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Men's Help-Seeking for Depression:  
The Efficacy of a Male-Sensitive Brochure about Counseling

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To download a copy of the male-sensitive brochure developed for this study, please visit:

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Abstract

While depression among men is becoming better understood, men still underutilize counseling services. Hence, there is an important need for improved ways to reach out to depressed men. This study examined the efficacy of a male-sensitive brochure aimed toward improving attitudes about seeking counseling and reducing the self-stigma of seeking counseling among 1,397 depressed men who had not previously sought help for their depression. Results indicate that the male-sensitive brochure, which incorporated current knowledge from the psychology of men and masculinity and mental health marketing, improved participants' attitudes and reduced their self-stigma towards counseling. Furthermore, the new brochure improved attitudes and reduced stigma to a greater degree than previously developed brochures. Implications for mental health marketing, practice, and research are discussed.

Keywords: Men, Depression, Help-Seeking, Attitude Change, Self-Stigma

### Men's Help-Seeking for Depression:

#### The Efficacy of a Male-Sensitive Brochure about Counseling

Worldwide, depression leads to the loss of 850,000 lives every year through suicide—one of the three leading causes of death among 15 to 44 year olds (World Health Organization, 2007). To combat this international issue, multi-million dollar depression awareness campaigns have been commissioned by nations across the world to educate the public about the disorder and its treatment, and to encourage earlier treatment utilization (Nemec, 2005). Furthermore, acknowledging that men commit suicide at four times the rate of women in the U.S. (Kochanek, 2004) and are less likely to seek professional psychological help for depression than women (Addis & Mahalik, 2003), campaigns targeting men specifically have started to be implemented. For example, in 2003 NIMH launched the *Real Men Real Depression* (RMRD) campaign. The RMRD campaign sought to raise awareness about depression among men by using several male-targeted strategies (e.g., using credible peer reference group spokespeople and acknowledging the difficulty of seeking help as a man). Researchers have posited that these strategies hold promise for reaching men, particularly men who might not recognize or seek treatment for their depression (Rochlen, Whilde, & Hoyer, 2005).

With the rise of awareness campaigns focused on specific populations there has also been an increased acknowledgement of the need to assess the effectiveness of these interventions to determine if changes in approach are needed or whether the targeted interventions work at all (Siegel, Doner, & Lotenberg, 2007). NIMH reports some successes from their RMRD campaign through anecdotal evidence and via reports that it has reached more than 40 million people. However, while studies have empirically assessed and validated the impact of target-specific campaign interventions in other domains (Nemec, 2005), only one study has empirically examined the effectiveness of a male-targeted intervention. Rochlen, McKelley, and Pituch (2006) compared a brochure developed for the RMRD campaign, which included male-targeted strategies, to two brochures that used a gender-neutral format (i.e., not tailored toward men) by randomly assigning college participants to brochure condition. Interestingly, they found that the

RMRD brochure did not improve attitudes towards seeking help more than the gender-neutral brochures. Thus, Rochlen and colleagues concluded that all brochures might hold “the same amount of promise in educating men about depression, improving help-seeking attitudes, and providing treatment options” (p. 9), and therefore tailoring specific outreach efforts to men may not be needed.

However, there are several omissions in the literature that engender uncertainty around this conclusion. Most importantly, researchers have not examined the efficacy of male-targeted interventions for depression with men currently experiencing depression who have not yet sought help for depression. Men who are not currently depressed are unlikely to consider seeking help for depression and so are less likely to find the intervention materials relevant. In turn, men who are currently depressed but have previously sought or are currently seeking help are already likely to hold somewhat improved views of counseling (Fischer & Farina, 1995; Blazina & Marks, 2001) and so are less likely to respond to the materials with further attitudinal improvement. Since the goal of these campaigns is to help men experiencing depression who have not yet sought help get the services they need, the key target group has not been assessed and this limits the field’s ability to measure the true efficacy of male-targeted interventions (i.e., a male-targeted brochure).

Another omission in the literature is that studies examining the effectiveness of interventions aimed at increasing help seeking tend to employ only a single measure of change. For example, the most widely used measure in help-seeking research is a general attitude towards seeking help measure (i.e., Attitudes Towards Seeking Professional Psychological Help Scale; Fischer & Farina, 1995) which assesses overall positive and negative beliefs about counseling (e.g., “The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.”). The use of a general attitude measure may limit the ability to detect effects, as other constructs may more accurately capture changes in help-seeking decisions.

One important factor that has been implicated in the extant literature is stigma. Recent research asserts that “stigma represents a significant public health concern because it is a major barrier to care seeking” (Corrigan, 2004, p. 619), a position echoed in the United States Government’s New Freedom Commission on Mental Health Report (Hogan, 2003). Similarly, the National Institute of Mental Health has put out calls for interventions that directly focus on “Reducing Mental Illness Stigma and Discrimination” (see <http://grants.nih.gov/grants/guide/pa-files/PAR-08-040.html>) further highlighting the need to address stigma. Specifically for men, fear of stigma has been cited as one of the most important barriers to men’s decisions to seek help (Mahalik, Good, & Englar-Carlson, 2003) and recently researchers have examined the effects of a type of stigma that may be particularly salient for men, called self-stigma. Self-stigma is defined as the perception of oneself as inadequate or weak if one were to seek professional help (e.g., “I would feel inadequate if I went to a therapist for psychological help”; Vogel, Wade, & Haake, 2006). Concerns about self-stigma may be particularly relevant for men because traditional male gender roles require men to be independent and in control of their emotions. This can increase apprehension about seeking help, due to fears of feeling dependent and not in control if they were not able to handle an emotional issue on their own (Addis & Mahalik, 2003). Therefore, if a man perceived that he needed psychological help, he may feel like he has failed as a man (i.e., increased self-stigma), which would make the act of seeking counseling less likely. Consistent with this, male college students report greater self-stigma for seeking counseling than female college students (Vogel, Wade, & Hackler 2007) and male college students who endorse more traditional male gender roles report greater self-stigma associated with mental health concerns than those who endorse fewer traditional male roles (Magovcevic & Addis, 2005). As a result, in assessing the effects of a male-targeted intervention, it may be important to not only assess general attitudes towards seeking help but directly assess the self-stigma that a man may feel about seeking counseling (Vogel et al., 2007).

Previous research also may not have shown the expected differences between brochure interventions because researchers did not include some important male-sensitive information

recently suggested in the literature. For example, researchers have suggested that men may mask underlying depression with externalizing behaviors (e.g., workaholism, substance use, aggression, recklessness, and withdrawing from family and friends; Magovcevic & Addis, 2008). To sensitively address this more masculine type of depression, researchers have noted the potential need to use language more compatible with traditional male gender roles in describing depression and counseling. Examples include replacing the word “therapist” with “consultant” and describing counseling as an active process where the client sets the agenda (Robertson & Fitzgerald, 1992; Rochlen, Blazina, & Raghunathan, 2002, Rochlen & O’Brien, 2002b). Another suggestion has been to normalize and explain depression symptoms when working with male clients, due to the stigma and misunderstanding surrounding depression in men (e.g., Rosen, Walter, Casey, & Hocking, 2000; Schreiber & Hartricku, 2002). Similarly, men’s concerns about the lack of perceived value and anticipated costs of counseling have been identified as additional barriers that need to be addressed (Rochlen et al., 2006; Rochlen & O’Brien, 2002a; Vogel & Wester, 2003). As a result, research assessing the effectiveness of male-targeted interventions may need to specifically highlight the characteristics of depression and counseling most relevant to men.

Given the previous limitations, research is needed to examine the effects of a male-sensitive intervention on men’s help-seeking decisions in greater detail. Therefore, the current study sought to compare the efficacy of a newly developed male-sensitive brochure to the original RMRD brochure and a gender-neutral brochure used by Rochlen and colleagues (2006). The most recent research on male-targeted mental health marketing was used in the development of the new brochure. In addition, we reduced potential issues with previous research by focusing on men who were clinically depressed and who had not yet sought help for their depression. We also assessed the efficacy of the brochure across both general attitudes towards seeking counseling and the self-stigma associated with seeking counseling. We hypothesized that the new male-sensitive brochure would improve men’s attitudes towards seeking help and decrease

their self-stigma associated with seeking help significantly more than the previously developed brochures.

## Methods

### *Participants*

Men ( $N = 4,967$ ) were recruited via Internet websites (e.g., [yourpersonality.net](http://yourpersonality.net), [askmen.com](http://askmen.com)). To increase the diversity of our sample, we also targeted specific group listservs (e.g., Prostate Cancer and Gay Men) and websites (e.g., [BlackMenInAmerica.com](http://BlackMenInAmerica.com)). A recent analysis concluded that results from Internet data are consistent with results from paper and pencil measures (Gosling, Vazire, Srivastava, & John, 2004). As we were interested in helping men who were depressed but had not yet sought help for depression, only men ( $n = 1,397$ ) who met the criteria for depression (see measures below) and indicated that they had not sought help for depression were included in the current study. They ranged in age from 18 to 69 years ( $M = 29.44$  years,  $SD = 10.19$ ), and consisted of 964 (69.0%) White, 165 (11.8%) Asian, 100 (7.2%) Hispanic, 74 (5.3%) Black, 61 (4.4%) Multiracial, and 8 (0.6%) Native American men. Participants' educational level consisted of 31 (2.2%) with less than a high school diploma, 226 (16.2%) with a high school diploma or GED, 425 (30.4%) with some college experience, 118 (8.4%) with a 2-year college degree, 379 (27.1%) with a 4-year college degree, 129 (9.2%) with a masters degree, 22 (1.6%) with a doctoral degree, and 35 (2.5%) with a professional degree. Current household income varied as follows: 344 (20.7%) under \$20,000, 263 (18.8%) between 20,000 and 40,000, 308 (22.1%) between 40,000 and 75,000, 274 (19.6%) over 75,000, and 195 (14.0%) declined to disclose their income. The sexual orientation of the respondents consisted of 1,195 (85.5%) heterosexual men, 103 (7.4%) homosexual men, and 83 (5.9%) bisexual men.

### *Brochures*

Three brochures were examined in the current study (to view the brochures, visit <http://education.missouri.edu/orgs/mmrc/research.php>). The RMRD brochure was developed and distributed by NIMH. This brochure contains facts specific to men and depression, testimonials and photographs of men of various racial groups that have experienced depression, and a section

on depressive symptoms. The gender-neutral brochure was developed by Rochlen et al. (2006). This brochure was similar to the RMRD brochure with the exclusion of a male focus throughout the materials. For example, Rochlen et al. modified the tagline from “Real Men. Real Depression.” to “Real People. Real Depression.” In addition, statistics about the prevalence of depression in the U.S. population were changed to include both men and women.

The new male-sensitive brochure was developed to improve upon the RMRD brochure by incorporating current knowledge from the psychology of men and masculinity and mental health marketing (e.g. Addis & Mahalik, 2003; Rochlen & Hoyer, 2005; Timlin-Scalera, Ponterotto, Blumberg, & Jackson 2003; Vogel, Wester, Larson, & Wade, 2006). Specifically, the male-sensitive brochure described symptoms thought to characterize “masculine depression,” used language more compatible with traditional masculine gender roles (e.g., “mental health consultant,” “strategy for attacking,” describing counseling as a solution-focused, cost-effective, client-directed team effort), addressed the misconception about depression being the product of a weak will by citing a medical-model explanation, discussed the cost-effectiveness of proactive counseling versus later medical treatment, and displayed more stereotypically masculine-looking men in the testimonial portraits. The male-sensitive brochure was examined and deemed appropriate by professionals not associated with the study with expertise in the field, including two independent practitioners who specialize in working with men and three faculty members whose research focuses on men’s issues.

### *Procedures*

Procedures were approved by the institutional review board. Participants gave their consent (by clicking the “continue” button on the web page after reading the consent script) and completed the pre-intervention measures (i.e., attitudes towards counseling, self-stigma, and depression) and some demographic questions including their age, race-ethnicity, level of education, annual income, sexual orientation, and previous experience with seeking help for depression (i.e., “Have you ever been treated for depression?”). After completing the measures, participants viewed one of three randomly assigned brochures and then completed the post-



intervention measures (attitudes and self-stigma). Following completion of the experiment, participants were debriefed and provided phone numbers and Web addresses of resources providing additional information on depression and treatment options.

### *Measures*

*Attitudes Towards Seeking Professional Psychological Help Scale* (ATSPPHS; Fischer & Farina, 1995). General attitudes toward seeking professional help for psychological concerns were measured with the 10-item short version the ATSPPHS. The 10-item version correlates .87 with the longer 29-item version (Fischer & Farina, 1995). This instrument asks participants to rate their level of agreement with each item on a Likert scale ranging from *strongly disagree* (0) to *strongly agree* (3), with 5-items being reverse scored so that higher scores indicate more positive attitudes toward seeking help. The test-retest correlation with a 1-month interval between administrations has been reported as .80 and the Cronbach's alpha coefficient has been reported to be .84 (Fischer & Farina, 1995) in a sample of college students. Theoretically, attitudes are determinants of intentions and behaviors (Ajzen & Fishbein, 1980; Ajzen, 2005) and research demonstrates consistency between attitudes and behavior in general (Crano & Prislin, 2006). Consistent with this larger literature, scores from the original scale have been found to discriminate between participants who have and have not sought out psychological assistance (Fischer & Turner, 1970). Studies have also found statistically significant positive associations between scores on the 10-item scale and intentions to seek treatment for interpersonal issues ( $r = .56$ ), academic issues ( $r = .21$ ), and drug and alcohol issues ( $r = .26$ ) among college students (Vogel, Wester, Wei, & Boysen, 2005), as well as with lifetime treatment use, among samples of college students (Fischer and Farina, 1995; Cohen, 1999; Mackenzie et al., 2004), local community residents (Mackenzie, Knox, Gekowski, & Macaulay, 2004), and the general population (Lin & Parikh, 1999). In the current sample, the alpha coefficients on the pretest and posttest were .85 and .87, respectively.

*Self-Stigma Of Seeking Help* (SSOSH; Vogel et al., 2006). Respondents' self-stigma associated with seeking psychological help was measured with the SSOSH. The SSOSH is a 10-

item measure that uses a 5-point Likert-type response scale from *strongly disagree* (1) to *strongly agree* (5) with the mid-point being *agree and disagree equally*. Half of the items are reverse-scored so that higher total scores indicate greater self-stigma. In support of its validity, the SSOSH was related to attitudes toward seeking counseling (from  $r = -.54$  to  $-.63$ ), intentions to seek counseling (from  $-.34$  to  $-.38$ ), the tendency to self-disclose distressing information ( $-.25$ ), and the tendency to self-conceal (.15). The SSOSH significantly differentiated between those who eventually sought psychological services and those who had not. The authors reported alpha coefficients between .86 and .92 (Vogel et al., 2006) across five college student samples. With the current sample, the alpha coefficients on the pretest and posttest were .89 and .91, respectively.

*Center for Epidemiological Studies Depression scale* (CES-D; Radloff, 1977). The CES-D, a widely used measure consisting of 20-items measuring cognitive, affective, and vegetative symptoms of depression measured on a 4-point Likert scale ranging from *rarely or none of the time* (0) to *most or all of the time* (3). Summed scores ranged from 0 to 60, with higher scores reflecting greater depressive symptoms. Participants were included in the study if they met the scale's clinical cutoff score (16) for depression. While this criterion was not optimal for insuring the inclusion of men with more "masculine depression" symptoms in the sample, research suggests the CES-D is one of the most suitable measures for use in evaluating men (Sharp & Lipsky, 2002). Validity evidence has been supported through positive correlations (from  $r = .86$  to  $.87$ ) with scores on the Beck Depression Inventory (Santor, Zuroff, Ramsay, Cervantes, & Palacios, 1995) in both college and depressed outpatient samples, and good psychometric properties across ethnic group community samples (Roberts, 1980). Radloff reported the alpha coefficient to be .85 in the development sample; an alpha coefficient of .78 was found in the present study.

## Results

### *Descriptive Statistics*

Table 1 shows the correlations, means, standard deviations, and internal consistency estimates for all scales used in this study.

### *Pretreatment Differences*

First, we tested for pre-treatment differences across the three brochure conditions (see Table 2), by conducting a one-way multivariate analysis of variance with brochure condition as the independent variable and age, attitudes towards seeking help, self-stigma of seeking help, and level of depression as the dependent variables. All tests were not statistically significant ( $p > .05$ ), suggesting that participants randomly assigned to brochure condition had similar scores on these variables.

### *Primary Analysis*

To determine whether there was differential improvement in attitudes towards seeking help and a reduction in self-stigma of seeking help between the brochures, we conducted repeated-measures ANOVAs to identify changes across the three brochure conditions for both attitudes and self-stigma. Brochure (male-sensitive brochure vs. RMRD vs. gender-neutral) was the between subjects condition and time (pre- and posttest) was the repeated condition. Attitudes and self-stigma were separate dependent variables. We report partial  $\eta^2$  as the indicator of the effect size. Partial  $\eta^2$  is the strength of association of “factor A with a dependent variable Y from which all other nonerror sources of variance ... in the experiment are removed” (Cohen, 1973, p. 108). Cohen (1988) suggests that a  $\eta^2$  of .099 is equal to an  $f$  of .10 (small effect), a  $\eta^2$  of .0588 is equal to an  $f$  of .25 (medium effect), and a  $\eta^2$  of .1379 is equal to an  $f$  of .40 (large effect).

We hypothesized that the male-sensitive brochure would improve participants' attitudes towards seeking help and decrease self-stigma of seeking help to a greater degree than the other two brochures. Thus, we expected an interaction between brochure condition and time. The interaction between brochure and time for both attitudes,  $F(2, 1308) = 3.5, p = .03$ , partial  $\eta^2 = .005$  and self-stigma  $F(2, 1272) = 5.9, p = .003$ , partial  $\eta^2 = .009$ , was statistically significant,

indicating that there were significant changes in participants' attitudes and self-stigma across the brochures. To determine which brochure(s) performed better, we conducted follow-up analyses for both attitudes and self-stigma, comparing each brochure to the other two. Table 2 shows the pre, post, and change in the means for attitudes and self-stigma for each of the brochure conditions. For attitudes, the male-sensitive brochure produced significantly greater improvements than the RMRD brochure,  $F(1, 871) = 6.7, p = .01$ , partial  $\eta^2 = .008$ , while the improvements over the gender-neutral brochure did not reach significance ( $p = .086$ ). There was no significant difference between RMRD and the gender-neutral brochure,  $F(1, 883) = .73, p > .10$ , partial  $\eta^2 = .001$ . For self-stigma, the male-sensitive brochure produced significantly greater improvements than both the RMRD brochure,  $F(1, 837) = 12.2, p < .001$ , partial  $\eta^2 = .014$  and the gender-neutral brochure,  $F(1, 842) = 4.1, p = .043$ , partial  $\eta^2 = .005$ . Again, there were no significant difference between the RMRD and the gender-neutral brochure,  $F(1, 865) = 1.8, p > .10$ , partial  $\eta^2 = .002$ . Examining the within condition changes, we found that all three conditions led to improvement in attitudes, though the medium to large effect size of the male-sensitive brochure (partial  $\eta^2 = .120$ ) was approximately twice the effect sizes of the RMRD (partial  $\eta^2 = .055$ ) and gender-neutral (partial  $\eta^2 = .075$ ) brochures. For self-stigma, we found that the male-sensitive brochure was the only brochure to significantly reduce self-stigma, with a small to medium effect (partial  $\eta^2 = .034$ ).

*Demographic Analyses.* We examined the brochures' varying effectiveness for attitude improvement and self-stigma reduction for several underserved populations. Performing separate tests for men who are part of a racial or sexual minority, over 60 years of age, and less than high school educated, we identified only one significant effect. The male-sensitive brochure was more effective than the RMRD brochure in improving attitudes,  $F(1, 353) = 8.9, p = .003$ , partial  $\eta^2 = .025$ , among men making less than \$20,000 a year (and who were older than 23—to exclude those being supported by parents during higher education).

## Discussion

The current study compared the efficacy of a new male-sensitive brochure on depression to the brochure produced for the *Real Men Real Depression* campaign and a gender-neutral version of the campaign brochure. Our hypothesis that the new male-sensitive brochure would improve attitudes towards seeking help and decrease the self-stigma of seeking help to a greater degree than the other two brochures was partially supported. Specifically, the male-sensitive brochure improved attitudes significantly more than the RMRD brochure though the improvements over the gender-neutral brochure did not reach significance. The male-sensitive brochure's effect size was also approximately twice that of the other two brochures. Notably, the male-sensitive brochure was also the only brochure with a significant effect for self-stigma reduction. These findings suggest, in contrast to the conclusions of Rochlen and colleagues (2002b; 2006), that certain male-tailored approaches may improve depressed men's attitudes and reduce their self-stigma of seeking help with greater efficacy than other types of brochures.

The current findings replicate Rochlen et al.'s (2006) finding that the RMRD and gender-neutral brochures showed few differences. However, the findings also extended Rochlen et al.'s study by showing that certain male-sensitive strategies may lead to improvements in men's attitudes and self-stigma. Several differences between the studies may explain these new findings. First, in the current study all the men included in the analysis met the clinical cutoff for depression and had not yet sought help for depression. These men are the most likely to have a need for the intervention and therefore are more likely to find the intervention relevant. Therefore, unlike previous investigations, the current study focused on the target population of interest. Second, the current study measured both general attitudes and self-stigma. Interestingly, we found clearer differences between the brochures on changes in self-stigma than attitudes. One reason for this finding is that all brochures may address issues related to attitudes (i.e., seeking help is beneficial) and thus may not be as sensitive to the changes made in the brochures. In turn, self-stigma may more accurately capture the male-specific changes made in the brochure (e.g., discussion of how depression is not simply the result of weak willpower), which supports the

previous assertions that self-stigma is an important barrier to seeking help for men (Vogel et al., 2007).

The current findings extend the recent counseling research on strategies for effective marketing toward men (Rochlen & Hoyer, 2005), and provide support for the theoretical recommendations from recent men's help-seeking scholarship (e.g., Addis & Mahalik, 2003; Good & Brooks, 2005; Mahalik, Good, & Englar-Carlson, 2003). The changes made to the brochure, including discussion of the unique symptoms of masculine depression, use of language more compatible with traditional masculine gender roles, and direct challenge of the misconception that seeking help is a sign of weakness, seem to hold promise for addressing some of the identified barriers to men's help-seeking (Mansfield, Addis, & Courtenay, 2005). To determine which changes were most useful, future researchers might consider targeting specific aspects of the brochures and examining their effectiveness to see which elements are most important (e.g., comparing a brochure that focuses on the importance of getting help so one can get "back to being productive" versus one that focuses on educating men about the externalizing behaviors that may be a sign of depression in men). Investigations should continue to empirically examine the utility of new strategies suggested by future men's help-seeking theory (McKelley & Rochlen, 2007), and insights from mental health marketing (Andreasen, 1994; Lancaster, 1989), to further encourage evidence-based practice within our field (Levant, 2005). Future studies should also explore the efficacy of these strategies with other clinically distressed male samples, such as men suffering from anxiety. Furthermore, assessment of interventions in the form of interactive web sites, television spots, and radio messages would extend research beyond examination of print materials. Lastly, as men who endorse more traditional gender roles report less positive attitudes regarding seeking counseling (Good & Wood, 1995; Blazina & Marks, 2001), future researchers may want to examine the impact of masculine gender roles (i.e., as a moderator) on the effectiveness of an intervention in improving help-seeking attitudes.

Our analyses of brochure effects across different demographic characteristics of the men in the sample found mixed results. Our finding that the male-sensitive brochure improved

attitudes more than the RMRD brochure for those with lower incomes is notable, as unmet need for treatment is greatest among those with low incomes (Wang et al., 2005). It is possible that the description of counseling as potentially time-limited and billed on a sliding scale appealed to these men, as time away from work and incurring additional expenses may be an important concern for them. Interestingly though, no statistically significant differences were found for men of color, gay or bisexual men, older men, or men with less than a high school education. While our study was larger than most studies in this area, we still may have lacked the ability to detect small differences between demographic groups due to lower statistical power. Since tailored cultural interventions tend to be more efficacious than general interventions (Ryan & Lauver, 2002), future research may want to continue to examine the efficacy of materials developed for men of differing cultural identities.

With respect to clinical practice, these findings offer several suggestions to individual counselors looking to advertise and tailor their practice to depressed male clients. For instance, when discussing the nature of counseling with potential or new male clients, counselors might consider framing the process as a solution-focused, cost-effective, client-directed team effort. Instead of describing counseling as a time for sharing vulnerabilities and feelings, counselors may want to use language more compatible with traditional masculine gender roles (e.g., “tackle the problem,” “defeat depression,” “team up”) in order to create an environment in which men will feel more comfortable to explore their problems. These differences in terminology may be particularly important for men who endorse traditional masculine roles as these men may be most resistant to counseling (Blazina & Marks, 2001). Furthermore, some male clients may be skeptical of the economic return that counseling would offer them. Providing them with research suggesting that proactive counseling can lower health care costs to the point of paying for itself may be especially well-received by these men (Blount et al., 2007). It may also be important to directly address issues related to any self-stigma that a potential or current male client is experiencing. Doing so may both help in the initial decision to seek help as well as in preventing premature termination by building the rapport with the client (Vogel et al., 2007). One way to

address these concerns may be to reframe the act of seeking counseling as “courageous” and taking “strength.” Another way might be to highlight the biological bases of depression in order to help clear up the common misconception that depression is the result of weak personal willpower, a misconception that has the potential to hinder clients’ self-esteem (Vogel et al., 2006). Lastly, making a point of discussing the symptoms thought to characterize masculine depression (e.g., substance use, aggression, withdrawing from family and friends, and workaholism) may allow easier detection of latent depression in male clients.

More broadly, incorporating empirically supported approaches in future mental health marketing initiatives may help improve attitudes and reduce the self-stigma around seeking help for larger depressed male audiences. Since men experiencing depression are more likely to report somatic complaints than women (Hammen & Padesky, 1977; Padesky & Hammen, 1981), they may more readily consult with a medical physician regarding how they are feeling (Andrews, Issakidis, & Carter, 2001). Thus, distributing male-sensitive materials to physicians and medical centers may be an excellent way to reach these men (Dew, Bromet, Schulberg, Parkinson, & Curtis, 1991). If briefly viewing the male-sensitive brochure during an Internet-based social science experiment can produce detectable attitudinal improvements, picking up and reading a similar brochure in the waiting room may accomplish the same or better.

#### *Limitations and Conclusion*

There are some limitations of the current study that necessitate additional lines of inquiry. First, self-reports of help-seeking attitudes and self-stigma are good but imperfect measures of actual help-seeking behavior. As such, utilizing longitudinal research measuring actual help-seeking behavior after exposure to the intervention, as well as the permanence of the attitudinal changes, would prove useful for future research. Also, while some of the effect sizes reported are small, even a small effect size is important since even getting a small percentage of men who would not otherwise seek help to do so could alleviate considerable suffering. Furthermore, the fact that we found an effect with a single exposure to the intervention is noteworthy, as attitude change is often difficult to produce from short-term interventions. The online data collection may



have also had some influence on the results. While online studies have the benefit of reaching larger audiences and have been shown to produce results on measures that are similar or better in terms of psychometric properties (Birnbaum, 2004; Gosling et al., 2004), there may be some biases in the sample as not all men have access to a computer, belong to the listservs, or visit the websites where the study was advertised. The majority of the sample was white, educated, middle class, and heterosexual, which limits the generalizability of the findings to men of color, gay and bisexual men, and poor and working class men with limited access to higher education. However, the current sample does have the benefit of increased generality over most studies in this area that have used samples mainly comprised of Caucasian college students; only 10% of our sample fit this demographic. Furthermore, the current study used a large sample of depressed men who had not yet sought help for their depression, the target population most important to the *Real Men Real Depression* campaign. The results, therefore, provide some important evidence regarding the promise of a male-sensitive approach to mental health marketing and empirically support the inclusion of theory-driven enhancements in group-targeted campaign efforts.

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Table 1

Descriptive Statistics and Correlations Between Scales.

Scale	1	2	3	4	5	6
1. ATSPPHS (posttest)	----	.88*	-.60*	-.58*	.28*	-.02
2. ATSPPHS (pretest)		----	-.62*	-.65*	.36*	-.02
3. SSOSH (posttest)			----	.89*	-.23*	.13*
4. SSOSH (pretest)				----	-.27*	.16*
5. Effectiveness for Men					----	-.05
6. CES-D						----
M	1.31	1.40	2.80	2.77	2.92	25.94
SD	0.66	0.64	0.91	0.94	0.81	8.49
Range	3	3	4	4	4	44
$\alpha$	0.85	0.87	0.89	0.91	0.69	0.78

Note.  $N = 1397$ . ATSPPHS = Attitudes Toward Seeking Professional Psychological Help Scale; SSOSH = Self-Stigma of Seeking Help; EFM = Effectiveness for Men; CES-D = Center for Epidemiological Studies Depression.

Table 2

Pretest, Posttest, and Change in Means for Attitude (ATSPPHS) and Self-Stigma (SSOSH).

	Brochure Condition		
	Male Sensitive	RMRD	Gender Neutral
Attitude (ATSPPHS) Mean			
Pretest	1.29	1.36	1.29
Posttest	1.41	1.43	1.37
▲	0.12	0.07	0.08
Self-Stigma (SSOSH) Mean			
Pretest	2.78	2.76	2.86
Posttest	2.69	2.76	2.85
▲	-0.09	0	-0.01

Note. ATSPPHS = Attitudes Toward Seeking Professional Psychological Help Scale, SSOSH = Self-Stigma of Seeking Help. Higher scores on ATSPPHS and SSOSH indicate more positive attitudes and greater self-stigma, respectively.