Males’ Expectations of Counseling

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MALES’ EXPECTATIONS OF COUNSELING

by

Sheryl Kelly

A dissertation submitted to the Graduate College
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
Counselor Education and Counseling Psychology
Western Michigan University
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Doctoral Committee:

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In today’s society, a man upholding masculinity alone is not enough. There is a constant need to “prove” their masculinity. Men’s inability to recognize when they are experiencing stress, strain, and sickness is noted as being due to them being socialized to ignore their feelings (Wilson, n.d.). Although research that addresses the concept of help-seeking has expanded, it continues to be limited in its focus on men. In addition, not much attention has been given to counseling expectations. The purpose of the present study is to expand the current knowledge base on men and their counseling expectations. This study examined the relationship that SES, counseling stigma, ethnic identity, and counseling barriers have with males’ counseling expectations. One hundred and thirty-two males participated in this study. A canonical analysis provided support in examining the relationships between the predictor variables and outcome/criterion variables. Findings from the canonical analysis supported the proposed hypothesis. Although this study contributes to the limited research on counseling expectations, specifically the counseling expectations of men, further exploration is need.
ACKNOWLEDGMENTS

“I can do all things through Christ who strengthens me” (Philippians 4:13).

Words cannot express how thankful and humbled I am to have made it this far. This journey has been full of joy and some pain, but because of God, I am victorious. Thank You Jesus!

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To God be the glory!

Sheryl Kelly
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CHAPTER I

INTRODUCTION

The Research Problem

In today’s society, a man upholding masculinity alone is not enough. There is a constant need to “prove” their masculinity. Men’s inability to recognize when they are experiencing stress, strain, and sickness is noted as being due to them being socialized to ignore their feelings (Wilson, n.d.). The nature of “manliness” is described as being emotionally inexpressive (Wilson, n.d.). Balswick (1982) calls it “male inexpressiveness” and defines an inexpressive male “as one who does not verbally express his feelings, either because he has no feelings or because he has been socialized not to.” Skovholt (1978) defines the phenomenon as “restrictive emotionality” since men find it difficult to openly express their feelings, be vulnerable, and release control of their emotions. Bill Pollack (1998) has referred to this process as the “normative trauma of male socialization,” and Ron Levant (1992) defines it as “normative aleythimia,” which occurs when men are taught to exhibit characteristics that are “strong, stiff-upper lip, tough, hard, and nonfeminine masculinity” (as cited by Jordan, 2010).

American men are more hesitant and less willing than women when seeking counseling services (Cheatham, Shelton, & Ray, 1987; Rice, 1978; Sher, 1979, 1981; & Chesler, 1972). Research shows that men are less likely to voluntarily seek counseling services, unless they are legally mandated to do so (O’ Neil, 1981; Fischer & Farina,
It is safe to say that men’s avoidance of counseling is not due to them being more psychologically healthy (Robertson & Fitzgerald, 1992). In addition to mental health difficulties associated with restrictive emotionality, gender role conflict has been reported to possibly decrease one’s psychological well-being (Sharpe & Heppner, 1991). It is further believed that the masculine socialization process plays a large role in men’s unwillingness to voluntarily participate in counseling. As noted by Robertson (2001), “Traditional counseling requires men to set aside much of their masculine socialization simply to get through the door and ask for help” (p. 148).

It is easy to see how traditional male socialization could lead men to avoid help-seeking. Help-seeking is a coping method that is purposed to aid individuals in adapting to behaviors and concerns (Gulas, 1974). It has been suggested that men who actively seek help and support are classified as weak, vulnerable, and potentially incompetent (O’Neil, 1981; McCarthy & Holliday, 2004). Cultural norms that men are socialized to abide by are believed to promote “fear of femininity” within some men (O’Neil, 1981). This fear of femininity can manifest itself in one or a combination of patterns of behavior: (a) restrictive emotionality; (b) socialized control, power, and competition; (c) homophobia; (d) restrictive sexual and affectionate behavior; (e) obsession with achievement and success; and (f) health care problems (O’Neil, 1981). As a result of asking for help being associated with femininity, men are more likely to “avoid” seeking services (Smith, 2002).

Men experience more conflict about help-seeking as they become more socialized to norms associated with masculinity (Levant & Pollack, 1995). According to Vogel,
Wester, and Larson (2007), the “perceived barriers” that are associated with the utilization of counseling services can be affected by cultural beliefs, norms, and values. For instance, feelings of failure may be experienced by a man who is aware of the need to ask for help (Vogel, Wester, & Larson, 2007). Men of color likely experience additional barriers to seeking counseling. Sue and Sue (1999) suggested that minority clients may be suspicious toward white counselors, expecting them to maintain the “status-quo” (i.e., stereotypical views; positions of oppression and privilege). Furthermore, Smith (2002) noted that this suspicion is an extension of African American males’ belief that white counselors view them in an oppressive position that has resulted in harm. The broad impact of clients’ beliefs about counseling has been explored from the perspective of expectations.

Before an individual enters therapy, they have a generalized perception of what to expect during their counseling experience. Research indicates that expectancies produce experiences that effect one’s behavior and psychological function (Kirsch, 1985). It has been argued that the counseling expectations of clients shape the nature of communication and facilitate or hinder the benefits of therapy (Tinsley, Bowman, & Ray, 1988). Although previous research that has been conducted on clients’ expectations of therapy has produced mixed results, several common expectations have been identified. More specifically, counselors are expected to be warmly interested in each client; be a highly trained expert; be confident in their ability to help the client; be problem centered on a personal level; be thoroughly prepared for each session; be at ease with the presenting problem; and maintain confidentiality (Tinsley & Harris, 1974).
There is an understanding that the expectations of counseling vary by the individual. It has been suggested that counseling expectations affect whether a person enters counseling, and provide insight into what the perceived relationship between the counselor and client will be, predicting the clinical outcome (Satterfield, Buelow, Lyddon, & Johnson, 1995; Patterson, Uhlin, & Anderson, 2008). Research has specifically identified alliance ratings from the third session as predictors of the outcome of therapy (Horvath & Bedi, 2002). In addition, studies have shown that clients’ relationship expectation (expectation to spontaneously self-disclose and have an unbiased relationship with their therapist), and their expectation to accept responsibility for the work that they do throughout the therapeutic process are related to their perceived bond with their therapist (Al-Durmarki & Kivligher, 1993; Patterson, Uhlin, & Anderson, 2008). Expectations about counseling most often held by clients have been operationalized by H. E. A. Tinsley, Workman, and Kass (1980) who identified four expectation factors: Personal Commitment (the client’s self-expectations about motivation, openness toward counseling, and responsibility in the counseling process); Facilitative Conditions (the client’s expectations for acceptance, genuineness, trustworthiness, and confrontation); Counselor Expertise (the client’s expectations that his or her counselor will be knowledgeable, empathetic, and directive) and; Nurturance (the client’s expectations for support and care from his or her counselor).

**Purpose of the Study**

The purpose of the present study is to expand the current knowledge base on men and their counseling expectations. It is believed that an individual’s decision to enter
counseling and their preconceived perception of the effectiveness of therapy is based on their expectations of counseling (Tinsley, et al., 1988). However, there has not been enough research conducted on men, especially men of color, in counseling. The author believes that if men do not get their mental health needs met, their interpersonal, intrapersonal, and vocational relationships will be inhibited. The author expects this research to provide those in mental health professions with insight on how to more effectively market and tailor services for men and provide non-traditional mental health services to men. More specifically, a canonical correlation analysis will be used to observe if there are relationships between a set of predictor variables previously identified as important predictors of help-seeking (socio-economic status, counseling stigma, counseling barriers, and ethnic identity) and set expectations about counseling. For this study, expectations about counseling are operationalized using the Expectations About Counseling Questionnaire - Brief Form (EAC-B), and the four subscales (i.e., personal commitment, facilitative conditions, counselor expertise, and nurturance) will be observed. Due to the uniqueness of each sub-scale and its potential to provide unique information that may not be gained through the full scale score, the researcher decided to treat each subscale as an independent scale. Previous research has utilized canonical analysis when utilizing this scale because of the uniqueness of the individual sub scales (Schuab & Williams, 2007; Scatterfield, et al., 1995). Though there is a need to obtain much information on men in regards to counseling and expectations, the literature review will focus primarily on understanding male gender roles and how they may create resistance or hesitancy towards men potentially participating in counseling. As a result, the research hypothesis has been limited to the following:
Hypothesis 1: SES, counseling stigma, counseling barriers, and ethnic identity will be related to expectations about counseling. This hypothesis will be analyzed with SES, counseling stigma, counseling barriers, and ethnic identity as the predictor variables, and expectations about counseling as the outcome variable.

Summary

Chapter I demonstrated that counseling expectations are an understudied variable, and are significant in the outcome of the counseling process. In addition to there being limited research on men and counseling, research on the counseling expectations of men is also limited. However, there are some conceptual ideas about how the socialization of male gender roles may interact with counseling expectations and create counseling barriers. Chapter II will review the relevant literature on male gender role socialization and help-seeking, men of color and their experiences of gender role socialization, counseling barriers, counseling stigma, and counseling expectations. Chapter III reviews the research methods and procedures utilized in this study, which include the participants, measures, procedures, and research design. Chapter IV provides descriptive statistics for the present sample and the results of the canonical analysis conducted for this study. A discussion of these results is provided in Chapter V.
CHAPTER II

LITERATURE REVIEW

Introduction

Although research that addresses the concept of help-seeking has expanded, it continues to be limited in its focus on men. In addition, not much attention has been given to counseling expectations. The purpose of this chapter is to review the literature surrounding men and counseling expectations. The literature reviewed will address help seeking and male gender role socialization, men of color (i.e., African American, Hispanic American, American Indian, and Asian American), counseling stigma, and counseling expectations. This chapter concludes with the identified purpose of this study and the research hypothesis.

It has been suggested that the privileged position that men hold because of their gender makes it difficult for them to be viewed as disadvantaged (Wester, 2008). However, the focus that counseling has on verbal expression can put men in a disadvantaged position because they have been socialized to believe that disclosure can lead to their masculinity being challenged (Brooks, 1998). Fallon and Bawles (2001) reported that individuals that willingly seek counseling gain the ability to better adapt to changes, while experiencing less behavior and emotional problems. Research has consistently shown that men are less likely to seek counseling, harbor negative attitudes toward counseling, and are less willing than women to seek therapy for psychological
problems regardless of culture, race, or ethnicity (Addis & Mahalik, 2003; McCarthy & Holliday, 2004; Smith, Tran, & Thompson, 2008). However, men’s reluctance to seek counseling does not shield them from the negative effects of emotional and psychological problems (Addis & Mahalik, 2003). Given this paradox, researchers are driven to identify reasons why men are reluctant to utilize counseling services. Their underutilization of psychological resources has been identified as a social problem (O’Brien, Hunt, & Hart, 2005).

One way to help clarify this paradoxical phenomenon may be to examine those variables that may influence men’s expectations for counseling. This researcher examined variables that may relate to the differing expectations of counseling that men may hold. This literature review is purposed to emphasize the need for research that focuses on the counseling expectations of men. The following literature review begins with overviews of help-seeking and gender role socialization for men. It then summarizes related literature for men of color, the stigma associated with counseling, and counseling expectations from the perspective of clients and non-clients. Afterwards, the purpose of the study will be presented, along with the research hypothesis.

**Male Gender Role Socialization and Help-seeking**

As a result of the field of psychology acknowledging the significance of having a multicultural focus, the fact that one’s world-views are shaped by gender and other factors such as race and ethnicity is becoming more explicit (Schaub & Williams, 2007). O’Neil (1981) identified “restricted emotionality” as a pattern within men that insinuates the control that they have over their emotions and feelings, which is parallel to their
desired control over managing occurrences and people in their lives (Harris & Harper, 2008). The following sections will provide a cultural view of male gender role socialization as it relates to gender role conflict and counseling barriers, counseling stigma, and counseling expectations.

According to Brook and Good (2001), it would be beneficial for gender, especially for men, to be viewed as a culture. Kimmel (1994, p. 122) stated that “manhood means different things at different times, to different people. We come to know what it means to be a man in our culture by setting our definitions in opposition to a set of “others” – racial minorities, sexual minorities, and above all, women.” Furthermore, he believed that “masculinity must be proved, and no sooner proved that it is again questioned and must be proved again” (Kimmel, 1994, p. 122). Due to men being socialized to be stoic, interpersonally dominant, and self-reliant, they tend to resist and experience shame when they feel vulnerable and are involved in intimate relationships (Addis & Mahalik, 2003; Real, 2002; Pollak, 1995). Through learning to repress their vulnerability, feelings of shame and fears of being ridiculed are often avoided by men (Krugman, 1995). A review concerning men and help-seeking noted that “men are often characterized as unwilling to ask for help when they experience problems in living. Popular stereotypes portray men as avoiding seeking needed help from professionals. A large body of empirical research supports the popular belief that men are reluctant to seek help from health professionals” (Addis & Mahalik, 2003, p.5).

Research suggests that women are more willing to acknowledge a problem, even if the symptoms or issues are minimal (Adamson, Ben-Shlome, Chaturvedi, & Donovan, 2003; Hunt, Ford, Hawkins, & Wyke, 1999; Wyke, Hunt, & Ford, 1998). Participating in
therapy requires men to face what they have been socialized to avoid. Men are asked to be vulnerable, seek help when it is needed, and give up control, which goes against the essence of how they, according to society, should be (Robertson & Fitzgerald, 1992). For example, African American men expect to be socially embarrassed when seeking mental health services (Cooper-Patrick, Crum, Powe, Pratt, & Ford, 1995). By refusing to attend therapy or by presenting themselves as being stoic or by acting out, men unconsciously attempt to prevent therapeutic relationships from developing (Good, Thomson, & Brathwaite, 2005). According to Good (1998), men are also believed to not have a lot of experience and skills in expressing their vulnerable feelings and understanding them.

Results from previous research have indicated that men that attribute counseling to femininity (i.e., having to express their emotions) are less willing to participate in career counseling (Graef, Toker, & Kaut, 2010). This rejection of counseling is due to their belief that it goes against what it means to be a man. In a study conducted by Graef et al. (2010), the results indicated that men who adhere to the traditional roles of masculinity devalue career counseling, view it as a sign of weakness, and believe it to be shameful. Research has also shown that men who reported that they suppress their emotions and avoid affectionate behavior with men, have more stigma toward career counseling (Rochlen & O’Brien, 2002; Graef, Tokar, & Kaut, 2010). Furthermore, the stigma of seeking treatment is the most noted reason for avoiding the experience of feelings that are painful for the individual (Vogel, Wade, & Haake, 2006; Komiya, Good, & Sherrod, 2000; Corrigan, 2004; Corrigan & Penn, 1999). To resolve the discomfort that they experience as a result of having to repress their feelings, men may express their
feelings to their partner or to others that they trust, which allows them to comfortably operate outside of their gender roles.

Men’s views of counseling are the result of teachings gained at an early age that are purposed to instruct them to avoid self-disclosing because their masculinity could be challenged (Brooks, 1998). Masculine socialization is the process through which men exemplify masculine characteristics that society believes that they should display (O’Neil, 1981). Men abiding by cultural gender roles produce negative consequences that manifest themselves cognitively, affectively, and behaviorally in individuals (O’Neil, et al., 1986). Men’s refusal to acknowledge weakness or needing help is identified as key indicators of one’s masculinity (Courtenay, 2000). Cultural expectations are developed through one’s experiences. According to the social constructivist theory, gender is constructed based on what is at risk in certain situations including race, ethnicity, sexual orientation, and class (Mansfield, Addis, & Mahalik, 2003). “By dismissing their healthcare needs, men are constructing gender” (Courtenay, 2000, p. 1389). Men are taught that repressing their emotions results in them being viewed as strong and invulnerable. Previous research has shown that men tend to “endure pain and be strong and silent about “trivial” symptoms, and especially about mental health and emotional problems” (O’Brien, 2005, p. 514). These characteristics are strongly identified as being associated with masculinity. This suggests that boys being socialized to be masculine results in them eventually detaching themselves from the vulnerable emotions needed to nurture others (Wester, 2008).

Seeking help, especially for issues that are not critical is believed to challenge one’s masculinity and present conflict in gender roles. Male gender roles shape
worldviews and differ between races and cultures. Gender role conflict is defined as a “psychological state in which specialized gender roles have negative consequences on the person or others” (O’Neil, Good, & Holmes, 1995, p. 166). Gender role conflict has been hypothesized to be a result of conflict that exists between one’s self-concept and societal gender expectations (Schuab & Williams, 2007). Due to this conflict, men are at risk of being limited in reaching their full potential, or of preventing other men from reaching their potential so that societal and cultural expectations may be maintained (Schuab & Williams, 2007).

Heppner (1995) believed that some of the concerns that men have are inclusive of gender role issues as they relate to respective cultures. Male gender roles vary across backgrounds, race, and cultures (Wade, 1996; Kimmel & Messner, 2004). For instance, the socializing experiences of African American men are not the same as those of White men (Franklin, 1987; Wade, 1996). Previous research has demonstrated that traditional approaches to therapy lack the sensitivity needed when explaining the unique experiences of people of color and men (Wester, 2008). This is demonstrated through the majority of men in the United States being socialized to assimilate to the dominant European American culture of masculinity, which teaches men to not verbally express their emotions (Wester, 2008). Due to the perceived emphasis on being emotionally expressive in therapy and there being a risk of gender role violation, men are likely to approach therapy in a cautious manner (Addis & Mahalik, 2003). In addition, researchers have reported men to be unwilling to seek help in cases where they do not want to acknowledge physical, emotional, and sexual problems (McKee, 1998, p. 601), they choose not to take responsibility for their health (Calman, 1993), or they feel the need to
maintain “constricting gender roles” (Maharaj, 2000; Good & Dell, 1989). Due to there being an emphasis on individuals openly expressing their emotions while in therapy, men may see a need to be highly cautious to prevent gender role conflict (Addis & Mahalik, 2003) or appearing weak (Bereger, Levant, McMillan, Keheller, & Sellers, 2005).

Theoretical models that have been used to illustrate the experiences of white men in the United States note that males are socialized to embrace characteristics that require them to restrict and suppress their emotions, strive for independence and achievement, and avoid all things that are associated with femininity and homosexuality (Wester, 2008). This requires men to operate from a position of ego centrality, which is determined by society to demonstrate “their ability to be emotionally cool under pressure and solve problems on their own” (Mansfield et al., 2003). A man’s inability to meet the cultural standards may result in him feeling ostracized, ridiculed, and ashamed.

According to research, gender role conflict is believed to increase “psychological maladaption” (Blazina & Watkins, 1996, 2000, 2001; Cournoyer & Mahalik, 1995; Good, Dell, & Mintz, 1990; Good et al., 1995; Good, Robertson, Fitzgerald, Stevens, & Bartels, 1996; Hayes & Mahalik, 2000; Mahalik & Cournoyer, 2000; Sharpe & Heppner, 1991; Simonsen, Blazina, & Watkins, 2000). This conflict may manifest itself in four different patterns:

1. Men’s desire to achieve and be successful, that is demonstrated through their success, power, and competitive nature.
2. Men restricting their emotions and feelings.
3. Men not allowing themselves to express their emotions to other men demonstrates how they have been socialized to not be vulnerable with other men.

4. Men’s difficulty with balancing work and family is demonstrated through conflict that exists between work and family (Wester, 2008).

The power that men have is believed to play a role in the negative attitudes that men have about counseling. Freud (1937; 1963) perceived men to experience feelings of inferiority or a loss of their power at the thought of considering participating in therapy. This loss of power was also suggested in a therapeutic model that was developed by Tracey (1985) and built upon by Blazina and Watkins (1996). Blazina and Watkins (1996) suggested that men’s anticipation of losing power in therapy may result in them not participating in therapy due to gender role conflict, or terminating prematurely. In addition, cultural roles and expectations, particularly those of men of color, may play a role in their underutilization of counseling.

**Gender Role Socialization and Men of Color**

The methods of how gender roles are learned and experienced are based on one’s cultural experiences. Cultural norms are known to define gender roles (Lazur & Majors, 1995). It is often understood by men that they are required by society to perform specific behaviors that are believed to help them to achieve success in certain situations. This performance in order to achieve success is referred to as a “conversation” (Lazur, 1983, 1992). In the process of the conversation, men come to know what it means to be a man within the realm of his culture (Lazur & Majors, 1995). The acceptance of projected self-
images, which are demonstrated through one’s self-presentation, is influenced by societal norms (Lazur & Majors, 1995; Goffman, 1959). Although the behaviors may result in success in some situations, they may become maladaptive in others. Race and sexual orientation are dimensions that make things more complex, resulting in more situational conflict (Wester, 2008). It is important to be aware of this within-group variation between men in general, as well as variations among men (people) of color.

The fact that diverse groups of men experience conflict in gender role messages is a common theme in the literature (Wester, 2008). Men of color are not considered to be a part of the dominant culture, which results in them experiencing economic setbacks and societal discrimination (Lazur & Majors, 1995). In addition to racism and oppression, men of color experience a struggle between meeting the demands of their culture and the demands of the “popular” dominant culture. In order for men of color to belong, they are expected to adopt the expectations of the dominant culture. It is highly necessary for men of color to find a way for their cultural and male identities to healthily coexist with economic and social obstacles (Lazur & Majors, 1995).

Men of color must integrate the restrictions of the dominant society in order to define their gender role (Lazur & Majors, 1995). Men of color measuring themselves against the standards of the male dominant culture does not grant access to the same opportunities, resulting in men of color continuing to experience frustration, emotions that cannot be freely expressed, and a continuous drive to survive (Lazur & Majors, 1995). The U.S. Surgeon General (Satcher, 2003) observed that men of color are often “overlooked and underserved” by the mental health system. This may support a sense of invisibility, defined as an individual’s internal struggle with feelings that their
personality, talents, abilities, and sense of self-worth are not of any value and are not acknowledged because of prejudices and racism (Franklin, 1999). The development of one’s racial identity, which influences individuals’ perception of the environment and how they interact with it at different stages, is believed to influence how men of color display their masculinity (Franklin, 1999).

“The values and beliefs of cultures such as African American, Asian American, Latina/os, and Native American Indians… can change and enrich our practices in a reconstructed view of the help-seeking process” (Ivey, 1993, p. 225). For example, within Asian cultures, an emphasis is placed on “family hierarchy, emotional restraint, avoidance of shame, and saving “face” (Shea & Yeh, 2008; Flakerud & Liu, 1990; Uba, 1994; Zane & Yeh, 2002). Research has also suggested that clinicians may not recognize symptoms that American Indians identify as important, or understand their fears, needs, and concerns (Johnson & Cameron, 2001). In order for clinicians to work effectively with culturally diverse populations, it is important to have an awareness of more culturally defined gender role socialization and experienced barriers.

According to Mansfield, Addis, and Mahalik (2003), “gender role socialization theories hold that social environments from the level of culture down to individual family and peer relationships, teach men and women to display distinct sex-typed behaviors and attitudes.” “Alexithymia,” which is defined as “meaning without words,” is believed to potentially be the result of male gender role socialization (Levant, 1998). In addition, higher levels of “alexithymia” has been associated with men’s experiences with restricted emotionality (Fischer & Good, 1997; Shepard, 1994), increased paranoia and psychoticism (Good, Robertson, Fitzgerald, Stevens, & Barel, 1996), fear of intimacy
(Cournoyer & Mahalik, 1995; Fischer & Good, 1997; Good et al., 1995), higher levels of depression (Cournoyer & Mahalik, 1995; Good & Mintz, 1990; Good, et al., 1996), greater hostile-submissive personality styles (Mahalik, 2000), and higher levels of anxiety, anger, and personality styles similar to those of substance abusers (Blazina & Watkins, 1996). Although psychological dysfunction is correlated with traditional male gender roles, men continue to demonstrate hesitancy towards seeking counseling (Cheatham, Shelton, & Ray, 1987). Identified psychological barriers that are associated with fear of help-seeking are anticipated costs (Vogel & Wester, 2003), avoidance of addressing information that causes distress (Cepeda-Benito & Short, 1998; Cramer, 1999; Kelly & Achter, 1995; Vogel & Wester, 2003); avoidance of experiencing painful emotions (Komiya, Good, & Sherrod, 2000), and avoidance of negative judgments or social stigma (Deane & Chamberlain, 1994). This section will include detailed descriptions of male gender role socialization and associated barriers, and perceptions of therapy from the perspectives of several racially/ethnically diverse groups: African American, Hispanic American, American Indian, and Asian American.

**Cultural socialization and barriers to counseling for African American men.**

Research concerning the psychological experiences and mental health concerns of African Americans has significantly increased over the past three decades (Snowden, 2001; Wheley, 2001). According to the National Survey of Black Mental Health (Jackson, Neighbors, & Gurin, 1986), although African Americans sought services due to mental anguish, only 9 percent of the individuals surveyed received services from a mental health professional. In comparison to White Americans, African Americans are likely to attend fewer counseling sessions, if any, and terminate prematurely (Sue & Sue,
Researchers have suggested that African Americans underutilize mental health services due to certain barriers: (a) Racial and cultural barriers such as cultural mistrust (Terrell & Terrell, 1984; Whaley, 2001) and racial identity (Parham & Helms, 1981); (b) Service access barriers such as transportation, lack of flexibility in work schedules, and little to no knowledge of mental health resources (Snowden, 1998, 2001; Thompson, Bazile, & Akbar, 2004); and (c) Economic difficulties (Snowden, 1998, 2001). African Americans are more likely than others to receive emergency care (Hu, Snowden, Jerrell, & Nguyen, 1991), which may be due to them being forced or legally obligated to receive treatment (Akutsu, Snowden, & Organista, 1996; Takeuchi & Cheung, 1998). As of 2006, although 12% of the American population was African Americans, only a small percentage were represented in mental health professions (e.g., 2% psychiatrists, 2% social workers, and 2% psychologists), which results in not enough African American professionals being available to African American clients (Calloway, 2006).

Furthermore, African American men with mental illnesses that are undetected and not treated are more susceptible to substance abuse, incarceration, homelessness, homicide, and suicide (HHS, 1999).

Many African American men believe that help for them is not accessible as long as there is a lack of appreciation of what it means to be Black and male in a society that is dominated by European American culture (Franklin, 1999). According to White (1984), African American’s attempts to imitate the ways of the dominant culture results in experienced inferiority. African American men have been stereotyped as being moreso animalistic than human. Much of the research that has focused on African American men is negative and characterizes them as being unintelligent, substance abusers, violent,
sexual predators who are incarcerated and unemployed (Johnson, 2006). In addition to being labeled an “endangered species” (Gibbs, 1984, 1989), “Black males are particularly vulnerable to gender role identity problems” (Pleck, 1981, p. 25). According to Franklin (1999), in order for African American men to make their way in a society that has immersed itself in European American culture, they must translate the behavior that others demonstrate towards them and respond in a manner that represents who they are. This is done with the expected outcome being that visibility, victory, and self-validation are gained (Wester, 2008).

African American men gaining validation, respect, and a sense of belongingness from those within the African American community may grant them the sense of visibility that has not been given to them by mainstream society (Wester, 2008). To belong, perspectives and behaviors are adopted by the individual. Men of color are known to utilize survival techniques to aid in protecting them against feelings of inferiority and oppression (Lazur & Majors, 1995). African American males have adopted the “cool pose” as a coping strategy (Majors, 1983, 1986, 1988, 1990, 1991, 1994; Majors & Mancini Billson, 1992), which is defined as “a ritualized form of masculinity that entails behaviors, scripts, physical posturing, impression management, and carefully crafted performances that deliver a single, critical message: pride, strength, and control (Majors & Mancini Billson, 1992, p. 4). The “cool pose” is purposed to provide African American men with senses of protection, pride, and social competence (Lazur & Majors, 1995). Furthermore, it has produced an awareness of African American males’ distrust in the dominant culture (Lazur & Majors, 1995). This strategy is a proclamation of him being an African American male.
African American men experience living in a society that often prevents them from meeting African American and European American cultural expectations. Meeting one set of gender roles may result in conflict existing with other gender roles (Wester, 2008). African American men are typically able to function productively due to them effectively incorporating values and behaviors from both cultural gender roles (Cose, 2002). By doing so, African American men are able to maintain a balance between maintaining cultural values, support and interpersonal relationships, along with integrating behaviors that would allow them to succeed in the dominant European American society (Wester, 2008).

Maintaining the strategy of the cool pose comes at a cost. Heterosexual relationships are jeopardized because of the need that African American men have to protect themselves from the dominant culture (Lazur & Majors, 1995). This strategy also comes at the cost of mistreatment of self and others. African American males’ inability to be vulnerable and express themselves, and the constant pressure to prove themselves to be manly men may result in them coping through unhealthy behaviors (e.g., alcoholism or substance abuse) (Lazur & Majors, 1995).

Block (1981) suggested that as a result of African American men being socialized to suppress emotions that develop as a result of daily life experiences, they are not likely to voluntarily seek mental health services. Individuals that identify as having a mental illness have admitted to being embarrassed and feeling ashamed because of their psychological concerns (Snowden, 2001). This feeling of embarrassment is considered to be a barrier that is more significant for African Americans, in comparison to Whites (Snowden, 2001). African Americans, in particular, are believed to avoid psychological
services because they are not normalized in their culture, and to prevent them from being seen as “crazy people” (Constantine, Chin, & Ceesay, 1997; Thompson, Bazile, & Akbar, 2004). Research has indicated that African American men’s help-seeking attitudes are more negative than African American women, which has shown to be consistent across other ethnic and racial groups (Wallace & Constantine, 2005; Lopez et al., 1998; Lucas, 2002; Luedders, 1998; Tedeschi & Willis, 1993). Previous research that has focused on African American males that have participated in therapy reported that they end therapy prematurely, are not satisfied with the therapy, and have few successful outcomes (Nickerson, Helms, & Terrell, 1994; Ridley, 1984; Terrell & Terrell, 1981). In addition, therapists report African American males to be nonresponsive and evasive during therapy sessions (Campbell-Flint, 2000; Ridley, 1984).

The cultural environment of African American men is believed to shape how they are socialized, and how African American men and youth are able to establish positive relationships with their health and psychosocial development (Akbar, 1991; Crawley & Freeman, 1993; Hare & Hare, 1985; Lee, 1996; Majors & Bilson, 1992; Oliver, 1989). In lieu of the fact that African Americans continue to experience the societal pressures of discrimination and racism, their cultural traditions are believed to provide them with a vast amount of community, respect, commitment, and spirituality that play a role in them developing positive attitudes, behaviors, and values (Lee, 1997).

**Masculinity and cultural expectations of Hispanic American males.**

Traditionally, Hispanic American men are socially viewed as the authority or dominant figure in the family (Baruth & Manning, 1999; Paniagua, 1998). They are expected to be “strong, dominant, and the provider for the family” (Sue & Sue, 1999, p. 293).
Unfortunately, these men may not be able to meet their culture’s expectations due to barriers that are experienced (e.g., immigration or racism/discrimination) resulting in psychological distress (Fragoso & Kashubeck, 2000). When discussing Hispanic American males, it is important for three things to be acknowledged: (a) The diversity within the group; (b) Their interpretation of their experiences and the importance of using them to gain more awareness and understanding of the daily issues faced by Hispanic American males; and (c) Due to there being variations within this group, there is also diversity of beliefs and values (Wester, 2008). Hispanic American men are believed to abide by the machismo code, which emphasizes the importance of honor, virility, and physical strength (Ruiz, 1981; Stevens, 1973; Valdes, Baron, & Ponce, 1987). However, this concept is identified as being an inaccurate, overly simplistic description that is taken from dated, racist research (Wester, 2008).

Machismo is considered to be a bipolar construct that consists of two poles. The poles provide a more informed understanding of the concept. The negative pole emphasizes an exaggerated form of masculinity that requires Hispanic American men to abide by traditional roles, illustrating control, maintaining self-esteem, and avoiding all situations that may present them as being weak (Mirande, 2004). The demonstration of assertive, respective, and responsible behaviors are recognized as being on the positive pole of machismo (Mirande, 2004). In the European American culture, men that are dominant, strong, and economically successful are considered to be the ideal (Wester, 2008). The men that do not meet the standards of the dominant culture work to find a balance so that he may reconcile any differences and integrate the standards of both White and Latino culture (Lazur & Majors, 1995).
Avila and Avila (1988) believe Hispanic Americans are “looked upon as foreigners who have to be acculturated…usually at the expense of his or her own cultural heritage” (p. 311). Acculturation is the process of how one adjusts to a new environment and the new culture, and their integration of both cultures. Previous research has indicated that an inconsistent relationship between acculturation and mental health exists. For example, in some studies mental health among Hispanic Americans is reported to be better when acculturation levels are high (Moyaman & Forman, 1992; Rogler, Cortes, & Melgady, 1991; Golding & Burr, 1990; Griffith, 1983; Mena, Padilla, & Malonado, 1987; Torres-Maturillo, 1976). Other studies have shown lower acculturation to have the same effect that high acculturation is reported to have on mental health (Bumam, Hough, Karno, Escobar, & Telles, 1987; Krause, Bennett, & Van Tran, 1989; Moscicki, Locke, Rae, & Boyd, 1989). However, gender role conflict may be experienced as a result of the acculturation process (Cuellar, 1995).

**Cultural expectations and barriers to help-seeking for American Indian males.** American Indians are also known to underutilize mental health services. Compared to nine percent of individuals in the general population, thirteen percent of individuals in the American Indian population have been reported to experience distress frequently (U.S. Department of Health & Human Services, 2001). Psychological and physiological problems that are experienced by American Indians are culturally believed to be a result of “human weaknesses” (LaFromboise, Trimble, & Mohatt, 1990). For American-Indians, culture plays a vital role. Their ability to avoid help from others during weak moments is required in order for cultural values to be maintained, and is recognized as cultural respect (LaFromboise, Trimble, & Mohatt, 1990). Although
literature on help-seeking behaviors within this population is limited, identified cultural barriers to American Indian’s help-seeking behaviors are inclusive of the role of social-cultural factors, the clinician’s understanding of how their culture can influence the help-seeking behaviors of American Indians, and trust related issues (Johnson & Cameron, 2001).

American Indians have learned to not trust services provided by the government and white practitioners (U.S. Department of Health & Human Services, 2001). The dominant culture has worked to overrule American Indian males and their culture (Braveheart-Jordan, 1993; Schroeder, 1991). This has resulted in a lack of role models available to American Indian males, and conflict between the American Indian culture and the dominant culture (Lazur & Majors, 1995). Unlike other cultures, American-Indians identify themselves as individuals that are extensions of the tribe which “provides them with a sense of belonging and security, with which they form an interdependent system” (Sue & Sue, 1990, p. 177). In addition to everyone having an essential role in the functioning of the tribe, behaviors are evaluated based on how the tribe is benefited. If an individual in the tribe is experiencing a problem, it is seen as a community problem. The community is supportive in alleviating the concern with little force (LaFromboise, Trimble, & Mohatt, 1990).

Acculturation is also important to consider when referring to American Indians. Johnson and Cameron (2001) reported that American Indians, as a result of history, have “learned through governmental practices of planned genocide, separation of children from families, broken treaties, and general disrespect” that their cultural identity is not considered to be worth retaining (p. 217). Gender role conflict may be an issue when
individuals seek to completely adopt the values of the dominant culture and not value their own culture. A Tsimshian Indian, Doug Modig, declared, “Our culture has been destroyed” (Weaver, 1988, p. 43). The American-Indian males’ inability to maintain the role of the protector (during the war) resulted in him losing an important identity. Protecting his community is no longer achievable due to self-hatred and learned helplessness that develops as a result of pain that they cannot avoid (Lazur & Majors, 1995). Through time, Native American males have witnessed their culture being taken away from them, while experiencing a sense of powerlessness, hopelessness, and depression. Attempting to integrate the expectations of both cultures has proved to be difficult and unsuccessful (Lazur & Majors, 1995).

**Socialization and conflict experienced by Asian American males.** All Asian Americans are unfortunately treated alike in society because of the dominant culture’s inability to distinguish among Asian subgroups and their refusal to acknowledge within group diversity (Lazur & Majors, 1995). Unlike other groups, Asian American males’ masculinity is defined by the relationships that they have with their family and business (Wester, 2008). In addition to being overlooked by the dominant European American culture without receiving much assistance from society, they are still expected to fulfill their obligations to work, provide for, and raise their family and contribute to the economy (Lazur & Majors, 1995). The successes that follow from these expectations often result in an image of Asians Americans as the model minority (Chua & Fujino, 1999); this image, however, glosses over and justifies the effects that occur as a result of racism, and the dominant culture’s lack of responsibility for acknowledging their role in
the issues that other men of color experience (e.g., African American) (Lazur & Majors, 1995).

Like previously mentioned groups, Asian Americans underutilize mental health services. Approximately half of the Asian American population is not proficient in the English language. In addition, not many mental health providers are able to effectively communicate with Asian Americans, resulting in services being limited (U.S. Department of Health and Human Services, 2001). Research has found Asian American men to be less likely to seek help from informal services (i.e., family members; friends) (Young, 1998; Chang & Subramaniam, 2008). Young’s (1998) research demonstrated that of the 17 percent of Asian American individuals that sought services for psychological issues, only 6 percent went to a mental health professional.

Asian American cultures place men in a position of high regard, while requiring them to suppress their emotions. (Lazur & Majors, 1995). In the Asian American culture, much value is placed on the family name and how certain behaviors will reflect on the family. Therefore, much attention is placed on the values of the family to aid them in avoiding negative perceptions from others (Webster & Fretz, 1978), remaining silent and not acknowledging problems publically, and avoiding help-seeking (S. Sue & Kitano, 1973). Therefore, problems are more often resolved within the context of the family rather than through outside resources. In addition, since traditional psychotherapy tends to focus on the individual, Asian-Americans may consider it to be inappropriate because focusing on oneself is believed to be selfish.

Chan (1992, p. 9) noted that “The distinction between the public and private self is really the very important concept in Asian cultures. The public self is that which
conforms to gendered and familial role expectations. The public self-behaves in a manner which follows social norms, which seeks to avoid actions which would bring shame upon one’s family and one’s community…. The private self is never seen by anyone other than one’s most intimate relationships.” An Asian American males’ ability to integrate, who he is publically and privately, is based on how much he has immersed himself in his culture (Lazur & Majors, 1995). Asian American men feel pressured to perform the gender roles of multiple cultures and coexist in “two different gender roles” (Sue, 2001; Chua & Fujino, 1999). Within the context of his culture and societal demands, he attempts to understand his gender roles.

Summary

Research has demonstrated that men continue to have negative views towards counseling, and are not willing to seek counseling (Addis & Mahalki, 2003; McCarthy & Holliday, 2004; Smith, Tran, & Thompson, 2008). Men of color commonly underutilize mental health services, and experience pressure to assimilate to gender roles of their culture and the “dominant” culture. This literature review has demonstrated that gender role expectations across cultures create barriers to help-seeking. Gender role expectations also play a role in creating a sense of stigma to those who do seek counseling.

Counseling Stigma

A stigma is defined as a behavior that is socially unacceptable (Blaine, 2000). The “stigma associated with seeking mental health services, therefore, is the perception
that a person who seeks psychological treatment is undesirable or socially unacceptable” (Vogel, Wade, & Haake, 2006, p. 325). Research has demonstrated that stigma is a contributing factor in the underutilization of mental health services (Corrigan, 2004; Komiti, Judd, & Jackson, 2006; Vogel, Wade, & Hackler, 2007b). How individuals conform to behaviors is an indicator of what behaviors will be normed (Asch, 1955). Quite a few people who have reported experiencing interpersonal and psychological concerns are not likely to seek counseling (Corrigan, 2004). According to the surgeon general’s report in 1999 and research conducted by Addis and Mahalik (2003), a fear of being stigmatized was identified as the cause of individuals not acknowledging that a problem exists and not seeking counseling services (Satcher, 1999). This fear of being stigmatized is highly existent in men, which is a part of how they have been socialized in their gender roles (Satcher, 1999).

There have been reports of counseling clients receiving more stigma than nonclients (Vogel et al., 2007). For example, Asian Americans risk being stigmatized as weak, and inflicting shame upon their family if they seek professional mental health services (Leong & Zachan, 1999; Vogel, Wester, Wei, & Boyen, 2005). Marriages and employment can also be affected if someone in the Asian American community is identified with a mental illness (U.S. Department of Health & Human Services, 2001). The Native American community stresses the importance of individuals receiving strength from sources available within the community (LaFromboise et al., 1990). They are socialized to receive guidance from the Native American church and some tribes (LaFromboise et al., 1990).
The stigma that comes with seeking mental health services is also a barrier for African Americans (Ayalon & Alvidrez, 2007; Thompson, Bazil, & Akbar, 2004). To prevent being referred to as “crazy people,” African Americans choose not to utilize mental health services (Constantine, M. G., Chen, E. C., & Ceesay, P., 1997; Thompson, V. L. S., Bazile, A., & Akbar, M., 2004). The African American church is historically noted to have “served as a foundation for psychological, spiritual, social, and economic support for many African Americans” (Queener & Martin, 2001; Boyd-Franklin, 1989; Dunn & Dawes, 1999; Frame, Williams, & Greene, 1999; Hines & Boyd-Franklin, 1996; Karenga, 1980; Sue & Sue, 1999). In addition, Asian Americans and African Americans are believed to stigmatize those that have been diagnosed with psychological disorders more than Caucasians (Masuda et al., 2009).

Research has shown that individuals that have read vignettes that were not race specific and described individuals with mental illnesses, believed those that were diagnosed were dangerous and incompetent (Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). In contrast, Whaley’s (1997) research demonstrated a difference in perception when race and ethnicity were specified. Stigma towards individuals with mental illnesses was reduced for whites when they were in contact with those that were mentally ill (U.S. Department of Health & Human Services, 2001). However, stigma was not reduced for African Americans, when in similar situations. In comparison to whites, Asian and Hispanic Americans identified individuals with mental illnesses to be more dangerous (U.S. Department of Health & Human Services, 2001). These results suggest that mental illnesses are stigmatized more within ethnic and minority racial groups.
Considering the negative stigma that is directed to counseling clients, it is not surprising that individuals prefer to avoid seeking counseling services to prevent harm from being stigmatized (Corrigan and Matthews, 2003). The results of research conducted by Vogel et al. (2007) indicated that “perceptions of the public stigma associated with mental illness predicted the self-stigma associated with seeking counseling, which in turn, predicted attitudes toward seeking help and, finally, willingness to seek counseling services for psychological and interpersonal concerns.” Furthermore, it is believed that men may internalize the stigmatization more than women because of the fact that seeking counseling services goes against traditional gender roles (Vogel, et al., 2007; Martin et al., 1997). Unfortunately, not much is known about stigma as it relates to males. However, the stigma that is associated with help-seeking creates the perception of a person being undesirable if they seek mental health services (Vogel, Wade, & Haake, 2006), which contributes to preconceived counseling expectations.

**Counseling Expectations**

Expectations have been identified as a significant factor that is a reflection of the characteristics of a client that are responsive to interventions used in therapy (Dew & Bickman, 2005; H. E. A. Tinsley, Bowman, & Barich, 1993; H. E. A. Tinsely, Bowman, & Ray, 1988). In addition, expectations appear to have a direct effect of the therapeutic working alliance (Patterson, Uhlin, & Anderson, 2008). Research has shown that counseling expectations and the assumed roles of the counselor significantly affect the counseling process (Bordin, 1955; Heilbrum, 1974; Tinsley & Harris, 1976). Role expectations have been reviewed, and identified as “patterns of behavior viewed as
appropriate or expected of a person who is in a particular position” (Arkoff, Glass, & Shapiro, 2002). Results of a study conducted by Patterson, Uhlin, and Anderson (2008) indicated that clients’ expectations of their personal commitment in therapy participation played a strong role in developing a working alliance. A client/therapist relationship that was strong, collaborative, and productive was better understood by clients that expected to participate in therapy (Patterson, et al., 2008).

Literature has shown that there are links between expectations and other counseling variables that are empirical and theoretical (Schub & Williams, 2007). Male gender role conflict is another variable that research has shown to be related to counseling expectations (Pederson & Vogel, 2007; Schaub & Williams, 2007; Segalla, 1995). Male gender roles that have persuaded men to work to fix their problems on their own, not acknowledge psychological concerns, and suppress their emotions (e.g., Levant, 1992; O’Neil, 1981) may result in their fear towards emotionally expressing themselves being magnified, an increase in stigma towards counseling, and a decrease in their willingness to seek help (Pederson & Voges, 2007). Men that were not comfortable with expressing their emotions with other men, have a hard time self-disclosing, and emphasize the importance of success and competition, expected counselors to be experts, but did not expect themselves to have personal responsibility throughout the counseling process (Schaub & Williams, 2007). This suggests that men that are experiencing high gender role conflict expect therapists to be highly directive and empathic, but they do not expect to personally participate (Schaub & Williams, 2007) On the other hand, men that have reported experiencing distress expect to be more willing to participate in therapy (Schaub & Williams, 2007).
Satterfield, Buelow, Lyddon, and Johnson (1995) conducted research that demonstrated that the state of change that was found to be inversely related to client expectations was the precontemplation stage. Individuals that have been identified as being in the precontemplation stage of change reported having “low expectations of making a personal commitment in counseling and low expectations that the counselor would create an environment conducive of change” (Shuab & Williams, 2007; Rotschek & Hershberger, 2005; Scatterfield, et al., 1995). Research has also shown that the stages of contemplation, action, and maintenance were positively associated with expectations (Scatterfield, et al., 1995). However, the counseling expectations of precontemplative clients in terms of acceptance, genuineness, trustworthiness, and confrontation were significantly lower (Scatterfield, et al., 1995).

An individual’s culture plays a major role in their development of what to expect from themselves and others, including mental health professionals (Patterson, 1958). Learned expectations are believed to be updated and repeated over time (Patterson, 1958). Research has shown that while European American college students do not expect their counselors to be highly directive and protective, African American college students expect for counselors to take a directive and nurturing authoritative approach (Yuen & Tinsley, 1981). Later research conducted by Kemp (1994) demonstrated that African American college students that were at a Historically Black College or University (HBCU) expected for counselors to be more directive, confrontational, genuine, accepting, nurturing, and more willing to self-disclose than the African Americans attending a White university. Asian American and African American college students
have reported expecting not to have as much of a personal commitment to therapy as European Americans (Kenny, 1994).

In traditional American Indian culture, therapy is purposed to take cultural values into account and consider the individual’s position within the community (LaFromboise, Trumble, & Mohatt, 1990). The values of the therapist are welcomed because the therapist respects the client’s values. In regards to counseling expectations, goals, and attitudes towards counseling in the American culture, a significant difference exists between American Indian clients and non-Indian clients (Trimble & Fleming, 1989).

Due to negative experiences, American Indians’ expectations of counseling are negative. American Indians have expressed concern that counselors’ focus will be on influencing and changing their values rather than tending to their presenting issues (LaFromboise, Trumble, & Mohatt, 1990). This negative outlook can hinder development of a trusting relationship between the client and therapist, resulting in an unhealthy and unbene ficial experience (LaFromboise, Dauphinais, & Lujan, 1981; Schoenfeld, Lyerly, & Miller, 1971).

Previous studies have acknowledged the importance of meeting the client’s expectations of counseling and a counselor (Watson, 2005; Subich and Coursol, 1985; Duckro, Beal, & George, 1979; Ziemelis, 1974; Frank, 1968; Goldstein, Heller, & Sechrest, 1966; Hein & Trosman, 1960; Goodstein & Grigg, 1959; Rosenthal & Frank, 1956; Bordin, 1955). Investigation of expectations being met in counseling producing positive outcomes produces mixed opinions. Research has demonstrated that clients expect counselors to be sensitive to their presenting concerns, understanding, sympathetic, and to acknowledge and deal with their expectations in an honest manner.
(Garfield & Wopin, 1963; Duckro, Beal, and George, 1979). Subich and Coursol (1985) noted that the expectations for openness, responsibility, and concreteness are expressed moreso from those that are seen individually than those that were in groups, which may be due to the belief that groups are riskier (Subich and Coursol, 1985). Current research has reported clients that are new to therapy expect therapists to operate from a psychodynamic approach (Glass, Arnkoff, & Shapiro, 2001). Counselors should be sensitive to the expectations of clients, acknowledge them, and realistically address them (Subich & Coursol, 1985). The counseling process may be disrupted if the counselor overlooks the expectations of the client and focuses only on their agenda (Hansen, Stevic, & Warner, 1982).

Client expectations are an understudied variable that can provide much insight into what is needed to develop a beneficial working alliance (Patterson, Uhlin, & Anderson, 2008). Clients’ counseling expectations determine how they will interact during the initial session (Tinsley, Tokar, & Helwig, 1994). Counseling expectations are inclusive of how the client expects to be treated in the event of a confrontation occurring during the session, how empathic, caring, and accepting the therapist is (Goldstein, 1962; Strong, 1968) or if the therapist will take an analytical or directive approach during therapy (Tinsley & Harris, 1976). Potential clients, regardless of their race, ethnicity, and college or community status, have predetermined expectations of themselves as clients and the counselor before attending their first session. Studying the counseling expectations of men will make counselors aware of men’s help-seeking behaviors and give some direction in determining the best interventions to utilize when working with men (Schaub & Williams, 2007).
Summary

The previously discussed research explores men and their experiences with male gender role socialization and help-seeking, unique counseling barriers experienced by men of color, counseling stigma, and counseling expectations. In addition, support for further exploration of each variable and men was provided. Although counseling expectations have been identified as an understudied variable, other variables have been shown to contribute to help-seeking. However, the relationships between counseling expectations and other predictors of help-seeking for men, specifically, is unknown. The canonical analysis that will be utilized in this present study is needed to examine the relationship among these sets of variables.

Due to continuing need for research concerning men and their underutilization of counseling services, the present study will examine the relationship between previously identified predictors of help-seeking and the counseling expectations of men.

Research Hypotheses

The purpose of the present study is to expand the current knowledge base on men and their counseling expectations. It is widely believed that an individual’s decision to enter counseling and their preconceived perception of the effectiveness of therapy is based on their expectations of counseling (Tinsley, et al., 1988). However, there has not been enough research conducted on men, especially men of color, in counseling. Though there is a need to obtain much information on this population in regards to counseling and expectations, the research hypothesis has been limited to the following:
Hypothesis 1: SES, counseling stigma, counseling barriers, and ethnic identity will be related to expectations about counseling. This hypothesis will be analyzed with SES, counseling stigma, counseling barriers, and ethnic identity as the predictor variables, and expectations about counseling as the outcome/criterion variables.
CHAPTER III

METHODS

Participants

Data for this study was collected from 201 males. Due to the online instrument being inadvertently opened before completed, 69 submitted questionnaires were declared incomplete and not included in this study. As a result, 132 males participated in this study. A total of 1.5% (n = 2) identified as American Indian, 2.3% identified as Asian/Pacific Islander (n = 3), 53.0% (n = 70) identified as African American/Black, 3.0% (n = 4) identified as Hispanic, 33.3% (n = 44) identified as White (not of Hispanic origin), and 6.8% (n = 9) identified as Bi-racial/Multi-racial. Participants’ ages ranged from 18 - 71 years (M = 34.26, SD = 13.05). Additionally, 16.7% (n = 22) had a high school diploma/GED, 31.1% (n = 41) had some college, 35.6% (n = 47) had a college degree, 11.4% (n = 15) had a master’s degree, and 5.3% (n = 7) had a doctorate degree. A total of 22.0% (n = 29) reported to have had previous counseling experience. The demographics of the participants are presented in Table 1. Table 1 also includes a summary of this information for African American men. This group of men is of particular interest because the group is large enough to allow some discussion of the experiences of men of color separately from the experiences of White men.
Table 1

Demographics and Percentages for Participants

<table>
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<tr>
<th>Participant Variables</th>
<th>Category</th>
<th>% Full Sample (N)</th>
<th>% American Indian (N)</th>
<th>% Asian/Pacific Islander (N)</th>
<th>% African American (N)</th>
<th>% Hispanic (N)</th>
<th>% White (N)</th>
<th>% Bi/Multi (N)</th>
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<td><strong>Age</strong></td>
<td>18-24</td>
<td>25.8 (34)</td>
<td>33.3 (1)</td>
<td>20.0 (14)</td>
<td>50.0 (2)</td>
<td>31.8 (14)</td>
<td>33.3 (3)</td>
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<td></td>
<td>25-34</td>
<td>34.0 (47)</td>
<td>100.0 (2)</td>
<td>40.0 (28)</td>
<td>25.0 (11)</td>
<td>25.0 (11)</td>
<td>44.1 (4)</td>
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<tr>
<td></td>
<td>35-44</td>
<td>19.8 (26)</td>
<td>66.7 (2)</td>
<td>21.6 (15)</td>
<td>25.0 (1)</td>
<td>18.2 (8)</td>
<td>11.1 (1)</td>
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<td></td>
<td>45-54</td>
<td>6.1 (8)</td>
<td>5.6 (4)</td>
<td>5.6 (4)</td>
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<td>31.4 (22)</td>
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Measures

Participants completed a demographic questionnaire designed for this study and 5 previously published measures: the Barratt Simplified Measure of Social Status (BSMSS) (Barratt, 2006), the Expectations About Counseling Brief Questionnaire (EAC-B) (Tinsley, Workman, & Kass, 1980), the Barriers to Help Seeking Scale (BHSS) (Mansfield, Addis, & Courtenay, 2005), the Revised Multigroup Ethnic Identity Measure (MEIM-R) (Phinney & Ong, 2007), and the Self-Stigma of Seeking Help Scale (SSOSH) (Vogel, Wade, & Haake, 2006).

Demographic Questionnaire

The Demographic Questionnaire is a 6-item self-report instrument designed by the researcher to obtain demographic information about the sample. This information included age, race/ethnicity, level of education, type of area raised in (i.e., rural, city, or suburbs), previous counseling experience, and number of sessions attended (see Appendix B).

Barratt Simplified Measure of Social Status (BSMSS)

The BSMSS (Barratt, 2006) is a measure of social status that was built from the work of Hollingshead (1957, 1975), who is known for developing a measure of Social Status that is based on marital status, retired/employed status (retired individual identified their former employment), education, and occupation. Two changes transformed the Hollingshead Four Factor Measure into the BSMSS: (1) Occupations listed in the measure are based on the work of Davis, Smith, Hodge, Hakao, and Treas (1991);
(2) The generational shift in social status was acknowledged. This is in respect to the educational attainment and occupational prestige of an individual’s parents, combined with the educational attainment and occupational prestige of the individual and their family (Barratt, 2012).

It is important to note that this measure does not produce absolute results for SES. To categorize SES, score on the BSMSS are in one of three categories of socio-economic status: low (8-27), middle (28-47), and high (48-66). According to Barratt (2012), because the BSMSS is not a scale, reliability was not considered to be an appropriate question to evaluate. However, validity was appropriate, and this scale is said to “provide a demographic question that helps frame an understanding of participants in a study” (Barratt, 2012).

**Expectations About Counseling Questionnaire – Brief Form (EAC-B)**

The Expectations About Counseling Questionnaire (Tinsley, Workman & Kass, 1980) was initially developed in the 1970’s. The EAC consists of 17 scales that focus on various expectancies about counseling, including client attitudes and behaviors, counselor characteristics, and quality of outcome. There are three or four items per scale on the short form, and each item is responded to on a 7-point continuum of *definitely do not expect this to be true* to *definitely do expect this to be true* (Subich & Coursol, 1985). Shortened by Tinsley (1982) from the original 203-item version of the EAC (Tinsley, et al., 1980), the EAC-B consists of 53 items answered on a 7-point Likert scale, ranging from not true (1) to definitely true (7) (Moore-Thomas & Lent, 2007). Larger scores on these indicate greater expectations for a behavior or characteristic.
The EAC was constructed to maximize both convergent and discriminant validities of items (Subich & Coursol, 1985). A factor analysis of the original EAC form indicated the presence of four factors: Personal Commitment, Counselor Expertise, Facilitative Conditions, and Nurturance (Subich & Coursol, 1985). The scale reliabilities of the EAC-B have been found to range from .69 to .81 (Tinsley, 1981). The brief scales have been reported to correlate well with the long form (.78-.95) and also to be more highly related to external validity criteria (Washington & Tinsley, 1982). Internal consistency for the initial study ranged from .77 to .89, with a median reliability of .82 (Tinsley et al., 1980). Cronbach’s alpha for the present study demonstrated good internal consistency for each of the subscales (Nurturance = .83; Personal Commitment = .93; Facilitative Conditions = .92; Counselor Expertise = .86).

**Barriers to Help Seeking Scale (BHSS)**

The BHSS (Mansfield, Addis, & Courtenay, 2005) was developed due to the authors’ awareness of men’s underutilization of help-seeking services. The authors designed this measure to increase awareness of the variables that men identify as barriers to their seeking help in the forms of mental health and physical health. This measure is a 54 item scale that focuses on why an individual may not seek help for a problem in their body. Forty-four of the items focus on help seeking in general, and the remaining 8 items focus on barriers that are specific to medical interventions (e.g., “It’s difficult for me to talk to doctors and health professionals.”).

This scale is inclusive of 5 subscales. Need for Control and Self-Reliance (10 items) focuses on concerns that seeking help will threaten one’s sense of autonomy and
their ability to function independently. Minimizing Problem and Resignation (6 items) focuses on concerns of the seriousness of problems experienced. Concrete Barriers and Distrust of Caregivers (6 items) focuses on concerns of lack of insurance, transportation, knowledge about resources, trust, and finances preventing one from seeking help. Privacy (5 items) focuses on concerns of physical and emotional vulnerability. Emotional Control (4 items) focuses on concerns of keeping emotions under control and not exposed to others.

Participants utilize a Likert scale that ranges from 1 to 7 (1 = strongly disagree; 7 = strongly agree) to rate the reason given for not seeking help for the described problem, and are presented with the following scenario: “Imagine that you begin to experience some psychological problem. The problem is not so overwhelming that you can’t function. However, it continues for a while and you notice it regularly. You consider seeking help from a professional. Below are several reasons why you might choose NOT to seek help. Please rate how you would describe yourself on each item with the scale from: 1 = strongly disagree; 2 = disagree; 3 = slightly disagree; 4 = neither agree nor disagree; 5 = slightly agree; 6 = agree; 7 = strongly agree.” The BHSS demonstrated coefficient alphas that ranged from .75 to .93, with an average of .84. (Mansfield, Addis, & Courtenay, 2005). The subscales also demonstrated very good internal consistency, with the following alphas: Need for Control and Self-reliance = .89; Minimizing Problem and Resignation = .75; Concrete Barriers and Distrust of Caregivers = .77; Privacy = .76; and Emotional Control = .85 (Mansfield, Addis, & Courtenay, 2005).
In the development of this scale, the test-retest reliability of total scores was found to be acceptable ($r = .73, p < .05$). However, the test-retest reliability of the subscales ranged from .35 to .94 ($M = .67$). Specifically, the subscales yielded the following test-retest reliability scores. Need for Control demonstrated marginally acceptable test-retest reliability ($r = .68, p < .05$). Minimizing the Problem and Resignation demonstrated poor test-retest reliability ($r = .35, p < .05$). Concrete Barriers and Distrust of Caregivers demonstrated excellent test-retest reliability ($r = .95; p < .01$). Privacy demonstrated acceptable test-retest reliability ($r = .79, p < .05$). Emotional Control demonstrated excellent test-retest reliability ($r = .93, p < .05$).

Validity was examined through observed correlations between the BHSS and the Gender Role Conflict Scale (GRCS; O’Neil, Good, & Holmes, 1986). Results indicated that the total score or the BHSS and GRCS were correlated ($r = .58$). The responses on the scales showed small to moderate correlations between the BHSS subscales and the GRCS subscales. However, consistent large correlations existed between the Minimizing Problem and Resignation subscale of the BHSS and each of the GRCS subscales. As predicted by the authors, there was a significant correlation between the Restrictive Emotionality subscale of the GRCS and the Emotional Control subscale of the BHSS ($r = .47$). Additionally, there was a significant correlations between the Success, Power, and Competition subscale of the GRCS and the Need for Control and Self-Reliance subscale of the BHSS ($r = .31$). Construct validity was also assessed by correlating scores on the BHSS with the Attitudes Towards Seeking Professional Psychological Help Scale (ASPPH). Results indicated that a negative correlation existed between the total score of...
the BHSS and the total score of the ASPPH ($r = -.55$), and the ASPPH negatively correlated with all of the BHSS subscales.

**The Revised Multigroup Ethnic Identity Measure (MEIM-R)**

The MEIM was developed by Phinney (1992) and was purposed to assess the strength of ethnic group identity (i.e., “a sense of belongingness within a group”). The scale has shown good reliability (i.e., alphas above .80) among a variety of ethnic groups. The revised Likert scale (Phinney & Ong, 2007) contains six statements, and consists of two factors, exploration (“a process-oriented developmental and cognitive component”) and commitment (“an affective and attitudinal component”) (Roberts et al., 1999). These factors are said to be “distinct processes that make separate contributions to the underlying structure of ethnic identity” (Phinney & Ong, 2007). Items are rated on a 5-point, partly anchored scale ranging from 1 (strongly disagree) to 5 (strongly agree). The MEIM-R is said to “provide a concise measure of the core aspects of group identity that determine the strength and security of ethnic identity or the degree to which ethnic identity has been achieved.” (Phinney and Ong, 2007). According to Phinney and Ong (2007), reliability analyses of the exploration and commitment subscales demonstrated good reliability (i.e., alphas of .76 for exploration; alphas of .78 for commitment; combined alpha of .81). Cronbach’s alphas for this scale demonstrated good internal consistency and are as follows: Exploration (.83); Commitment (.89).

Face and content validity of the MEIM were analyzed through conducted interviews and focus groups that investigated the relevancy of the items for groups of diverse minority adults. Several changes were made to the scale, as a result of the results
acquired from the interviews and focus groups (Phinney & Ong, 2007). The MEIM-R is said to concisely measure the core aspects of group identity that determine the degree of strength and security that one has in their ethnic identity. (Appendix C)

**Self-Stigma of Seeking Help Scale (SSOSH)**

The SSOSH (Vogel, Wade, & Haake, 2006) measures the experiences and internal reactions on individuals as it relates to their perspective of seeking mental health services based on the social stigmatization of mental health services. It is a 10-item scale that is inclusive of items such as “I would feel inadequate if I went to a therapist for psychological help.” Five of the items in this scale are reverse scored (i.e., “My self-confidence would NOT be threatened if I sought professional help.”). Items are rated on a 5-point, partly anchored scale ranging from 1 (strongly disagree) to 5 (strongly agree). Scale point 3 is anchored by agree and disagree equally. Higher scores are an indication of higher stigma and present a risk of mental health services being a threat to one’s self-worth (Pederson & Vogel, 2007). The sum of scores can range between 10 and 50 and would yield the following results: Total = 10-22 Low Stigma; Total = 23-32 Medium Stigma; Total = 33-50 High Stigma. Higher scores indicate higher stigma.

Internal consistency has been estimated to range from .86 to .90 and the 2-week test-retest reliability has been reported to be .72 in a sample of college students (Vogel, Wade, & Haake, 2006). Cronbach’s alpha for the present study demonstrated good internal consistency (.75). The SSOSH has been reported to have an unidimensional factor structure and validity has been demonstrated to be evident when the stigma scale is correlated with two variables: (a) attitudes toward seeking professional help ($r_s = -.53$ to -
and (b) intentions to seek counseling (-.32 to -.38) (Vogel et al., 2006). (Appendix D).

**Procedures**

Due to previous research demonstrating low percentages of multiculturally diverse participants, initially, the author used professional and social connections to identify rich populations of multiculturally diverse men. Although the Midwest was the author’s initial geographical target population due to accessibility, the author purposely broadened the search to include the United States. A variety of strategies to identify and recruit broadly diverse groups of men were exercised, and are inclusive of internet searches of college and university psychology programs and other departments on campuses, churches, social media, community events, and word of mouth. The author believes that her connection to African American churches in the Midwest resulted in more than half of the participants in this study being African American. Participants were asked to complete a survey through an online resource (i.e., survey monkey).

Each of the participants completed a demographic questionnaire, the Barratt Simplified Measure of Social Status, the Expectations About Counseling-Brief Form, the Barriers to Help-Seeking Scale, the Revised Multigroup Ethnic Identity Measure, and the Self-Stigma of Help-Seeking Scale. Participants were informed that completion of the measures would take up to 45 minutes.
Research Design

The purpose of this research was to see if social economic status, stigma, ethnic identity, and counseling barriers have a relationship with males’ counseling expectations. A canonical correlation analysis was performed to observe if there are relationships between a set of predictor variables (socio-economic status, counseling stigma, counseling barriers, and ethnic identity) and a set of criterion variables (expectations about counseling). The EAC-B has four subscales (i.e., personal commitment, facilitative conditions, counselor expertise, and nurturance). Due to the uniqueness of each sub-scale and its potential to provide unique information that may not be gained through the full scale score, each subscale was treated as an independent scale. Previous research has utilized canonical analysis when utilizing this scale because of the uniqueness of the individual subscales (Schuab & Williams, 2007; Scatterfield, et al., 1995).

According to Thompson (1984), canonical correlation analysis (CCA) should be used when examining relationships between a set of predictor variables and outcome variables when each contains at least two variables. CCA is appropriate when the goal is to study relationships between multiple predictor variables and multiple outcome variables (Stevens 2002). There are several advantages to performing CCA. First, according to Thompson (1991), utilizing multivariate techniques such as CCA limits the probability of Type I error anywhere within the study (Sherry & Henson, 2010). This analysis, along with other multivariate methods, has the ability to examine multiple variables of interest simultaneously (Henson, 2000; Fish, 1988; Henson in press; Thompson, in press). Another advantage is that CCA may be closely aligned with observed reality, which often includes multiple predictors influencing multiple outcomes.
(Sherry & Henson, 2010). Lastly, Sherry and Henson (2010) noted that CCA can be utilized instead of other parametric tests. For example, Henson (2000), Knapp (1978), and Thompson (1991) demonstrated that all of the parametric tests utilized in behavioral research may best be understood by performing CCA. Interestingly, CCA is said to be overlooked because of its flexibility and versatility (Henson, 2000). In the present study, a CCA was conducted in relation to the following hypothesis:

Hypothesis 1: SES, counseling stigma, counseling barriers, and ethnic identity will be related to expectations about counseling. This hypothesis will be analyzed with SES, counseling stigma (i.e., Self-Stigma), counseling barriers (i.e., Need for Control and Self Reliance; Minimizing Problem and Resignation; Concrete Barriers and Distrust of Caregivers; Privacy; and Emotional Control), and ethnic identity (i.e., Exploration; Commitment) as the predictor variables, and expectations about counseling (i.e., Nurturance; Personal Commitment; Facilitative Conditions; and Counselor Expertise) as the outcome/criterion variable.
CHAPTER IV

RESULTS

This chapter is inclusive of several sections. First, a report of preliminary analyses is provided. Next, descriptive statistics are given of each of the variables in the full sample, and specifically for African American males. Finally, this chapter concludes with the results of the canonical analysis conducted to identify relationships between the predictor variables (i.e., SES, counseling stigma [i.e., Self-Stigma], counseling barriers (i.e., Need for Control and Self Reliance; Minimizing Problem and Resignation; Concrete Barriers and Distrust of Caregivers; Privacy; and Emotional Control), and ethnic identity [i.e., Exploration; Commitment] and the outcome variables (i.e., counseling expectations – Nurturance, Personal Commitment, Facilitative Conditions, and Counselor Expertise) in this study.

Preliminary Analysis

Prior to conducting the canonical analysis, the data were screened for accuracy, missing data, outliers, and normality of distribution using SPSS 20. A total of 201 participants submitted their questionnaires online. Sixty nine cases were dropped from the analysis due to a procedural error, leaving a total of 132 participants for the main analysis. The researcher used graphical (histograms and qq plots) and statistical (skewness and kurtosis) observations to determine univariate normality among the variables. Additionally, multivariate normality was examined through a regression
analysis. The Kolmogorov-Smirnov test of normality demonstrated a violation of the assumption of normality for all variables except Counseling Barriers Concrete Barriers and Distrust of Caregivers, which is common in larger samples. Skew, histograms, and qq plots were examined to see the actual shape of the distribution. When examined, no variables were identified as problematic for the multivariate analysis. More specifically, Counseling Expectations Facilitative Conditions, had the largest skew (-.733), none were greater than 1. Therefore, the researcher proceeded with the analysis as planned.

**Descriptive Findings**

Means and standard deviations were computed for all of the observed variables in the study and are reported in Table 2. Means and standards deviations for each subgroup were also computed for all of the observed variables in the study and reported in Table 2. In addition, correlations were computed to determine the relationships between the observed variables in the study amongst the full sample (see Table 3). Correlations on the African American and White subgroups are also reported; these were the only subsamples with sufficient participants to this level of examination. Higher scores on the subscales of the Barratt Simplified Measure of Social Status (BSMSS), Expectations About Counseling (EAC-B), Multigroup Ethnic Identity (MEIM-R), and Barriers to Help Seeking (BHSS) measures indicate higher levels of each respective variable. Higher scores on Self-Stigma of Seeking Help (SSOSH), and Socio-economic Status (SES) also indicate higher levels for each respective variable.

Social status was observed using the Barratt Simplified Measure of Social Status (BSMSS) (Barratt, 2006). Scores for this measure can range from: 8-27 (low), 28-47
(middle), and 48-66 (high). The mean score for the full sample is 38.65 (SD = 13.50), which indicates that this sample is identified as middle class. Observed scores for the subgroups illustrated a diverse range of scores. While the American Indian subgroup was identified, according to the scale, as low SES, the remainder of the subgroups were identified as middle SES.

Counseling expectations were observed using the Expectations About Counseling Scale – Brief Form (EAC-B) (Tinsley, Workman, & Kass, 1980). The subscales for this measure include Nurturance, Personal Commitment, Facilitative Conditions and Counselor Expertise. Scores on each subscale can range from 1 to 7, with higher scores indicating higher expectations for the specified counseling behaviors or counselor characteristic. The mean scores for the full sample are the following: Nurturance (M = 4.81, SD = 1.45); Personal Commitment (M = 4.77; SD = 1.48); Facilitative Conditions (M = 5.15; SD = 1.37); and Counselor Expertise (M = 4.43; SD = 1.60). In respect to the observed scores of the subgroups, the Asian subgroup averaged higher in the area of Nurturance (Asian – M = 5.22; SD = 1.07), and the Hispanic subgroup averaged lower in the areas of Personal Commitment (Hispanic – M = 3.86; SD = 1.91), Facilitative Conditions (Hispanic – M = 3.87; SD = 2.10), and Counselor Expertise (Hispanic – M = 3.56; SD = 2.26). A score of 4 represents the “fairly true” response between 3 = somewhat true and 5 = quite true.

Basic descriptives in the study of Tinsley, Workman, and Kass (1980) for the development of the EAC-B varied. Men demonstrated a high expectation of Counselor Expertise and Nurturance. In addition, men had low expectations in the areas of Facilitative Conditions and Personal Commitment. More specifically, in the scale
development sample, men demonstrated a high expectation of Counselor Expertise and Nurturance and low expectations for Facilitative Conditions and Personal Commitment. (Tinsley, Workman, & Kass, 1980). The descriptives of the present study differ from those in the initial study of the development of the EAC. The present sample, in respect to the questions in this measure, responded with “fairly true” and “quite true” for questions that explored expectations for Nurturance (i.e., the client’s expectations for support and care from his or her counselor), Personal Commitment (i.e., the client’s self-expectations about motivation, openness toward counseling, and responsibility in the counseling process), Facilitative Conditions (i.e., the client’s expectations for acceptance, genuineness, trust-worthiness, and confrontation), and Counselor Expertise (i.e., the client’s expectations that his or her counselor will be knowledgeable, empathic, and directive).

Ethnic identity was assessed using the Revised Multigroup Ethnic Identity Measure (MEIM-R) (Phinney & Ong, 2007), and the two subscales within this measure (i.e., exploration and commitment) were observed. Total scores on each subscale range from 1 to 5, with higher scores indicating a stronger sense of ethnic identity. The mean scores for the full sample are the following: Exploration (M = 3.35; SD = .97); and Commitment (M = 3.77; SD = .94). A score of 3 on the MEIM-R represented the neutral response between 2 = disagree and 4 = agree. Interestingly, the White subgroup averaged lower than other subgroups in both Exploration (White – M = 2.98; SD = .97) and Commitment (White – M = 3.41; SD = .32). Additionally, American Indian and Asian males agree with committing to their ethnic identity, and Hispanic and Bi/Multi racial
males agree with exploring and committing to their ethnic identity. A score of 4 on the MEIM-R represents the “agree” response between 3 = Neutral and 5 = Strongly Agree.

Counseling barriers were assessed using the Barriers of Help Seeking Scale (BHSS) (Mansfield, Addis, & Courtenay, 2005). The subscales that were observed within this measure were: Need for Control and Self-Reliance; Minimizing Problem and Resignation; Concrete Barriers and Distrust of Caregivers; Privacy; and Emotional Control. Total scores range from 1 to 6 on each subscale, with higher scores indicating higher counseling barriers. The mean scores for the full sample are the following: Need for Control and Self-Reliance (M = 3.80; SD = 1.18); Minimizing Problem and Resignation (M = 4.07; SD = 1.11); Concrete Barriers and Distrust of Caregivers (M = 3.42; SD = 1.12); Privacy (M = 4.25; SD = 1.50); and Emotional Control (M = 3.85; SD = 1.37). A score of 3 represents the “slightly disagree” response and a score of 4 represents the “neither agree nor disagree” response between 2 = disagree and 5 = slightly agree. Overall both the full sample and the subgroups are reporting limited counseling barriers, which is similar to the results obtained in the scale development study.

Internalized stigma associated with participating in counseling was assessed using the Self-Stigma of Seeking Help Scale (SSOSH) (Vogel, Wade, & Haake, 2006). The scores on this scale can range from 10 to 50, and are interpreted as follows: 10-22 indicates low stigma; 23-32 indicates medium stigma; and 33-50 indicates high stigma. The mean score for the full sample is 23.80/medium stigma (SD = 6.12). The observed scores for the subgroups also indicated medium stigma. Basic descriptives statistics from the present study were similar to Vogel, Wade, and Haake’s (2006) initial study in the
development of SSOSH (M = 27.1; SD = 7.7). Both the full sample and the subgroups, are reporting only low-medium internalized stigma towards participating in counseling.

Table 2

Means and Standard Deviations of the Measured Variables

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<tr>
<th>Variables</th>
<th>Mean (SD) Full Sample N=132</th>
<th>Mean (SD) American Indian Males N=2</th>
<th>Mean (SD) Asian Males N=3</th>
<th>Mean (SD) African American Males N=70</th>
<th>Mean (SD) Hispanic Males N=4</th>
<th>Mean (SD) White Males N=44</th>
<th>Mean (SD) Bi/Multi Males N=9</th>
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Note. Values of SES are the mean of reported scores on one of three categories of socio-economic status (8-27 = low, 28-47 = middle, 48-66 = high) on the Barratt Simplified Measure of Social Status (BSMSS). The mean scores of Expectations of Nurturance, Expectations of Personal Commitment, Expectations of Facilitative Conditioning, and Expectations of Counselor Expertise are based upon a 7-point Likert scale (1 = not true, 7 = definitely true) on the Expectations About Counseling Questionnaire – Brief Form (EAC-B). The mean scores of Ethnic Identity Exploration and Ethnic Identity Commitment are based upon a 5-point scale (1 = strongly disagree, 5 = strongly agree) on the Revised Multigroup Ethnic Identity Measure (MEIM-R). Values of Counseling Barrier – Need for Control & Self-Reliance, Counseling Barrier – Minimizing Problem & Resignation, Counseling Barrier – Concrete Barriers & Distrust of Caregivers, Counseling Barrier – Privacy, and Counseling Barrier – Emotional Control are mean scores that are based upon a 7-point Likert scale (1 = strongly disagree, 7 = strongly agree) on the Barriers to Help Seeking Scale (BHSS). The reported means for self-stigma are based upon a sum of scores that can range between 10 and 50 (10-22 = Low Stigma, 23-32 = Medium Stigma, 33-50 = High stigma).

aStandard Deviations.
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**p<.01  *p<.05

Note. Correlations for the full sample (N=132) appear on the top row for each variable. Correlations for the African American subgroup (N=70) appear on the second row in parentheses for each variable, and correlations for the White subgroup (N=44) appear on the bottom row and are underlined.
**Research Hypotheses**

Socio-economic status, counseling stigma, barriers, and ethnic identity will be related to expectations about counseling. A canonical analysis was conducted using the 4 expectations subscales (i.e., Counseling Expectation Nurturance, Counseling Expectation Personal Commitment, Counseling Expectation Facilitative Conditions, and Counseling Expectation Counselor Expertise) as outcome variables of the 9 predictor variables (i.e., Ethnic Identity Exploration, Ethnic Identity Commitment, SES, Counseling Barrier Need for Control and Self-Reliance, Counseling Barrier Minimizing Problem and Resignation, Counseling Barrier Concrete Barrier and Distrust of Caregivers, Counseling Barrier Privacy, Counseling Barrier Emotional Control, and Self-Stigma) to evaluate the multivariate shared relationship between variable sets. The analysis yielded four functions with squared canonical correlations ($R_c^2$) of .231, .101, .085, and .010 for each successive function. Collectively, the full model across all functions was statistically significant using the Wilke’s $\lambda = .63$ criteria, $F(36, 447.69) = 1.654, p = .011$. Due to Wilke’s representing the variance unexplained by the model, $1 - \lambda$ yields the full model effect size in an $r^2$ metric (Sherry & Henson, 2005). Thus, the $r^2$ effect size for the set of four canonical functions was .374 ($1 - .626 = .374$), which indicates that the full model explained about 37% of the variance shared between the variable sets.

The dimension reduction analysis allows the researcher to test the hierarchal arrangement of functions for statistical significance (Sherry & Henson, 2005). It was previously noted that the full model (Functions 1 to 4) was statistically significant, $F(36, 447.69) = 1.654, p = .001$. The remaining functions, Function 2 to 4 ($F(24, 348.64) = 1.066, p = .381$), Function 3 to 4
(F(14, 242.00) = .874, p = .588), and Function 4 to 4 (F(6, 122.00) = .201, p = .976) did not explain a statistically significant amount of shared variance between the variable sets.

Looking at the functions individually, functions 1 and 2 were the only functions that were noteworthy, due to the observed $R_c^2$ effects for each function (23.1% and 10.1% of shared variance respectively). The remaining functions were sufficiently weak to warrant interpretation, explaining only 8.5% and 1% of the remaining variance in the variable sets after the removal of the prior functions.

Table 4 presents the standardized canonical function coefficients and structure coefficients for Functions 1 and 2. In addition, the structure coefficients ($r_s$) and the commonality coefficients ($h^2$) across the two functions for each variable are also given. Looking at Function 1, the relevant predictor variable was Ethnic Identity Exploration, with Ethnic Identity Commitment, Counseling Barriers Need for Control, Counseling Barriers Minimize Problems, Counseling Barriers Emotional Control, and Self-Stigma making additional contributions to the synthetic predictor variable. This conclusion is supported by the squared structure coefficients, which are an indication of the amount of variance the observed variable can contribute to the synthetic predictor variable (Sherry and Henson, 2005).

Typically the variables with the largest structure coefficients are also the variables with the largest canonical function coefficients. Canonical function coefficients summarize the weight of each variable in the canonical function equation. For Function 1, Ethnic Identity Commitment and Self Stigma had modest function coefficients, but large structure coefficients, which is a result of the multicollinearity that these two variables had with other predictor variables. Ethnic Identity Commitment has a high correlation with Ethnic Identity Exploration, which was the variable yielding the strongest structure coefficient in this set. In addition, Self-
Stigma has a high correlation with Counseling Barriers Emotional Control, which is the also a strong structure coefficient. It is safe to assume that the linear equation that used the standardized coefficients to combine predictor variables in Function 1 only modestly incorporated the variance of the Ethnic Identity Commitment and Self-Stigma variables, when these variables could have contributed significantly to the created synthetic predictor variables (as shown by $r_s$ and $r_s^2$).

Table 4 also provides information about the variables contributing to the synthetic criterion variable for Function 1. Review of the squared structure coefficients indicates that each of the counseling expectation variables (i.e., Personal Commitment, Facilitative Conditions, Counselor Expertise, and Nurturance) were primary contributors to the outcome synthetic variable. Finally, the canonical correlation results indicate that the predictor variables Exploration and Total Commitment were positively related to counseling expectations, while the predictor variables of Minimizing Problem and Resignation, Emotional Control, and Self Stigma were negatively related to the counseling expectation variables. This means that when ethnic identity (Exploration and Commitment) is high and counseling barriers (Need for Control, Minimize Problems, Concrete Barriers, and Emotional Control) are low, men expect to be committed and for counseling to be a facilitative process. In addition, men expect the counselor to be an expert and to provide a nurturing atmosphere.

Information about the variables that are contributing to the synthetic criterion and predictor variables for function 2 is also provided in table 4. Within this function, the largest predictor variables were SES, Counseling Barriers Need for Control, Counseling Barriers Concrete Barriers and Distrust of Caregivers, and Counseling Barriers Emotional Control. Other variables that contributed to the synthetic predictor variable were Ethnic Identity Commitment,
Concrete Barriers Minimize Problems and Resignation, and Concrete Barriers Privacy. This conclusion is supported by the observed shared variance demonstrated by the squared structure coefficients. Looking at the weight of each variable in the canonical function for function 2, Counseling Barriers Concrete Barriers and Distrust of Caregivers and Counseling Barriers Privacy had modest function coefficients, but large structure coefficients, indicating the multicollinearity that these two variables had with other predictor variables.

With respect to the synthetic criterion variable, review of the squared structure coefficients indicates that several of the counseling expectations variables (i.e., Counseling Expectations Personal Commitment, Counseling Expectations Facilitative Conditions, and Counseling Expectations Nurturance) were primary contributors to the synthetic criterion variable. The observed pattern of structure coefficients demonstrated a pattern that contrasts Counseling Expectations Personal Commitment and Counseling Expectations Facilitative Conditions with Counseling Expectations Nurturance. Counseling Expectations Counselor Expertise did not contribute. The first identified pattern in function 2 demonstrated that when SES is high, Ethnic Identity Commitment is low, and all of the counseling barriers are low, men expect to be committed to counseling and for counseling to be a facilitative process. In addition, men with these characteristics expect lower levels of nurturance in the counseling environment. In contrast, when SES is low and Ethnic Identity Commitment and counseling barriers are high, men expect to have a lower level of personal commitment and a lower expectation of counseling being a facilitative process. Furthermore, men with those characteristics expect a more nurturing counseling environment.
Table 4

*Canonical Solution for SES, Counseling Stigma, Barriers, and Ethnic Identity Predicting Counseling Expectations*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Function 1</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coef.</td>
<td>$r_s$</td>
<td>$r_s^2$</td>
<td>Coef.</td>
<td>$r_s$</td>
<td>$r_s^2$</td>
<td>$h^2$</td>
</tr>
<tr>
<td>Ethnic Identity Exploration</td>
<td>.600</td>
<td>.688</td>
<td>47.33</td>
<td>-.182</td>
<td>-.262</td>
<td>6.86</td>
<td>54.19</td>
</tr>
<tr>
<td>Ethnic Identity Commitment</td>
<td>-.057</td>
<td>.472</td>
<td>22.28</td>
<td>-.197</td>
<td>-.322</td>
<td>10.37</td>
<td>32.65</td>
</tr>
<tr>
<td>SES</td>
<td>-.036</td>
<td>.076</td>
<td>0.58</td>
<td>.474</td>
<td>.624</td>
<td>38.94</td>
<td>39.52</td>
</tr>
<tr>
<td>Counseling Barriers - Need for Control</td>
<td>.328</td>
<td>-.311</td>
<td>9.67</td>
<td>-.535</td>
<td>-.710</td>
<td>50.41</td>
<td>60.08</td>
</tr>
<tr>
<td>Counseling Barriers - Minimize Problems &amp; Resignation</td>
<td>-.499</td>
<td>-.498</td>
<td>24.80</td>
<td>.311</td>
<td>-.349</td>
<td>12.18</td>
<td>36.98</td>
</tr>
<tr>
<td>Counseling Barriers - Concrete Barriers &amp; Distrust of Caregivers</td>
<td>-.113</td>
<td>-.196</td>
<td>3.84</td>
<td>-.282</td>
<td>-.646</td>
<td>41.73</td>
<td>45.57</td>
</tr>
<tr>
<td>Counseling Barriers – Privacy</td>
<td>.435</td>
<td>.214</td>
<td>4.58</td>
<td>.143</td>
<td>-.420</td>
<td>17.64</td>
<td>22.22</td>
</tr>
<tr>
<td>Counseling Barriers - Emotional Control</td>
<td>-.525</td>
<td>-.526</td>
<td>27.67</td>
<td>-.383</td>
<td>-.578</td>
<td>33.41</td>
<td>61.08</td>
</tr>
<tr>
<td>Self-Stigma</td>
<td>-.165</td>
<td>-.488</td>
<td>23.81</td>
<td>.095</td>
<td>-.179</td>
<td>3.20</td>
<td>27.01</td>
</tr>
</tbody>
</table>
Table 4—Continued

| Variable                                     | Function 1 | | Function 2 | |
|----------------------------------------------|------------|----------------|------------|
|                                              | Coef.      | $r_s$          | $r_s^2$(%)  | Coef.      | $r_s$          | $r_s^2$(%)  | $h^2$(%)   |
| $R_c^2$                                      |            | 23.10          | 10.12       |            |                |             |            |
| Counseling Expectations - Personal Commitment| -.859      | .728           | 53.00       | .567       | .365           | 13.23       | 66.23      |
| Counseling Expectations - Facilitative       | 1.07       | .874           | 76.39       | .850       | .444           | 19.71       | 96.10      |
| Conditions                                   |            |                |             |            |                |             |            |
| Counseling Expectations - Counselor Expertise| .307       | .796           | 63.36       | -.291      | .239           | 5.71        | 69.07      |
| Counseling Expectations - Nurture            | .545       | .820           | 67.24       | -1.13      | -.430          | 18.49       | 85.73      |

*Note.* Structure coefficients ($r_s$) greater than .30 are underlined. Communality coefficients ($h^2$) greater than 30% are underlined. Coef = standardized canonical function coefficient; $r_s$ = structure coefficient; $r_s^2$ = squared structure coefficient; $h^2$ = communality coefficient.
CHAPTER V

DISCUSSION

The purpose of this study was to expand the current knowledge base on men and their counseling expectations. This study examined the relationship that SES, counseling stigma, ethnic identity, and counseling barriers have with males’ counseling expectations. An abundance of literature has suggested that male gender role socialization has resulted in the development of barriers to counseling (O’Neil et al., 1995; Good et al., 1989), and expectations that pursuing counseling will result in the development of more gender role conflict (Cheatham, Shelton, & Ray, 1987; Berger et al., 2005). The findings of this study can provide basic information about the counseling expectations held by men, and the counseling barriers that they report. Some understanding of the relationship that exists between demographic variables, counseling barriers, and counseling expectations is also provided, demonstrating a view that is beyond the conceptual observations that are cited in the literature review. This present chapter begins with the study hypothesis and summarized findings, which are presented in the context of previous research on counseling expectations. This chapter concludes with a discussion of the implications of this study, limitations of the study, and recommendations for future research.

Review of the Study’s Hypothesis

Hypothesis 1: SES, counseling stigma, counseling barriers, and ethnic identity will be related to expectations about counseling.
Hypothesis 1 predicted that SES, counseling stigma (Self-Stigma), counseling barriers (Need for Control & Self-Reliance, Minimizing Problem & Resignation, Concrete Barriers & Distrust of Caregivers, Privacy, and Emotional Control), and ethnic identity (Exploration and Commitment) would be related to males’ expectations about counseling; this hypothesis was supported. Descriptive statistics further indicated that overall, these men expressed moderately high (corresponding to response choice of “fairly true”) expectations that their counselor would provide nurturance and facilitative conditions. Although their expectation of their counselors being experts was somewhat lower, they reported a moderately high expectation of personal commitment to counseling. Interestingly, the men in this study endorsed to disagree with or have a neutral perspective towards counseling barriers (i.e., Need for Control, Minimize Problems & Resignation, Concrete Barriers, Privacy, and Emotional Control) and low-medium counseling stigma.

The results of the canonical correlation analysis indicated that Functions 1 and 2 best described the relationships between the observed variables. The first function indicated that men that have an elevated sense of ethnic identity, low counseling barriers, and low self-stigma have high expectations of personal commitment. Additionally, their expectations of counselors being experts and providing a facilitative and nurturing environment are fairly high. The second function indicated that three out of the four expectations variables are predicted by a combination of the predictor variables. The observed results demonstrate that men with high SES, and low ethnic identity commitment and counseling barriers expect to be committed to counseling and for the
process to be facilitative. However, they may experience difficulty in believing that
counselors can demonstrate care and concern towards them.

Function 2 can also provide information about relationships between counseling
barriers and counseling expectations when SES is low and Ethnic Identity is high. In this
case, expectations of personal commitment and facilitative conditions would be expected
to be low while the expectation of nurturance would be high. Men with low SES and
high Ethnic Identity might be assumed to have been socialized to traditional gender roles
(Addis & Mahalik, 2003; Real, 2002; Pollak, 1995), and/or have experienced their
manhood being repeatedly questioned, resulting in an internal determination to continue
to demonstrate traditional expressions of masculinity. Previous research has found that
clients that demonstrate low expectations of personal commitment and facilitative
conditions are in the precontemplative stage (Satterfield et al. 1995). The expectation of
nurturance can possibly result in emotional expression, which is risk of gender role
violation (Addis & Mahalik, 2003). Therefore, it is important for counselors to be
flexible in their approaches with men, and allow them to identify their definition of
therapeutic change (Wester, 2008).

**Implications for Future Research and Counseling**

The objective of this study was to examine the relationships that exist between
SES, counseling stigma, counseling barriers, ethnic identity, and counseling expectations
of men. Although counseling expectations is an understudied variable, several studies
have emphasized the significance of counseling expectations and their effect on the
outcome of the counseling process. The literature has progressed in acknowledging the
role that culture plays in counseling expectations. However, there is a gap in the research on the counseling expectations of men. This present study focused on the counseling expectations of men and the relationship that exists between these expectations and SES, counseling stigma, counseling barriers, and ethnic identity.

The hypothesis in this study was supported by the findings. This study demonstrated that SES, counseling stigma, counseling barriers, and ethnic identity are related to the counseling expectations of men. The two observed functions demonstrated that men with high counseling expectations are more connected to their ethnic identity, and have low counseling barriers and self-stigma towards counseling. The second function demonstrated that as men’s SES decreases, they have a lower expectation of personal commitment and counseling being a facilitative process; however, they do expect the counselor to provide a nurturing environment. The second function also highlights the negative relationship between counseling barriers (especially Need for Control & Self-Reliance and Emotional Control) and expectations of personal commitment and facilitative conditions.

The findings from this study should challenge therapists and mental health professionals to not be led by their assumptions of men. The men in this study endorsed moderately high (corresponding with the response choice of “fairly true”) expectations of making a personal commitment to counseling, and moderately high expectations that counselors would provide facilitative conditions, expertise, and nurturance. In addition their views of counseling were not highly “stigmatized.” These findings provide some direction for therapists and mental health professionals in their efforts to determine effective interventions to utilize in their work with men. Counselors should modify their
expectations to focus on providing men with an environment that will promote a more action oriented process, assisting them in their growth development. Although nurturance may be viewed as a feminine characteristic, it has been identified as an environment that men expect counselors to provide. However, this may not be true for men who are higher in SES and lower in Ethnic Identity Commitment, since the second function demonstrates that they have a lower expectation of nurturance. Whether or not counseling expectations are perceived to be positive or negative, and the influence that counseling expectations have on men’s decision to participate in counseling would be a great addition to this research. Furthermore, counselors should be thoughtful in their implementation of nurturance into counseling, and keep in mind the cultural and societal messages that men have received.

Although men in this study have reported counseling expectations that could be perceived positively (e.g., expectations of making personal commitment; expectations of facilitative conditions), it is understood that some men may continue to resist participating in traditional counseling. Counselors would benefit from considering non-traditional forms of therapy (i.e., psychoeducational training; workshops; community intervention), particularly when targeting men of color. It is important for counselors to ensure that marketing efforts do not promote weakness and femininity when advertising to men. For example, an effective method of advertising may focus on problem solving or guided help.

These findings have implications for therapists and other mental health professionals. Previous research has demonstrated that culture plays a significant role in an individual’s counseling expectations (Patterson, 1958). This study provides insight
into the observed variables that are related to the counseling expectations of men of color. Understanding what men of color expect in counseling provides therapist and mental health professionals with a non-stereotypical view that can possibly counteract any preconceived views that may be held about men of color. For example, men of color may be more successfully engaged in counseling when it is presented as helping them fulfill expected family and community roles. Intercorrelations for the measured variables, in addition to the full sample, were specifically observed for the African American and White subgroups because they accounted for the majority of the participants in this study. Although some similarities exist, some differences in can also be seen. For example, correlations between Ethnic Identity Exploration and Counseling Barriers Privacy, Ethnic Identity Commitment and Counseling Barriers Privacy, and Counseling Barriers Privacy and Self-Stigma are different between the African American and White subgroup. This suggests that counseling barriers may differ amongst groups of people, however, more research is needed to determine these differences. Since there is much more to learn about African American men, it would be beneficial to get a larger sample of African American men and examine them alone.

Future research should assess more diverse populations of men, including African American men. In addition to counseling expectations being an understudied variable, there is not much known about the counseling expectations of men, specifically men that are culturally diverse. The present study included seventy African American men, two American Indian men, three Asian men, four Hispanic men, and nine Bi/Multi-racial men. The researcher believes that if the research was more “culturally sensitive,” more men would have participated in the study. “Cultural sensitivity” would have been
demonstrated through a shorter survey and the provision of hard copies of the surveys to participants. This research may also produce more extensive results in the form of a qualitative study.

**Contributions and Limitations of the Study**

Due to research on counseling expectations being limited, this study fills a gap in the literature. This research provides needed extension of counseling expectations, and while focusing on men, addresses the relationship between their counseling expectations and SES, counseling stigma, counseling barriers, and ethnic identity. The contributions of this study demonstrate that more insight is needed about the counseling expectations of men within a cultural context. This study demonstrates the importance of conducting research that specifically focuses on the counseling expectations of men, which adds to this area of research.

Although there were one hundred and thirty-two participants in this study, more participants may have provided more significant findings. Having a more diverse sample would have provided more insight into populations that have not been observed in this area of research.

**Closing Remarks**

The present chapter reviewed and explained the findings of this study. The hypothesis of this study was supported, and this research has contributed to filling gaps within the area of counseling expectations. The present study expanded current
knowledge of counseling expectations by focusing specifically upon men, which is overwhelmingly needed in this area of research.
REFERENCES


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Phinney, J. & Ong, A. (2007). Conceptualization and measurement of ethnic identity: 


Appendix A

Human Subjects Institutional Review Board
Letter of Approval
Date: July 31, 2012

To: Lonnie Duncan, Principal Investigator
    Sheryl Kelly, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number 12-06-27

This letter will serve as confirmation that your research project titled "Males' Expectations of Counseling" has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may only be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., you must request a post approval change to enroll subjects beyond the number stated in your application under "Number of subjects you want to complete the study"). Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: July 31, 2013
Appendix B

Demographic Questionnaire
Demographic Questionnaire

Age: ______

Race/Ethnicity: _________________________

Level of Education Received (Please Circle One):  Less than a high school diploma/GED

High School Diploma/GED  Some College  College Degree  Masters Degree  Doctorate Degree

Type of Area Raised In (Please Circle One):  Rural  City  Suburban

Previous Counseling Experience (Please Circle One):  Yes  No

How many sessions did you attend? _____
Appendix C

The Revised Multigroup Ethnic Identity Measure
The Revised Multigroup Ethnic Identity Measure (MEIM-R)

The MEIM-R is described in the following article:


The measure is available for research without permission. Please use the above information as a reference.

Multigroup Ethnic Identity Measure - Revised (MEIM-R) (6-items)

1- I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.

2- I have a strong sense of belonging to my own ethnic group.

3- I understand pretty well what my ethnic group membership means to me.

4- I have often done things that will help me understand my ethnic background better.

5- I have often talked to other people in order to learn more about my ethnic group.

6- I feel a strong attachment towards my own ethnic group.

Response scale:

(1) Strong disagree   (2) Disagree   (3) Neutral   (4) Agree   (5) Strongly Agree

Notes:

In administering the measure, these items should be preceded by an open-ended questions that elicit the respondent’s spontaneous ethnic self-label. It should conclude with a list of appropriate ethnic groups that the respondent can check to indicate both own and parents’ ethnic background, including options for mixed heritage and other. These items are used only for determining the ethnicity of the respondent and are not part of the scale per se.

The usual response options are on a five-point scale, from strongly disagree (1) to strongly agree (5), with 3 as a neutral position. Items 1, 4, and 5 assess exploration; items 2, 3, and 6 assess commitment. The score is calculated as the mean of items in each subscale (exploration and commitment) or of the scale as a whole. Cluster analysis may be used with the two subscales to derive ethnic identity statuses (Phinney & Ong, 2007).
Appendix D

Self-Stigma of Seeking Help
Self-Stigma of Seeking Help (SSOSH) (Vogel, Wade, & Haake, 2006)

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = 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 professional help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

Items 2, 4, 5, 7, and 9 are reverse scored.