Additionally, as Self-Reliance was found to have a low reliability coefficient, it is possible that this could have affected the results. The remaining results of the hypothesis were as anticipated, with positive relationships occurring between Self-Reliance and NMA, Self-Reliance and TMRS, and Self-Reliance and Self-Stigma. The relationship between Self-Reliance and TMRS is a new finding not examined in previous literature. However, relationships between Self-Reliance and NMA, as well as Self-

Reliance and Self-Stigma, have been supported by past research, although with mostly European American populations (Levant et al., 2003; Levant et al., 2014; Levant et al., 2015; Pederson & Vogel, 2007). These results indicate that men who are high in Self-Reliance are likely to have difficulty expressing and discussing their emotions, experience masculinity-related shame, and hold self-stigmatizing beliefs about seeking psychological help. Given the findings, this hypothesis was partially supported.

Hypothesis 7

For hypothesis 7, it was expected that NMA would directly predict Disclosure and TMRS such that NMA would negatively predict Disclosure and positively predict TMRS in both the Emotional Control and Self-Reliance models. The hypothesis was fully supported in both models. Men who have difficulty expressing and discussing their emotions were less likely to self-disclose to others. Men with emotional expression difficulties were also likely to feel shame from perceiving that their masculinity had been threatened. The current study is the only one to date to have examined this relationship. However, based on Pleck's (1995) GRSP, men are constantly seeking a level of masculinity that is all-consuming and ultimately unattainable. One tangible way this might be achieved is by suppressing one's emotions. However, suppression does not mean that emotions are not experienced (Bennett, 2007; Cui & Fiske, 2021). Perhaps, the very feeling of their emotions is by itself a perceived threat to their masculinity.

Hypothesis 8

Hypothesis 8 predicted that Disclosure, NMA, and TMRS would directly predict feelings of Inadequacy and Deficiency such that high scores on Disclosure would

negatively predict Inadequacy and Deficiency, and NMA and TMRS would positively predict Inadequacy and Deficiency. This hypothesis was partially supported for both models. In both models, Disclosure failed to be significantly associated with Inadequacy and Deficiency. Research has not yet examined this relationship, so it is unclear why this occurred. However, it could be that men choose not to disclose rather than are physically unable to do so. This choice, rather than a lack of ability to do so, may lesson any feelings of internal shame. Another possibility might be that the act of not disclosing their problems to others is a sign of self-sufficiency, which would likely not incite feelings of inadequacy and deficiency.

The remaining parts of this hypothesis were confirmed such that in both models, NMA and TMRS positively predicted Inadequacy and Deficiency. In other words, men who struggled with expressing their emotions were likely to feel inadequate and deficient. This is the first research study to have assessed this relationship. It is possible that, because they are unable to express their emotions to others, some men are less likely to feel connected with their loved ones and, therefore, feel deficient in some way. In turn, the people close to them may notice this lack of emotional reciprocity and could point it out or end the relationship all together, inciting feelings of inadequacy and deficiency in the men afflicted. Finally, in the current study, men who experience some shame associated with a perceived threat in their masculinity were likely to experience Inadequacy and Deficiency. Although this has also not been assessed in previous literature, it supports masculinity and shame theory (Lewis, 1971; Pleck, 1995). For instance, Pleck's (1995) discrepancy strain posits that, because attaining true masculinity is unattainable, men feel inadequate when they ultimately fail. Lewis's (1971)

conceptualization of shame is also similar, such that failing to achieve personal expectations often result in feeling inadequate. This finding had a moderate effect size and served as the largest effect size in both models, making it a potentially important finding.

Hypothesis 9

Hypothesis 9 stated that Inadequacy and Deficiency would have a positive, direct path to Self-Stigma in both the Emotional Control and Self-Reliance models. This hypothesis was fully supported. For both models, men experiencing feelings of inadequacy and deficiency held higher self-stigma associated with seeking psychological help. Although this specific relationship was never assessed in previous studies, some studies have found that shame may be a prominent barrier to help-seeking, making this hypothesis consistent with previous findings (Clement et al., 2015; Heath et al., 2017; Herbst et al., 2014). This finding provides more understanding into why some men do not seek psychological help. It also suggests that the men who may need help most are being held back by beliefs that seeking psychological help makes them inferior or lesser in some way. Similar to the previous hypothesis, this finding supports Pleck's (1995) GRSP, as men are taught that seeking help from others is a sign of weakness.

Controlling for Psychological Well-being

Due to significant findings in partial correlations involving Psychological Well-being, the aforementioned models were run a second time with Psychological Well-being acting as a control variable. For both models, Psychological Well-being demonstrated significant paths with all variables except for TMRS and Self-Stigma. Psychological

Well-being was positively related to Disclosure, suggesting that men with high levels of Psychological Well-being are more likely to Disclose than men who are low on Psychological Well-being. This could provide insight into a barrier for men seeking out and being successful in treatment. Additionally, men with low Psychological Well-being are likely to have more feelings of inadequacy and deficiency. It could be that men feel unable to disclose, and that causes feelings that they are not good enough or are undeserving in some way. Alternatively, they could be feeling inadequate due to another variable, perhaps related to their masculinity such that they are interpreting their mental illness as a weakness due to some perceived deficit in their masculine identity.

Psychological Well-being appears to be negatively related to NMA such that men with high levels of well-being may have less difficulty expressing their emotions. However, the inverse is indicated for men with low levels of well-being. Psychological Well-being was found to be negatively related to Self-Reliance and Emotional Control. Men who are low in well-being are likely to have high Self-Reliance and Emotional Control, perhaps because they prefer to deal with their low well-being on their own and controlling their emotions is one method of doing so.

Regarding the nonsignificant relationship between Psychological Well-being and TMRS, it is possible that mental health may not be a factor in whether men experience TMRS and suggests that TMRS may be a frequent occurrence that could go undetected in those not experiencing mental health concerns. It is also interesting that Psychological Well-being was not significantly related to Self-Stigma. Research suggests that Self-Stigma significantly influences Psychological Well-being (Mills et al., 2020; Williamson

et al., 2019); it is unclear if the inverse of this relationship would also be significant. It could be that the status of someone's mental health is simply not associated with feelings of self-stigma toward seeking psychological help. This could also be another instance in which a third variable is involved, such as level of masculinity, attitudes toward seeking help, or the chronicity of one's mental condition. Some studies have examined these variables and determined them to be relevant to understanding self-stigma about seeking help (Kayrouz et al., 2015; McLaughlin et al., 2022; Noble et al., 2021).

The hypothesized paths in the model remained significant even after factoring out variance associated with Psychological Well-being, indicating that these relationships could occur despite the presence of psychological health. Interestingly, the paths involving Disclosure and Inadequacy and Deficiency were significant for the models with Psychological Well-being as a covariate, although they were not significant during original model testing. This indicates that Psychological Well-being may be an important factor in understanding what men may feel in response to disclosing their problems to others. In this case, men who are struggling psychologically may be more likely to feel increased inadequacy and deficiency as they disclose their problems, which is consistent with Pleck's (1995) discrepancy strain theory.

Hypothesis 10

Hypothesis 10 sought to examine racial and ethnic differences in the relation between Inadequacy and Deficiency and Self-Stigma. Specifically, it was hypothesized that the relation between these variables would be stronger for men of Color than for White/European American men. Using moderation analyses, it was found that, although

there was a significant relationship between Inadequacy and Deficiency and Self-Stigma for all men of Color, there were no significant interactions. This may indicate that race or ethnicity being measured as distal variables are not sufficient to impact the relationship between Inadequacy and Deficiency and Self-Stigma, making this hypothesis unsupported. It is notable, however, that the direct path between Inadequacy and Deficiency and Self-Stigma remains significant for all men, regardless of racial or ethnic identity, suggesting that there may be more similarities than differences between groups.

Hypothesis 11

The final hypothesis sought to examine differences between Hispanic/Latino American men and Asian American men such that the relation between Emotional Control and NMA was expected to be stronger for Hispanic/Latino American men and weaker for Asian American men. Using moderation analysis, this hypothesis was not unsupported. Contrary to previous literature (Levant et al., 2015), there were no differences in the strength of the path from Emotional Control to NMA for Hispanic/Latino American men and Asian American men. In the Levant et al. (2015) study, they examined the Restrictive Emotionality scale, a scale similar to Emotional Control but not identical. Therefore, it is possible that a relationship may exist with Restrictive Emotionality when it does not with Emotional Control. As mentioned in previous hypotheses measuring group differences, the use of distal variables and a likely priming effect of gender over racial and ethnic identity might have contributed to this study's lack of success with discovering group differences.

Taken together, the current study used two models examining two masculinity constructs, Emotional Control and Self-Reliance, in relation to men's emotional expression, disclosure of problems, shame, and self-stigma associated with seeking psychological help. Even after accounting for psychological well-being, men who were high in Emotional Control and/or Self-Reliance suffered from difficulties expressing and understanding their emotions (i.e., NMA); for Emotional Control only, men were likely to suffer from an inability to disclose their problems to others and were susceptible to shame associated with threatened masculinity. For both models, high NMA was related to feelings of inadequacy and deficiency, which was, in turn, related to increase self-stigma associated with seeking psychological help. For the Emotional Control model only, difficulties in disclosing problems to others was, like NMA and TMRS, linked to feelings of Inadequacy and Deficiency. These models tell us that certain masculinity constructs (i.e., Emotional Control and Self-Reliance) are associated with a host of problems that serve as barriers for men to seek help and are linked to increased Self-Stigma, a likely major factor in whether men seek treatment (Lannin et al., 2016; Mahalik & DiBianca, 2021; Nobel et al., 2021). As is the case with most research, findings reflect experiences of mostly European American men. As Emotional Control was significantly related to every variable in the model, this area might be an area of emphasis in future research and clinical work with men. **Theoretical Implications**

The current study was founded on several theories, including Pleck's Gender Role Strain Paradigm (GRSP; Pleck, 1995), Masculine Gender Role Stress (MGRS; Eisler & Skidmore, 1987), precarious manhood (Vandello & Bosson, 2013), and intersectionality

(Collins, 2015). The findings of the current study are largely aligned with these theories, especially the GRSP.

The findings of the current study lend support to Pleck's discrepancy strain (Pleck, 1995), which posits that men feel a sense of shame when failing to uphold the masculine standards laid out by popular society. The strongest evidence for this is in the direct, positive relationship between TMRS and Inadequacy and Deficiency, which highlights that men who felt shame associated with perceiving themselves as failing to behave masculinely were likely to feel inadequate and deficient in a general sense. This is also aligned with MGRS (Eisler & Skidmore, 1987), which stated that men feel stress when they perceive situations as feminine or unmanly. The current study is also consistent with Pleck's dysfunction strain, which states that masculine norms are inherently harmful. According to the current study, men who were high in Emotional Control and Self-Reliance experienced difficulties with emotions and disclosure, as well as experienced significant feelings of shame in general and in regard to their masculinity, which, ultimately, predicted high self-stigma about seeking psychological helpBased on these findings, masculine norms (i.e., Emotional Control and Self-Reliance) were predictive of these relationships such that men who were lower on Emotional Control and Self-Reliance did not experience the same strain as men who were high in these norms.

The relationship between TMRS and Inadequacy and Deficiency is also consistent with the concept of precarious manhood (Vandello & Bosson, 2013) which can be summarized as masculinity is hard won and easily lost. Findings associated with TMRS largely speak to this, feelings of shame appear easily incited for some men, as evidenced

by some of the responses to the items of the Masculinity and Shame Questionnaire (MASQ; Gebhard et al., 2019). Examples consist of being unable to defend oneself, being perceived as gay, and being perceived as feminine. For some men, masculinity is fragile, and they must walk a narrow and steep path in their attempt to achieve the masculine standard. The current study highlighted this path and found that to stumble is to risk feelings of shame in relation to one's gender, as well as potentially having that shame internalized to be aimed at their entire being.

Regarding the theory of intersectionality (Collins, 2015), the current study aimed to capture the experiences of multiple racially diverse men. Unfortunately, the current study did not find any differences among the subsamples, which deviates from the idea that intersecting identities may lead to different experiences. Although the current study's lack of findings related to diverse racial/ethnic differences, this does not suggest that there are no differences between groups. Rather, race and ethnicity alone might not have been enough to understand true differences in experiencing masculinity. Overall, masculinity appears to have similar negative effects across groups, although an examination of concepts often pertinent in historically oppressed groups, such as discrimination, SES, and acculturation, might provide context into how these relationships manifest and differ. As such, the findings of the current study provide several suggestions for future research and practice. These will be discussed next.

Implications for Research

One main focus of the current study was to examine masculinity's relationship with self-stigma associated with seeking psychological help in a diverse population. A

review of research examining masculinity in men of Color, specifically Black/African American men, Hispanic/Latino American men, and Asian American men, indicated that the way masculinity is observed and displayed in these groups is largely guided by culture and historical struggles with oppression (Abalos, 2005; Allen 2017; Keo & Noguera, 2018). In masculinity research, there are numerous studies which examine masculinity within diverse racial identities (Levant et al., 2015; Levant & Wong, 2013; Terlizzi & Zablotsky, 2020). Research has also examined how factors that deeply affect men of Color but not White/European American men (e.g., racism, discrimination, acculturation and assimilation status) might affect relationships associated with masculinity (Ferver, 2007; Liang et al., 2011; Rogers et al., 2017; Shek, 2006). Future research should continue to examine these factors. No research to date has examined how specific cultural differences in masculinity might affect disclosure rates, threatened masculinity-related shame, and feelings of inadequacy and deficiency might impact self-stigma associated with seeking help. Although the current study found no group differences, future research should seek to further examine these variables with diverse populations while also measuring the impact of racism, discrimination, and other group-specific factors in addition to masculinity.

Previous research indicates that proximal variables (i.e., health, cognitive functioning, discrimination) are more effective at understanding differences between populations than simple distal variables (i.e., race, gender, age; Cho et al., 2013; Larson et al., 2012). Additionally, the current study did not seek to evaluate how biracial or multiracial groups might be affected. Future literature seeking to study diverse populations should keep these populations in mind and be open to examining how factors

associated with having a biracial or multiracial identity (e.g., feelings of isolation and intergroup discrimination; Chen et al., 2019; Franco et al., 2021) may impact the variables discussed in the current study. Finally, this study examined diversity through a more superficial lens and did not properly examine the multiple intersecting identities within participants. Going forward, research studies seeking to explore diversity and multiculturalism should be designed to examine more than one or two identities. Rather, future research should examine as many identities as possible, such as sexual orientation, SES, ability status, age, and religious affiliation, in order to fully understand the unique experiences of participants. For instance, a future study may consider examining masculinity scores from different age cohorts (e.g., adolescent, young adult, middle-aged adult, older adult) to explore how masculinity, and perhaps some of the variables presented in this study, might change as a function of age. Finally, in Chapter II, it was discussed how hegemonic masculinities serve to uphold sexist, racist, and homophobic standards (Crowell, 2011; Liu, 2020, Prasad et al., 2020). Future research should examine this within the context of an intersectional sample.

The current study also included several variables that had yet to be examined in present masculinity literature, such as Disclosure, Inadequacy and Deficiency, and TMRS. After accounting for Psychological Well-being, in the Emotional Control model only, Disclosure was positively related to feelings of inadequacy and deficiency. In both Emotional Control and Self-Reliance models, TMRS was positively related to Inadequacy and Deficiency. Regarding Disclosure, it makes sense that men who struggle to express and discuss their emotions might be less likely to disclose their problems to others. However, it is unclear if they do not disclose because they do not have the ability

or because they simply do not want to due to some perceived barrier. Future research might examine these potential barriers to disclosure. Past research suggests that shame might be a factor (Clement et al., 2015); however, this has not yet been examined extensively. Indeed, findings from the current study suggest that Disclosure is not related to Inadequacy and Deficiency, a form of shame, unless psychological well-being is accounted for. It is possible that the specific scale used in the current study had some effect. The disclosure scale used did not examine disclosure in a therapeutic sense; rather, it examined disclosure to loved ones. There is limited research on this, as much of previous literature examined men's disclosure to friends (Buhrmester at al., 1998; O'Loughlin et al., 2018), but it might be that men are more open to disclosing their problems to a romantic partner whom they may trust more and who sees them in many different capacities (Kito, 2005). Men seeking therapy are likely experiencing some psychological distress (Johnson et al., 2012; Levant et al., 2013) and, based on the present study, their disclosure rates could, therefore, be affected by feelings of inadequacy and deficiency. Future research should examine whether disclosure in a therapeutic context might alter its relationship with Inadequacy and Deficiency. Based on relationships after including Psychological Well-being in the model, men in particular may feel high levels of Inadequacy and Deficiency separate from their levels of Psychological Well-being. Future research could examine this in a sample of both men and women.

The current study also found that TMRS was moderately related to feelings of inadequacy and deficiency. This suggests that shame associated with one's masculinity is linked to a deeper feeling of internalized shame (i.e., Inadequacy and Deficiency). Future

research should examine this relationship more closely. For example, research could examine the effects of these feelings of internalized shame, as they may be linked to low self-esteem and even feelings of self-hatred (as men may believe they, as a man, are flawed and inadequate). Inadequacy and Deficiency is a variable that has been included in masculinity theory (Pleck, 1995) but, until the current study, had yet to be quantified in a study on masculinity. It would be beneficial to explore potential results of the relationship between masculinity-related shame and internalized shame, such as mental illness or violence perpetration. Previous research has indicated that perceiving one's masculinity as being threatened has been associated with physically violent behavior (Gebhard et al., 2019). Given that there is now a scale which measures threatened masculinity, it is strongly recommended that future research examines the effects of threatened masculinity on men.

The current study sought to examine Emotional Control and NMA in racially diverse populations. However, results failed to find a significant difference in the strength of this relationship for Hispanic/Latino American men and Asian American men, although previous research found it with another scale measuring emotionality (Levant et al., 2015). Unfortunately, the scale which measured NMA, the NMAS (Levant & Parent, 2019), was found to have a lower-than-expected Cronbach's alpha. Future research using the NMAS should pay attention to the reliability coefficient to determine if this was simply a unique characteristic of the current sample or a more generalized finding. Finally, given that there are other scales that measure a similar construct in slightly different ways (e.g., restrictive emotionality, NMA), future research should

simultaneously examine multiple scales of emotionality to gain a more nuanced understanding of this important and multifaceted variable.

Finally, despite its racially and ethnically diverse sample, the current study did not include non-heterosexual men nor transwomen, non-binary, or third gender men who identified with a more feminine presentation. Future men and masculinity research should work to include these participants, as this will provide a more complete picture of masculinity and gender.

Implications for Practice

The findings of the present study present several suggestions for future clinical practice with men. Main foci of the current study include examining how adherence to masculinity norms and TMRS relate to men's ability to express their emotions, determining whether there was any presence of internalized shame (i.e., Inadequacy and Deficiency), and investigating how these factors converged to predict self-stigma associated with seeking help. The current study failed to find group differences in any of the hypothesized variables. It is possible they are consistent across men in different groups. Although this study found that these relationships were consistent across four racial groups, providers should be cautious about viewing all men as being affected by masculinity in the same way. Following the building of good rapport, providers should consider opening a dialogue with their patients, especially patients of Color, about their various identities and how they may affect their world experiences (e.g., racism, social class stress) and their individual perceptions about those experiences, as this allows for culturally responsive assessment to take place (Hays, 1996) and can be linked to

therapeutic outcomes (Anderson et al., 2019; Jones et al., 2018). It is important that clinicians examine each client's intersecting identities individually and consider how racial/ethnic stigma and masculinity-related stigma might influence fears of mental health providers and incite other obstacles that arise to keep diverse men from receiving treatment. Following rapport-building and obtaining adequate trust from the client, clinicians might consider working together with their client to map their oppressed and privileged identities and create a collaborative environment in which dialogue about intersectionality and mental health treatment can take place.

The current study originally failed to find significant results for the hypothesized relationship between Disclosure and Inadequacy and Deficiency. However, once Psychological Well-being was introduced into the model, the relationship became positive and significant. Providers may consider screening patients for levels of psychological distress and keep in mind how high levels of distress may affect how open men are in session when discussing their problems. Providers might consider normalizing how masculinity norms affect men's ability to be vulnerable and create an open dialogue about gender identity to determine if there are any barriers to treatment compliance and participation (e.g., avoidance). Offering psychoeducation about the helpfulness and efficacy of talking about one's problems might be beneficial (Blanchard & Farber, 2020; Mahaffey, 2010). Based on the current study, it is possible that talking about one's problems may reduce feelings of inadequacy and deficiency in men.

One of the main foci of the present study was to examine masculinity norms and shame (i.e., TMRS and Inadequacy and Deficiency). Based on the results, clinicians

should discuss with their male clients the socialization process of masculinity and how that process could be negatively affecting their feelings about themselves as men. This could help the client better conceptualize their problems and feel validated that the seemingly unreachable standards of masculinity norms are not only in their minds but felt by many others. The current study found an important link between TMRS and Inadequacy and Deficiency, a form of internalized shame. Clinicians may consider incorporating factors associated with masculinity-related shame into their work with men. Helping men recognize when they feel their masculinity is being threatened could build much-needed insight and help men cope with these feelings in a healthy way. Working to debunk common myths about masculinity and helping men build their own image of who they want to be rather than who society says they should be could help them build a more secure sense of self (Levant, 1992; Scholz et al., 2014). Research has yet to examine this but based on the current study reconstructing masculinity may reduce feelings of inadequacy and deficiency.

Regarding emotionality, providers may help men understand the importance of feeling and healthily expressing their emotions. In some cases, men may feel scared to "open that door," so to speak, and providers should be prepared to explain how emotions are useful tools that can be felt and expressed in safe ways with trusted loved ones. Most importantly, providers can help teach men that, when expressed in a health way, their emotions do not control them, but, rather, they can learn to build a mastery and even feel empowered to feel their emotions. For men who may benefit from a more concrete way of understanding emotions, a review of the KM-W model of emotions (KM-W, 1999) could help men understand the physiological and psychological science behind emotions

rather than some mystical concept (Wong & Rochlan, 2005). An empirically validated therapy that can be used to help men learn to feel and express their emotions is Alexithymia Reduction Treatment (ART; Levant et al., 209). ART is a short manualized treatment which has been found to reduce NMA by discussing the negative effects of masculinity norms, helping men build a more expansive emotion vocabulary, and insight into their day-to-day emotions.

Finally, the current study ultimately sought to examine self-stigma associated with seeking psychological help. Given that men are less likely to seek treatment (Addis & Mahalik, 2003; Mahalik & Di Bianca, 2021, Ramaeker & Petrie, 2019) and feel more stigma related to seeking treatment (Clement et al., 2015), the drop-out rate might be high. Providers should work to build buy-in with men early on. It might be helpful to discuss how stigma about seeking help is unfortunately common and examine their feelings about treatment and what motivated them to come. Another way to get men to participate in treatment are through men's groups, which have been empirically found to be beneficial in reducing suicide and increasing resilience (Heisel et al., 2020) and treating many mental health conditions such as hypersexual disorders (Hallberg et al., 2019) and depression (Ogrodniczuk & Oliffe, 2009).

The previous two sections sought to examine implications for research and practice. The final section of this document seeks to examine the strengths and limitations of the current study.

Strengths and Limitations

The current study includes many strengths and limitations. Beginning with limitations, the current study examined hypotheses using a diverse sample of men across four racial and ethnic groups. Although the findings were consistent across groups, I did not assess other moderating variables specific to diverse racial and ethnic groups, such as racism, colorism, or specific cultural values. Without these variables, it can be hard to understand whether there is true consistency, as the inclusion of more race- and ethnicity-related variables could affect the magnitude of the relationships hypothesized in this study. The current study also pulled a small number of men from the entire United States; geographic location was not included in the data collection, analysis, or interpretation of results. Understanding the influence of geographic location (e.g., Appalachian, rural, urban) may be important to fully map and examine diverse masculinities (Connell & Messerschmidt, 2005). Additionally, the majority of participants in the current study were reported as being middle class in the demographics questionnaire but reported lower income. In the survey procedures, I did not clearly define what might be constituted as "middle class," and it is unclear how participants understood that term. Future research should consider providing clear definitions of each social class in their questionnaires for more accurate reporting.

The current study only sought to examine hypotheses from Asian American men, Black/African American men, Hispanic/Latino American men, and White/European American men. The question evaluating race and ethnicity on the demographic questionnaire was set up with participants being able to multi-select options to accurately

match their racial and ethnic identities. However, the current study was constructed to examine biracial or multiracial participants, and participants who selected more than one race/ethnic background were placed in either a biracial or multiracial group. These groups were included in analyses examining the full sample (i.e., correlations, path analysis) but were excluded from analyses examining racial and ethnic differences across groups (i.e., moderation analyses, ANOVAs). Consequently, the group sizes were uneven. Future research should consider examining biracial and multiracial participants when utilizing a large diverse sample. Although the study examined Psychological Well-being as a possible covariate, it did not examine other possible covariates such as gender expression (e.g., sometimes masculine, sometimes feminine). Future research should consider examining these variables, as they might provide information on individual differences.

Although the current study used a racial and ethnically diverse sample, it was not diverse in sexual orientation or other possible intersecting identities. The only scale which assesses TMRS is the MASQ (Gebhard et al., 2019), which has been designed and validated for heterosexual men only. Any participants not identifying as heterosexual were excluded, as the MASQ used language that would not be appropriate for men with diverse orientations. Future research should consider designing and normalizing a scale measuring TMRS that is inclusive of LGBTQ participants, especially given that LGBTQ masculinities are a growing topic of significance in the men and masculinity literature (Eggenberger et al., 2022; Murgo et al., 2017; Pachankis et al., 2020).

Another important limitation in this study is the low reliability coefficients of two scales. The scale which measured NMA, the NMAS (Levant & Parent, 2019), and the Self-Reliance scale in the CMNI-30 (Levant et al., 2020), were found to have lower-than-expected Cronbach's alpha levels. Although several steps were taken in an attempt to understand and potentially rectify the issue, such as an item analysis, examination of scale scoring procedures, and a thorough look into the quality of the data (e.g., inconsistencies, random responding), nothing appeared to provide insight. Although post hoc analyses were run on Self-Reliance, they were not conducted on the NMAS or the SSOH, which also yielded low coefficients. This is a limitation, as it remains unclear if there might have been an item influencing the low coefficients in either of these scales. Due to these low coefficients, findings related to NMA and Self-Reliance must be interpreted with caution and might not reflect an entirely accurate picture of the hypothesized relationships. Both scales were shown to have excellent psychometric properties in past studies (Levant et al., 2013; Levant et al., 2020). For the NMAS, no psychometrics have been run on the scale with men of Color; therefore, it is possible that the large, diverse sample of the current study could have affected the reliability coefficient. Given that this study used self-report methods, the low reliability coefficients of the two scales could also simply be the result of a unique characteristic of the current data and not due to issues with scale construction or development. It is possible that participants engaged in satisficing, or not putting in much effort when answering questions, a common limitation of survey-based data that often leads to inconsistent responding and issues related to scale reliabilities (Barge & Gehlbach, 2012; Fang et al., 2014).

Notwithstanding the limitations, the current study has many strengths and provides major contributions to research on men and masculinity. The study included complex path analyses examining previously unstudied variables such as TMRS, Disclosure, and Inadequacy and Deficiency that should be replicated in future studies. Although this study did not examine proximal variables associated with race/ethnicity, it established a consistency between masculinity, emotion expression, shame, and help-seeking variables in four diverse groups of men so that future research might take the next step in examining variables such as discrimination, colorism, and acculturation. This study also sought to examine multiple gaps in the literature related to masculinity and men's self-stigma about seeking psychological help in a diverse sample of men. The large, diverse sample in the current study represents a strength, as it indicated that the results were consistent across racial and ethnic groups. Finally, the present study attempted to provide a foundation to examine masculinity from an intersectional lens, capturing unique perspectives of masculinity from various cultural backgrounds.

Research had yet to examine the role Disclosure might play in feelings of internalized shame (e.g., Inadequacy and Deficiency) and how internalized shame in men might be related to Self-Stigma. Most importantly, a study had yet to use the Threatened Masculinity Shame Scale, which quantitatively measures threatened masculinity-related shame, an important variable given its implications for violent behavior in men (Baugher & Gazmararian, 2015; Gebhard et al., 2019). This was also the first study to draw a link between threatened masculinity and feelings of inadequacy and deficiency, providing quantitative support for Pleck's (1995) discrepancy theory. The study examined multiple hypotheses using many diverse analytic strategies, such as bivariate and partial

correlations, path analysis, moderation, and ANOVA. Along with these analyses, the study examined a potential confounding variable (i.e., Psychological Well-being) and was able to provide evidence for a model of masculinity, emotional expressiveness, shame, and self-stigma while accounting for this variable. As a result, the findings from the current study provide strong and empirically based support for its posited hypotheses.

Using the above-mentioned diverse set of analyses, several relationships not previously examined in the literature contribute to the field of men and masculinity related to emotional expression, Disclosure, TMRS, Inadequacy and Deficiency, and Self-Stigma. Specifically, the current study was the first to find a significant and positive association between Emotional Control and Disclosure, as well as significant relationships between Emotional Control, Self-Reliance, and TMRS. The current study examined relationships among masculinity norms, TMRS, and internalized shame which, before the current study, were only theorized (Vandello & Bosson, 2013).

In addition to new discoveries, there were many findings which were consistent with previous literature. Findings related to Self-Reliance and Emotional Control in the current study are consistent with previous literature, which states that masculinity norms are associated with NMA (Levant et al., 2003; Levant et al., 2014; Levant et al., 2015). The direct association from Self-Reliance to Self-Stigma provides additional evidence that men are taught to deal with their problems by themselves and that men higher in this tendency may be even less likely to seek help due to increased self-stigma. This finding supports previous research (Pederson & Vogel, 2007). The connection between general internalized shame (i.e., Inadequacy and Deficiency) and Self-Stigma was also congruent

with past research, which identified shame as a major barrier in help-seeking (Clement et al., 2015; Heath et al., 2017; Herbst et al., 2014). If men are less likely to see help because of shame, such as feelings of inadequacy and deficiency, we may be able to use these findings to help men enter and stay in treatment. Based on the results of this study, shame, both general internalized shame (i.e., Inadequacy and Deficiency) and masculinity-based shame, may aid our of understanding why men do not seek help and why they should.

Conclusion

In conclusion, the current study suggests that masculinity is an important factor in understanding why men may have higher levels of self-stigma associated with seeking help. From a young age, men are socialized to conform to norms of masculinity (Pleck, 1995). Two such norms, Self-Reliance and Emotional Control, have been shown in previous literature (Heath et al., 2017; Mahalik & Di Bianca, 2020; McDermott et al., 2018), and in the current study, to be pivotal in understanding men's hesitancy to seek psychological help. Although research has identified that men often have more negative attitudes about seeking help (Berger et al., 2005; Levant et al., 2009; Levant et al., 2013; Ramaeker & Petrie, 2019) and typically seek help less in comparison to women (Yousaf et al., 2015), little research has examined the individual factors, in addition to masculinity, that might be predictive of this. The current study has illuminated many of these variables, including the ability to understand and express emotions, as well as experiences of shame.

According to the present study, men who struggle with emotions are predicted to be at increased risk of feeling ashamed. In this study, shame was measured in two parts, internalized shame (i.e., Inadequacy and Deficiency) and shame related to perceiving one's masculinity as being threatened. The current study has found a link between men's internal struggle with emotions and feelings of shame. When men are unable to express their emotions or understand how to deal with them, they may feel as if they are inadequate or even that there is something inherently wrong with them. Shame that is felt when one's masculinity is threatened is even more predictive of feeling as if they do not measure up. Regardless of whether shame is coming from feeling emotionally inept or that they are not masculine enough, when men feel inadequate, they may suffer from increased self-stigma about seeking help. Perhaps, this is due to feeling as if nothing can help them because at their core, they are deficient. In addition, the thought of seeking help for a problem they believe they alone should solve may even enhance their feelings of inadequacy. Therein may lie the problem: men are faced with an unwinnable scenario. They are raised to forgo vulnerable emotions but are expected to handle them on their own without building skills to competently do so, which may leave them feeling impaired. When this inevitably occurs, men are given messages that suggest seeking help is not an option. Therefore, the narrative that seeking help is the antithesis of strength should be changed. A replacement narrative could be that to seek help IS to be strong. Furthermore, men should be reassured that it is never too late to rewrite the childhood lessons that may be causing them pain in the present.

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APPENDICES

APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

Please click the button or buttons that answer the question most accurately for you. For those questions that ask you to specify further, please do so in the text box.

1. Gender: (please click the button or buttons that best represent your gender, and use the text box to specify further if needed)
    (1) Man
    (2) Transgender man
    (3) Woman
    (4) Transgender woman
    (4) Non-binary/ third gender
    (5) Prefer to self-describe _____
    (6) Prefer not to say

2. How would you describe the way you express your gender identity?
    (1) Mostly masculine
    (2) Sometimes masculine
    (3) Neither masculine nor feminine

(4) Sometimes feminine

(5) Mostly feminine

3. Race/Ethnicity (please click the button or buttons that best represent your race/ethnicity, and use the text box to specify further if needed)

(1) Asian or Asian American

(2) Biracial or multiracial: _____

(3) Black or African American

(4) Hispanic or Latinx or Latin American

(5) Middle Eastern/North African

(6) Native American or Alaska Native

(7) Native Hawaiian or Other Pacific Islander

(8) Prefer not to say

(9) Prefer to self-identify:

(10) White or European American

Age: _____

6. How do you identify your sexual orientation? (please click one button)

(1) Asexual

(2) Bisexual

(3) Gay

(4) Pansexual

(5) Prefer not to say

(6) Prefer to self-identify:

(7) Straight/heterosexual

7. Education (please click one button that represents the highest level achieved)

(1) Some high school.

(2) Completed high school/G.E.D.

(3) Completed some college but no degree.

(4) Currently enrolled in college.

(5) Completed Associate's Degree.

(6) Completed Bachelor's Degree (e.g., B.A., B.S.)

(7) Completed Master's Degree (e.g., M.A, M.S., M.Ed., M.B.A., M.P.H., etc.)

(8) Completed Specialist Degree (e.g., CAGS, Ed.S., Psy.S.)

(9) Completed Doctorate (e.g., Ph.D., Psy.D., Ed.D, M.D., J.D., etc.)

(10) Prefer not to say

8. Family/Household Income: (please click one button that represents your current income)

(1) Under $20,000

(2) $20,001-40,000

(3) $40,001-60,000

(4) $60,001-80,000

(5) $80,001-100,000

(6) $100,001-120,000

(7) $120,001-140,000

(8) $140,001-160,000

(9) $160,001-180,000

(10)$180,001-200,000

(11) Prefer not to say

9. Socioeconomic Status: (please click one button that represents your social class)

(1) Lower Class

(2) Lower Middle Class

(3) Middle Class

(4) Upper Middle Class

(5) Upper Class

(6) Prefer to self-identify:

(7) Prefer not to say

APPENDIX B

CONFORMITY TO MASCULINE NORMS – SHORT FORM

Please respond to what extent you agree or disagree with the following statements.

(0) Strongly Disagree

(1) Disagree

(2) Somewhat Disagree

(3) Somewhat Agree

(4) Agree

(5) Strongly Agree

1. I tend to share my feelings (R)
2. I like to talk about my feelings (R)
3. I bring up my feelings when talking to others (R)
4. It bothers me when I have to ask for help
5. I am not ashamed to ask for help (R)
6. I never ask for hel

7. For me, the best feeling in the world comes from winning
8. I will do anything to win
9. In general, I must get my way
10. I would feel good if I had many sexual partners
11. I would change sexual partners often if I could
12. I would find it enjoyable to date more than one person at a time
13. It's never ok for me to be violent (R)
14. I think that violence is sometimes necessary
15. I dislike any kind of violence (R)
16. It would be awful if people thought I was gay
17. I would get angry if people thought I was gay
18. I would be furious if someone thought I was gay
19. Having status is not important to me (R)
20. I think that trying to be important is a waste of time (R)
21. I would hate to be important (R)
22. Work comes first for me
23. I feel good when work is my first priority
24. I need to prioritize my work over other things
25. I love it when men are in charge of women
26. The women in my life should obey me
27. Things tend to be better when men are in charge
28. I enjoy taking risks
29. I take risks

30. I put myself in risky situations

APPENDIX C

NORMATIVE MALE ALEXITHYMIA SCALE – BRIEF FORM

Please respond to what extent you agree or disagree with the following statements.

(1) Strongly Disagree

(2) Disagree

(3) Somewhat Disagree

(4) Neither Agree or Disagree

(5) Somewhat Agree

(6) Agree

(7) Strongly Agree

1. I feel comfortable expressing my affection to family members and friends (R)
2. I have difficulty telling others that I care about them
3. When someone close to me hurts my feelings, I am able to tell them that I am hurt (R)
4. It is difficult for me to reveal my innermost feelings, even to close friends
5. I don't like to talk with others about my feelings
6. If someone asks how I am feeling, I typically say what I am not feeling (e.g., "not too bad")

APPENDIX D

INTERPERSONAL COMPETENCY QUESTIONNAIRE

Please rate your level of competence and comfort in handling each type of situation.

(1) I'm poor at this

(2) I'm only fair at this

(3) I'm okay at this

(4) I'm good at this

(5) I'm extremely good at this

1. Revealing something intimate about yourself while talking with someone you're just getting to know.

2. Confiding in a new friend/date and letting him, her, or them see your softer, more sensitive side.

3. Telling a close companion things about yourself that you're ashamed of.

4. Letting a new companion get to know the "real you.

5. Letting down your protective "outer shell" and trusting a close companion.

6. Telling a close companion about the things that secretly make you feel anxious or afraid.

7. Telling a close companion how much you appreciate and care for him, her, or them.

8. Knowing how to move a conversation with a date/acquaintance beyond superficial talk to really get to know each other.

APPENDIX E

INTERNALIZED SHAME SCALE

Read each statement carefully and select the response that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement.

(0) Never

(1) Rarely

(2) Sometimes

(3) Frequently

(4) Almost Always

1. Compared to other people I feel like I somehow never measure up

2. I see myself as being very small and insignificant

3. I feel like I am never quite good enough

4. When I compare myself to others I am just not as important

5. I think people look down on me

6. I feel intensely inadequate and full of self-doubt

7. I feel as if I am somehow defective as a person, like there is something basically wrong with me

8. I feel somehow left out

9. I feel insecure about others' opinions of me

10. I scold myself and put myself down

APPENDIX F

MASCULINITY AND SHAME QUESTIONNAIRE

Directions:

Below are situations that people are likely to encounter in day-today life, followed by several common reactions to those situations. As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in each of the ways described.

(1) Not Likely

(2)

(3)

(4)

(5) Very Likely

1. You take a highly regarded personality test and the results indicate that your personality is more feminine than masculine.

   How likely is it that . . .

   1a. You would feel like failure?

2. You are hanging out with friends for the evening, talking about which movie to watch. Someone suggests a movie that you and another friend already watched together. This friend says, “Alright, get out the tissues. [Your name] here bawled his eyes out when we saw it.” He is telling the truth.

   How likely is it that . . .

   2a. You would feel bad about yourself, like a loser?

3. You join a gym and meet with a trainer for the first gym. The trainer is doing your intake evaluation and comments that you “lift like a girl.”

   How likely is it that . . .

   3a. You would feel lousy about yourself, like a loser?

4. You are walking home from the movies with your romantic partner. As you walk down the street, you are mugged, and the mugger takes your money.

   How likely is it that . . .

   4a. You would think you are a lousy romantic partner for
   not being able to fend the mugger off?

5. You are playing a team sport, and there are 10 seconds left to score. You make a mistake that causes your team to lose.

   How likely is it that . . .

   5a. You would feel like a failure?

6. You are doing an online crossword competition. The crossword subject is masculinity, and all the clues are about things like cars, sports, mechanics, fitness, and other stereotypical masculine subjects. You perform worse than the rest of the online competitors, of whom a majority are women.

   How likely is it that . . .

   6a. You would feel like a failure?

7. You are playing poker and your friend accuses you of cheating when you are not.

   How likely is it that . . .

   7a. You would feel like a horrible person?

8. You are at a party and someone dares you to arm wrestle your girlfriend in front of everyone. She beats you.

   How likely is it that . . .

8a. You would feel inadequate?

9. Your manager criticizes your job performance and fires you.

How likely is it that . . .

9a. You would feel you didn't deserve to work there?

10. You are at a party and begin talking with a man. He asks you for your number and asks if you would be interested in a date.

How likely is it that . . .

10a. You would feel disappointed in yourself?

11. You are talking with a woman you just met, who you find attractive. She asks if you have plans for the weekend with your boyfriend, implying that she thinks you're gay.

How likely is it that . . .

11a. You would feel like a loser who doesn't deserve a date?

12. You overhear a coworker say that he thinks you're gay.

How likely is it that . . .

12a. You would feel bad about yourself, like a loser?

13. In the bedroom, your lover says that she is not sexually satisfied.

How likely is it that . . .

13a. You would feel like a failure?

14. You see someone who is bending over, but they are looking away. You perceive them to be a woman, and you find their backside attractive. When they stand up, you realize the person is a man.

How likely is it that . . .

14a. You would feel bad about yourself, like a loser?

15. You are at a party and begin talking with a woman who you find attractive. You ask her on a date, and she gives you her number. Later in the conversation, you find out that she is transgender, meaning that she was assigned "male" at birth but is a woman.

How likely is it that . . .

15a. You would feel disappointed in yourself?

16. You would like to find a romantic partner. Every woman you ask on a date turns you down.

How likely is it that . . .

16a. You would feel like someone who is too flawed to ever attract a partner?

17. You are unable to become sexually aroused when you want to be.

How likely is it that . . .

17a. You would feel like a failure?

APPENDIX G

SELF-STIGMA OF SEEKING HELP

Please respond to what extent you agree or disagree with the following statements.

(1) Strongly Disagree

(2) Disagree

(3) Agree and Disagree Equally

(4) Somewhat Agree

(5) Strongly Agree

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.

9. My self-confidence would remain the same if I sought help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

APPENDIX H

SCHWARTZ OUTCOMES SCALE – 10

Below are 10 statements about you and your life that help us see how you feel you are doing. Please respond to each statement by selecting the response number that best fits how you have generally been over the last seven days (1 week). There are no right, or wrong responses and it is important that your responses reflect how you feel you are doing. Often the first answer that comes to mind is best. Thank you for your thoughtful effort. Please be sure to respond to each statement.

(1) Never

(2)

(3)

(4)

(5) All of the time or nearly all of the time

1. Given my current physical condition, I am satisfied with what I can do.
2. I have confidence in my ability to sustain important relationships

3. I feel hopeful about my future.
4. I am often interested and excited about things in my life.
5. I am able to have fun.
6. I am generally satisfied with my psychological health.
7. I am able to forgive myself for my failures.
8. My life is progressing according to my experiences
9. I am able to handle conflicts with others
10. I have peace of mind.

APPENDIX I

ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP – SHORT FORM

Please respond to what extent you agree or disagree with the following statements.

(1) Strongly Disagree

(2) Disagree

(3) Agree and Disagree Equally

(4) Somewhat Agree

(5) Strongly Agree

1. Would obtain professional help if having amental breakdown

2. Talking about psychological problems is a poor way to solve emotional problems

3. Would find relief in psychotherapy if in emotional crisis

4. A person coping without professional help is admirable

5. Would obtain psychological help if upset for a long time

6. Might want counseling in the future

7. A person with an emotional problem is likely to solve it with professional help

8. Psychotherapy would not have value for me

9. A person should work out his/her problems without counseling

10. Emotional problems resolve by themselves