Men's Perceptions of Men Who Attend Mental Health Counseling

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Abstract: *This study utilized Q methodology to explore men's perceptions of other men who attend mental health counseling. Forty-three men from different areas of the United States sorted a Q sample of 48 statements. One common factor emerged with three specificities that reflected four perceptions of men attending mental health counseling. These factors were titled (a) Counseling Helps Men, (b) Caution, (c) Emergent Openness, and (d) Problem Solving. The results suggested that the participants were largely supportive of men who attend mental health counseling, with some expressing concern about stigmas associated with attendance. Additionally, men's perceptions of mental health counseling attendance are not well aligned with what some prominent theories would indicate. The findings have implications for those working in mental health, researching in men's issues, and educating counselors.*

Men are less likely than women to present for mental health counseling (MHC) (Uebelacker, Wang, Berglund, & Kessler, 2006; Vessey & Howard, 1993), but may nevertheless require more mental health services than women (Howard et al., 1996; Prior, 1999). Research on men and MHC has indicated that many men are reluctant to pursue treatment for mental health concerns (Cusack, Deane, Wilson, & Ciarrochi, 2004; O'Brien, Hunt, & Hart, 2005; Mojtabai et al., 2011). Part of this reluctance may stem from the shame of non-adherence to traditional male sex roles. This article presents information on the enforcement of traditional male sex roles, the mental health needs of men, and examines the nature of men's perceptions of men who attend MHC.

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Traditional Male Sex Role Adherence

Over the past several decades, scholarship on men and mental health has depicted men as being in a state of crisis (e.g., Brooks, 1998; Levant, 2011). What it means to be a man and to enact masculine ways of being has been largely static, resulting in many men feeling incompatible with the world around them (Levant & Kopecky, 1995). Some men feel like something is missing from their lives and are looking for something more, but may be uncertain about the nature of the problem (Brooks, 1998). The problems, or crises, men experience may stem from outdated modes of being that are evidenced in traditional male sex roles (Wexler, 2009).

Traditional male sex roles are socially prescribed stereotypes and norms to which men are expected to adhere (Kilmartin, 2000). These roles have common themes, which are frequently expressed cross-culturally. These themes include showing strength, taking risks, avoiding the feminine, expressing aggression, and taking sexual initiative (Gilmore, 1990). Adherence to these roles has been linked with negative emotional and affective states. Among these are anger (Blazina & Watkins, 1996), hostility (Hayes & Mahalik, 2000), depression, and anxiety (Cournoyer & Mahalik, 1995). Additional research has connected these ways of being with poor overall psychological wellbeing and diminished self-worth (Blazina & Watkins, 1996; Cournoyer & Mahalik, 1995; Shepard, 2002). Many men do not want to engage in these roles (Liu, Rochlen, & Mohr, 2005), but often adhere to them due to the threat of being shamed or stigmatized from non-adherence (Kilmartin, 2000).

Traditional male sex roles are often enforced through shame, which can come from internal or external evaluations. Men may evaluate themselves as to how they have achieved or failed to achieve traditional male sex roles (Krugman, 1995). According to Kaufman (1995), the crux of this shame lies in men believing that they must succeed. Therefore, any experience that approximates being unsuccessful (in whatever form that may take) is labeled as shameful and is avoided. Research has suggested that this form of self-stigmatizing is a barrier in men seeking out mental or physical health care (Pederson & Vogel, 2007; Shepherd & Rickard, 2012; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011).

Men are required to enact their masculinity in order for it to be evaluated by others as either meeting or failing social expectations (Edley & Wetherell, 1995; Gilmore, 1990). The performance can include particular ways of dressing and behaving, as well as evidencing masculine attitudes (Edwards, 2006). This presentation is evaluated socially, with men being shamed and stigmatized if they do not meet expectations (Kilmartin, 2000; McCusker & Galupo, 2011; Moss-Racusin,

Phelan, & Rudman, 2010). The distress experienced due to non-conformity is often sufficient to keep men acting in accordance with traditional masculine sex roles (Kilmartin, 2000).

Of all the people who evaluate this performance of masculinity, none are more complacent in perpetuating the roles than men themselves (Baker & Jencius, 2005; Kimmel, 2008). Most men do not feel comfortable with traditional male sex roles (Brooks, 1998), but challenging the role is breaking the role and can lead to feelings of vulnerability (Krugman, 1995). Men will often leave traditional male sex roles unchallenged and unacknowledged, which can adversely impact men's willingness to seek out mental health treatment (Cusack, Deane, Wilson, & Ciarrochi, 2004; Schaub & Williams, 2007).

Traditional Male Sex Roles and Mental Health Counseling

Multiple studies have indicated that the greater the adherence to traditional male sex roles the less likely a man will seek out MHC (e.g., Blazina & Watkins, 1996; Cusack, Deane, Wilson, & Ciarrochi, 2004; Schaub & Williams, 2007). Historically males and masculine traits were seen as the ideal in western culture, while females and feminine traits were viewed as pathological (Prior, 1999). The feminist movement challenged some of these traditionally held beliefs about gender and sex, leading many scholars to reassess the nature of pathology and its relationship to men and masculine norms (Sabo, 2005). With changes in conceptualizations of pathology came changes in epidemiological data indicating that men had greater levels of mental illness than initially anticipated (Prior, 1999). Epidemiological research has indicated that men and women have a probability of 0.38 and 0.34, respectively, of having at least one DSM diagnosis in their lifetime (Howard et al., 1996). Additionally, general mental health concerns have been repeatedly linked to aspects of traditional male sex roles (Englar-Carlson, 2009; Hayes & Mahalik, 2000; Wexler, 2009).

The above literature suggests that there is a need for mental health services in the male population. However, that need is going unmet. Even though men have a slightly higher incidence of mental health diagnosis, men will seek out MHC at only about half the rate that women do (Vessey & Howard, 1993). While outpatient care might be less frequented by men, men make up the majority of clients in inpatient and emergency room care (Prior, 1999). Greater utilization of high-levels of care may lend credence for the concept that traditional male sex roles require men to solve their own problems (Glicken, 2005). Men may wait to seek help until problems are too large for them to manage (Robertson, 2006).

Several theorists have indicated that the traditional male sex roles

are in conflict with the basic process of MHC (e.g., Brooks, 1998; Kiselica, 2005; Robertson & Fitzgerald, 1992). Robertson and Fitzgerald (1992) posited four points of incongruence: (a) MHC encourages a sharing of feelings, but men are socialized to keep their feelings to themselves; (b) admitting the presence of problems is often a requirement for MHC, but men are taught to hide the problems they have; (c) MHC will often highlight an individual's vulnerabilities, but men are expected to be strong; and (d) MHC utilizes a relationship between the client and counselor, but men learn that they need to be independent. The incongruence seems so great that many men would rather do nothing about a problem than seek out MHC (Cusack, Deane, Wilson, & Ciarrochi, 2004; Mahalik & Rochlen, 2006).

While this incongruence is salient, Vessey and Howard (1993) find that once in MHC men's and women's attendance rates are similar. So there may be another barrier to men attending MHC. Considering that MHC violates traditional male sex roles (Robertson & Fitzgerald, 1992) and that men are most guilty of enforcing those roles (Baker & Jencius, 2005; Kimmel, 2008), it might be that the threat of negative evaluation from other men deters men from MHC. To examine this threat, the study presented here examined men's perceptions of other men who attend MHC. While substantial work has been done on men's mental health issues and help-seeking behaviors, there has been little work on the evaluation that occurs between men. By exploring men's perceptions of men who attend MHC, the researchers hoped to understand whether there is a negative evaluation being expressed and the general nature of the views men hold.

Method

The Concourse and Q Sample

The concourse was generated through an incomplete sentence blank (ISB) tool and relevant scholarship. The ISB was comprised of 16 sentence stems concerning men in MHC (see Appendix 1.) The stems were created by the researchers and reviewed for face validity, a necessary quality of ISBs (Rogers, Bishop, & Lane, 2003). Nineteen men of varying ages and backgrounds completed the ISB, which resulted in 294 statements. An additional 85 statements were drawn from the review of scholarly literature pertaining to men in MHC. Those books and articles used for the construction of the concourse are marked with asterisks in the reference section.

The concourse was sampled using an unstructured technique, which is common in exploratory research (McKeown & Thomas, 1988). Stephenson (1953) noted that unstructured samples could be conceptualized as having at least two levels (p. 73). As an example, he highlighted a study on health wherein the unstructured sample would

likely balance between ill-health and health (p. 73). Similarly, this study contained statements that were supportive or positive towards men who attend MHC and oppositional or negative towards men who attend MHC. The statements were assessed for similarity, combined, and consolidated. Some statements were reworded in order to fit the nature of the present study. See Appendix 2 for the resulting 48 statements.

Participants (P Sample)

Participants were solicited through personal and professional connections from around the United States. Participants responded from Ohio, Virginia, New York, Florida, Louisiana, Washington, California, and Pennsylvania. One hundred and seventy two packets of research materials (i.e., consent forms, instructions, demographic sheets, and Q-sort materials) were posted or given out by hand. A total of 43 usable responses were received. Some demographic information was recorded (age, race, education, and counseling history).

Procedure

All but one participant completed a Q sort on their own, taking into account the degree to which the statements were like or unlike their views of men who attend MHC. Participants completed follow-up questionnaires concerning what they thought was important about the statements they ranked at the poles. They were also asked to highlight and describe any other significant statements. At the end of the follow-up questionnaire, participants were provided a space to share ideas that might have emerged during the sort.

Data Analysis

The data were analyzed using PQMethod (Schmolck & Atkinson, 2002). The initial data analysis utilized principal components analysis with a varimax rotation, resulting in highly correlated factors of ±0.7 or greater, which suggested that the between-factor similarities reflected a single factor. Accordingly, the unrotated principal components analysis was found to be a better solution for the data because it reflected what Brown (1981) termed a "consensus factor" (p. 631).

All 43 respondents loaded significantly on Factor I and five respondents had significant loadings on another factor. This suggested that while the participants agreed overall, some showed specificities in their sorting that reflected differing perceptions. The analysis below discusses the common factor, one bipolar factor, and one unipolar factor. (Appendix 2 provides the factor array.)

Results

Common Factor: MHC Helps Men

All 43 of the participants shared a perception that endorsed MHC as being helpful for men. Participants showed support for men who attend

MHC and viewed the MHC process as being largely helpful. It is accepted that men are emotional and any sense of traditional shame associated with being in MHC is absent. The highest-ranking statements reflected these sentiments: "Counseling can help men deal with issues" and "Men should go to counseling if they need to." Post-sort responses lent support to these judgments. For example, one participant noted, "I see counseling as very beneficial to most all people, especially men." If men are evaluating other men's performance of masculinity (Edley & Wetherell, 1995; Kimmel, 2008), it would appear that they are supporting men's MHC attendance. This perception captured all of the usable responses in the study and depicted a strong departure from the literature on men's experiences with MHC.

Expectations of male sex roles are violated when men attend MHC (Brooks, 1998; Robertson & Fitzgerald, 1992). When expectations are not met, men open themselves to shame and prejudice from others (Kaufman, 1995; Moss-Racusin, Phelan, & Rudman, 2010). Accepting men as being emotional, as participants did, is in violation of traditional male sex roles (Kilmartin, 2000). These perceptions were reflected in two +4-rated statements: "Men shouldn't be ashamed to be in counseling" and "It's ok for men to express their emotions." The post-sort responses focused heavily on the element of shame. The respondents expressed that they did not shame other men who sought out MHC for their problems. This may depict an acceptance of men who have problems and who admit to having those problems.

The factor also suggested that in order for MHC to be helpful for men, they needed to trust their counselors and talk about their problems. This was depicted in the negative rankings, which contained the statements: "Men shouldn't talk about their problems," "Men shouldn't trust counselors," and "Men don't need counseling because they can take care of themselves." Several participants provided clarifying responses in the post-sort questionnaire. For example, one participant noted, "Men's problems are not going to magically go away by themselves; talking problems out can help." This view is in contrast to the social expectation that men need to find their own solutions to problems (Glicken, 2005). The common factor was incongruent with this quality and offered men the freedom to seek out help in dealing with issues. While men are expected to be independent (Levant & Kopecky, 1995; Robertson & Fitzgerald, 1992), these respondents encouraged men to be connected to others, such as counselors. This aspect of the perception suggested that many men supported this type of incongruence.

The negative pole continued to challenge many trappings of traditional masculinity and assumptions about MHC. It suggested that men in MHC are not effeminate and that MHC is not just for women. According to male sex roles, men are expected to be the opposite of

women (Kilmartin, 2000). The array indicated negatively ranked statements, including "Counseling is really only good for women," "Men in counseling are effeminate," and "Men aren't emotional." Many of the follow-up responses validated men's emotional experiences and intimated that having feelings makes a man neither weak nor effeminate. By not feminizing men who attend MHC or emote, this perception may condone the incongruence with male sex roles and view these men as retaining their masculinity. The traditional attributes of male sex roles were directly affronted in this set of statements. The norms that men are supposed to be independent, unemotional, and the opposite of women (Levant & Kopecky, 1995) were considered moot by this perception.

While the MHC Helps Men factor was largely supportive of men who attend MHC, there were three specificities that referenced a stigma. These specificities shared other nuances that, in combination with the common factor, created three additional distinct perceptions. While they evidenced the presence of stigma, their shared loading on MHC Helps Men indicated little intention to directly reveal or act on any perceived stigma.

Caution Specificity

The caution specificity was reflected in Factor II, which was bipolar, and captured two participants on the positive pole. This specificity suggested that men needed to exercise caution when attending MHC because of the potential stigma. This was in line with most of the literature on men's mental health research to date (Levant, 2011). This perception suggested that the stigma might harm men should their attendance become public. Two statements reflected this view. On the positive side, "Men in counseling would want to keep it a secret," and on the negative side, "Men in counseling are normal." This perception highlighted a prejudice and recommended that men keep MHC attendance secret to avoid negative evaluations from other men (Moss-Racusin, Phelan, & Rudman, 2010). Post-sort responses reinforced this interpretation. One participant noted, "It can be a stigma that if you need counseling, you're weak." As such, secrecy was necessary in order to keep information private.

This perception also viewed men as being largely incompatible with the process of MHC, which was depicted as being uncomfortable and mysterious. Robertson and Fitzgerald (1992) noted that many men find the process of counseling antithetical to masculine ways of being, which may be reflective in this perception. Positively ranked statements included "Men are more closed and need help opening up," "Men in counseling will feel uncomfortable," and "Counseling is mysterious for men." One participant, who had attended MHC previously, responded, "I

am unsure what exactly happens during a session. The focus not being set ahead of time is a big mystery." Another response indicated that men were not very adept at discussing their feelings with others, thereby perpetuating some of the traditional masculine stereotypes (Kilmartin, 2000).

Overall this perception was supportive of men who attend MHC. However, the specificity suggested that men should be cautious about attending because of the stigma surrounding MHC for men. This stigma entailed being weak or abnormal in some manner. Mental health counseling was viewed as being somewhat incompatible with masculine ways of being and was considered a mysterious process. To that end, this perception asserted that men should only attend MHC if there is a specific reason or if forced to go by someone else, thus avoiding a confusing and potentially shameful experience.

Emergent-Openness Specificity

The negative pole of Factor II (Factor IV in Appendix 2) had one significant sort, from a 62-year-old man. His sort showed openness toward men attending MHC, which was in line with MHC Helps Men. It suggested a perception that was undergoing change, but was largely positive towards men who attend MHC. His highly ranked statements included "Men in counseling are normal," and "Men in counseling are strong." His post-sort responses normalized MHC, by highlighting that "some of the greatest people go through counseling . . . and men shouldn't be afraid to ask for help."

His perception became more nuanced in statements inwards from the poles. Seemingly negative statements about men attending MHC were ranked positively. This included "Counselors don't understand men's problems," and "Counseling is really only good for women." Upon initial inspection these statements appeared out of sync with the other positive endorsements of men attending MHC. However, the participant provided a post-sort response that gave context to these rankings. He responded:

> Men have always been raised to keep emotions in check. Crying was always a sign of weakness in my generation. Things change the older you get. You look back on things you should have acted on but did not. Trying to correct these things as you get older. There are more feelings, you realize that life, family, friends, etc. are a short time.

Kilmartin (2000) indicated that as men age they adopt a wider lens on sex roles, being able to move beyond stereotypes and norms. This perspective may reflect a similar type of widening, wherein MHC is becoming accepted.

This specificity may reflect some struggle between two ways of

perceiving men attending MHC, an older more restrictive perception and a newer, more open, perception. There is some evidence in the literature that men's perceptions about MHC change over time (O'Brien, Hunt, & Hart, 2005). In general, older men are more open about seeking out help than their younger counterparts (Cournoyer & Mahalik, 1995). This emerging openness still carried some stigma, potentially left over from older perceptions about men attending MHC, but was nevertheless positive overall.

Problem-Solving Specificity

This specificity (Factor III) contained two significant loadings and emphasized men solving problems in MHC. This was in line with male sex roles that prize problem solving when dealing with issues (Levant & Kopecky, 1995). While there is a tradition of problem solving in mental health counseling, there is often an equal emphasis on working through feelings (Nugent & Jones, 2005). In this specificity, working through feelings was perceived as a medium for solving particular problems. While overall this perception was supportive of men who attend MHC it was particular to solving problems, otherwise there was concern about stigmatization from other people.

The problem-focused perception was reflected in the highly ranked statements "Counseling is only good for men with really big problems," "Counseling is a way for men to vent their problems," and "Men in counseling are forced to address the problems in their lives." A respondent indicated that he had previously attended MHC to resolve particular issues, "Having had issues with panic disorder I couldn't overcome with just pills. I needed to talk to someone to figure out what triggered attacks."

In this specificity, working through feelings was perceived as a medium for solving particular problems. One respondent indicated, "Men can learn about their feelings and be more in control of their lives." This suggested that feelings can cause problems and, by controlling them, a problem is being solved. Traditional male sex roles often emphasize a regulation of emotion, in particular, restricting its expression (Levant, 2011). Furthermore, if a man is unable to control his emotions he may be viewed as being less masculine because he is out of control (Kilmartin, 2000).

The focus on solving problems was vital to this perception, and helped to check a concern about stigmatization from others. This was reflected in the statements "Men in counseling are effeminate," "Men shouldn't be ashamed to be in counseling," and "If a man goes to counseling it doesn't mean he's crazy." Each of these statements was a distinguishing statement ($p < 0.01$) and suggested that men who attend MHC should be ashamed because there is something wrong

with them (i.e., they are effeminate or crazy). This stigmatization reflected a traditional male sex-role attitude that could act as a barrier to pursuing treatment. Therefore, if the problem is sufficiently large to necessitate MHC, it should be done privately (Robertson, 2006).

The specificities in the present study emphasized stigma more than the common factor. However, due to that common factor, the perceptions were largely supportive of men who attend MHC. The perceptions that emerged in this study have the potential to influence the field of MHC, counselor educators, and researchers in men's issues.

Implications

The common perception and related specificities have potential benefit to mental health clinicians, researchers, and educators. The findings have the potential to assist new male clients and to shape outreach efforts. Additionally, they challenge some of the conceptualizations of researchers and provide fertile ground for continued research into men and MHC. Finally, they provide information that may help shape some curriculum decisions in counselor education.

From the present results, mental health counselors and administrators may be better prepared to support men who present for MHC. According to the literature, men are hesitant to pursue MHC because they perceive it as defying male sex roles (e.g., Brooks, 1998; Robertson & Fitzgerald, 1992; Wexler, 2009). As such, many men may need support overcoming this barrier as they enter MHC. This research may help administrators structure a clinic's approach to working with the concerns that men bring to MHC. If shame is a salient issue for men presenting to MHC, it may behoove administers to create psycho-education materials around men's perceptions of men who attend MHC. These materials would highlight how MHC can be a helpful and worthwhile experience for men, and that MHC can be free from shame or stigma.

The findings also speak to some different types of men who might present for MHC. Men who present with the perception espoused in MHC Helps Men may have very little difficulty in engaging in MHC. These men would believe that MHC can be helpful to them and that they do not need to suffer stigma or shame in attending. If men hold one of the three specificities (i.e., Caution, Emerging Openness, and Problem Solving), they may have a harder time accepting MHC. While these men may view MHC as a helpful activity for men, they may also be concerned about the stigma of attendance. Men who present to MHC with the Caution specificity may be wary of others finding out about their attendance. They may also struggle with the foreignness of the MHC process. These men may need a lot of information at the start of MHC in order to allay concerns and to provide clarity about the MHC process. Men who

present with the Emerging Openness specificity may not feel as comfortable as they might want to when attending MHC. These men might benefit from a close examination and deconstruction of these old belief systems. Finally, those with the Problem Solving specificity may present for MHC in crisis because they may wait until they deem the problem sufficiently large. Counselors will want to ensure an evaluation of the severity of the issues in order to assess the level of care necessary.

The study challenges the beliefs of some researchers in MHC and men's studies. The prevailing assumption is that men typically do not condone the use of MHC as a solution to problems (e.g., Brooks, 1998; Robertson & Fitzgerald, 1992; Wexler, 2009). This assumption may require reconsideration in light of the present findings. It appeared from MHC Helps Men that many men condone and support men who attend MHC. They endorsed behaviors that were incongruent with male sex roles and highlighted the useful aspects of MHC. The specificities added an additional level of complexity to the commonality by adding nuances that referenced the stigma that men might face when attending MHC. The findings also have implications for the larger study of men's studies, namely, how the respondents removed shame from their evaluation of men's behaviors. Shame has played a salient role in forcing men to adhere to male sex roles (Krugman, 1995). By removing this element from their evaluation of men's performance of masculinity, these respondents have done away with the enforcement of these norms.

Finally, counselors receive little to no professional training in men's issues (Mellinger & Liu, 2006). Although it has been presented as an important cultural consideration in MHC (Liu, 2005), the field of men's issues has been largely omitted. The complexity of the perceptions evidenced in the study, in combination with the implications for counselors, suggests that men in MHC is more complex than conventionally understood. The resultant perceptions suggested that men perceive men who attend MHC in at least four distinct ways. Furthermore, it is likely that many other perceptions exist, each with their own nuances. Counselor educators need to prepare counselors to work with these complex perceptions in session. Through understanding masculine culture and these various perceptions, counselors may be better able to assist male clients. It is the responsibility of counselor educators to integrate this type of material into the course sequence.

Limitations

The largest limitation to the study was due to the types of men who responded. The participants who returned their responses were largely Caucasians, heterosexuals, and college graduates. This sample is not fully reflective of the larger population, and it is unclear if these types of

demographic variables had anything to do with the emergence of a common factor. It is possible that with such a homogenous P sample there was not sufficient diversity to capture other perceptions. However, research by Vogel, Heimerdinger-Edwards, Hammer, and Hubbard (2011) suggested that traditional male sex roles stigmatize counseling across different backgrounds. As such, it is unclear what role that homogeneity played in the present study and it would be an important consideration if the study is replicated.

There may have also been homogeny in the P sample with regard to experiences with MHC. Seventy-four percent of respondents indicated that a close friend or family member had benefited from meeting with a counselor. Van Tubergen and Olins (1979) noted that people are more likely to respond to a Q methodological study if they have utilized the product or service under study. In the present study, it might have been this close friend or family member that provided relevance for participation. It is unclear what the exact implications are of this type of homogeny. It can be assumed that the majority of participants had a positive perception prior to participating because of this history of MHC being personally helpful to a close friend or family member.

Finally, Q methodology has traditionally utilized post-sort interviews to more fully understand the views of the participants (McKeown & Thomas, 1988). This was deemed impractical due to the sensitivity of the topic under study. However, the short written responses potentially hindered the depth of the interpretation possible. While it is unclear whether interviews would have made a difference, it may have clarified the meaning that participants ascribed to particular statements.

Future Research

The most prominent question that remains from this research is whether there any other perceptions. Q methodology makes no claims to capture all possible points of view, thus the present study cannot claim to be all-inclusive (Watts & Stenner, 2005). Future research needs to seek out and capture other potential perceptions. Additional perceptions of men who attend MHC might be found in a female P set. One respondent reported in his post-sort response that it had been difficult for him to attend MHC because his wife told him he was weak. In that case it appeared that it was not other men who were enforcing traditional male sex roles, but rather his wife. To further the understanding of the societal pressures on men attending MHC, future research might have women sort their perceptions of men who attend MHC.

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*[Items marked by * were consulted during sampling of the concourse]*

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Appendix 1: Male Incomplete Sentence Blank for Counseling (MISBC)

Below are sixteen unfinished sentences about counseling. Read the first part of the sentence provided and complete the sentence in words that best represent how you feel now. There are no right or wrong answers. Whether your responses are positive or negative, we ask that you be as honest as possible in your statements.

1 I think counseling is..._____
2 Going to counseling ..._____
3 I would go to counseling if..._____
4 Counselors are..._____
5 People who are in counseling... _____
6 Men in counseling..._____
7 Counseling does... _____
8 People go to counseling because..._____
9 Counseling is not..._____
10 If I were in counseling..._____
11 Men are..._____
12 Counseling is good for..._____
13 People go to counseling to..._____
14 Counseling does not..._____
15 Emotions are... _____
16 Men would not go to counseling because... ____

Appendix 2: Statements and Factor Array

		Factor			
	Statement	*I*	*II*	*III*	*IV*
1	Men go to counseling because they have no other support in their lives.	-1	0	-2	0
2	Men in counseling would want to keep it a secret.	0	5	2	-5
3	Counseling is only good for men with really big problems.	-1	1	5	-1
4	Men don't need counseling because they can take care of themselves.	-3	3	0	-3
5	Men shouldn't trust counselors.	-5	0	2	0
6	Men in counseling are stigmatized.	0	3	-1	-3
7	Men in counseling are not macho.	-2	2	-3	-2
8	Counseling doesn't help men because it focuses on feelings.	-2	0	0	0
9	Men shouldn't talk about their problems.	-5	1	2	-1
10	Men in counseling are strong.	0	-5	-3	5
11	Counseling would enhance men's lives.	2	-2	-2	2

		Factor			
	Statement	I	II	III	IV
12	Counseling would help men with their relationships.	4	0	0	0
13	Men can ask for help.	3	-4	3	4
14	Men in counseling are forced to address the problems in their lives.	1	-1	4	1
15	Men in counseling are normal.	1	-5	0	5
16	Men in counseling are weak.	-4	1	1	-1
17	Counseling is really only good for women.	-4	-3	-1	3
18	Counseling puts someone else in control of your life.	-2	1	-4	-1
19	Men in counseling are wasting their money.	-2	-1	0	1
20	Men go to counseling because others make them.	0	4	-2	-4
21	Men in counseling only talk and take no action.	-1	0	-1	0
22	Counseling is not a waste of time for men.	2	-2	-1	2
23	Counseling is helpful for some men.	3	2	0	-2
24	Men shouldn't be ashamed to be in counseling.	4	0	-4	0
25	If a man goes to counseling it doesn't mean he's crazy.	2	2	-3	-2
26	Men should go to counseling if they need to.	5	4	1	-4
27	Counselors generally care about men.	1	2	-3	-2
28	Counseling is mysterious for men.	0	3	-2	-3
29	Counseling would give men an edge over their competition.	0	0	-1	0
30	Counselors might want to have sex with their male clients.	-3	-3	-5	3
31	Men shouldn't share problems with strangers.	-2	-3	3	3
32	Men aren't emotional.	-3	-1	3	1
33	Men in counseling are effeminate.	-4	-2	4	2
34	Counseling helps men reduce stress.	2	-2	2	2
35	Counseling can help men deal with issues.	5	-1	0	1
36	Counseling can fix problems for men.	1	-3	-1	3
37	Counselors don't understand men's problems.	-3	-4	-2	4
38	Counseling is a way for men to vent their problems.	3	2	5	-2
39	Men in counseling can share their problems.	3	-4	4	4
40	Men are more closed and need help opening up.	2	5	1	-5
41	Men in counseling will feel uncomfortable.	0	4	0	-4
42	It's ok for men to express their emotions in counseling.	4	-1	1	1

		Factor			
	Statement	***I***	***II***	***III***	***IV***
43	Counseling helps men control their emotions.	1	-1	2	1
44	Men don't have time to go to counseling.	-1	1	-5	-1
45	Men should only share problems with those close to them.	-1	1	1	-1
46	Men go to counseling because they need a professional, third-party perspective.	1	0	1	0
47	Counseling would show fear to men's competitors.	-1	-2	-4	2
48	Men need a specific reason for going to counseling.	0	3	3	-3