International Journal of
Men's Social and Community Health

Original Article

PSYCHOLOGICAL DISTRESS AND HELP-SEEKING FACILITATORS IN QUEBEC MEN: FINDINGS FROM A PROVINCE-WIDE SURVEY

Corentin Montiel[1], Arnaud Duhoux[2], Gilles Tremblay[3], Raymond Villeneuve[4], Jacques Roy[5], Brigitte Lavoie[6], Janie Houle[1]

[1]Department of Psychology, Université du Québec à Montréal, Montreal, QC, Canada

[2]Faculty of Nursing, Université de Montréal, Montreal, QC, Canada

[3]School of Social Work and Criminology, Université Laval, Québec, QC, Canada

[4]Regroupement pour la Valorisation de la Paternité, Montreal, QC, Canada

[5]Department of Sociology, Université Laval, Québec, QC, Canada

[6]Lavoie Solutions, Pointe-Claire, QC, Canada

Author for correspondence: Janie Houle: houle.janie@uqam.ca

Submitted; 23 April 2021; Accepted: 29 September 2021; Published: 12 January 2022.

Abstract

Introduction

It has been well established that men are not inclined to seek psychosocial help. Although barriers preventing psychosocial help-seeking behaviors in men have been extensively documented, few studies have investigated perceived facilitators and preferences involved in these behaviors.

Methods

Based on an online survey of 2095 Quebec men, this descriptive study explores men's psychological distress and help-seeking behaviors, perceptions of effective facilitators of help-seeking behaviors, and psychosocial intervention preferences.

Results

About 30% of the men surveyed presented some form of psychological distress, and very few had used psychosocial services in the last year. Most men did not have a preference regarding the gender of their therapist, although they reported favoring solution-focused interventions and appreciating a continuity in the therapeutic relationship. Men also highly rated the importance of free or low-cost services to facilitate help-seeking behaviors. Finally, they indicated a high probability of consulting, if their doctor would tell them to, or if they noticed that their situation affected on their children, or if they experienced suicidal ideation.

Discussion

Understanding what encourages men to seek help for mental health difficulties and their preferences in services and intervention may lead to greater service use and improved mental health.

Keywords: psychological distress, men, help-seeking, facilitators, preferences, Quebec

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

INTRODUCTION

Research has shown that individuals living with mental health disorders or experiencing psychological distress are often reluctant to seek professional help.[1] Men, particularly young men (i.e., men aged between 18 and 34 years), are one of the least likely of all demographic groups to seek help,[2–5] though more recent data have shown changes in this trend.[6] Some authors argue that men are often, from an early age, discouraged to seek help from parents, peers, and other adults and that by the time they reach adulthood, they find it difficult to seek help from others.[7,8] While some physiological differences may explain differences in help-seeking (e.g., hormones), there is strong support for the mediating role of normative male gender-role expectations.[9] Gender differences in service utilization must be understood as the result of an interaction of different factors such as biology, gender roles, social context, and the functioning of the health care system.[9] This difference between men and women has generated a lot of attention from researchers, as men are also more likely to die by suicide, an event associated with untreated mental illness.[10,11] A recent systematic review identified other sociodemographic determinants related to help-seeking.[12] Age and education have been positively linked to help-seeking behaviors, and belonging to an ethnic minority group was associated with lower help-seeking rates. Half of the studies reviewed found no association between marital status and help-seeking, with the remaining studies finding positive or negative effects of being married.[12] Finally, most studies did not find any association between income and help-seeking behaviors, although one study found a positive relationship. Further research is needed on how these sociodemographic variables affect help-seeking behaviors, specifically in men.

To better understand help-seeking behaviors in men, more attention has been directed to existing barriers and facilitators to help-seeking. Barriers include miscommunication and avoidance of distress,[13] perceived stigma,[14] gender socialization,[15-17] familial[18,19] and personal attitudes,[20] use of alternative coping mechanisms,[6,21] and previous negative[22] or unhelpful[23] experiences. While most of the barriers investigated pertain to the individual, some are modifiable systemic and organizational hindrances to help-seeking in men. Interestingly, one study in a university setting showed that the majority of barriers to help-seeking identified by male college students themselves were at the individual level.[24] However, men mentioned the cost of services, lack of credibility of professionals, lack of knowledge and misinformation about services, the counseling process, and fear, uncertainty, and skepticism about professionals' ability to accept and respond to Gay Bisexual Transgender and Questioning/Queer (GBTQ)+ men and men of color as some of the barriers to help-seeking.[24] Other frequently reported barriers in another recent systematic review included limited hours of operation, and poor communication with health professionals.[25] This indicates that psychosocial professionals (i.e., trained mental health practitioners such as psychologists, psychiatric nurses, social workers, and other professionals authorized to perform psychosocial interventions) can also engage in actions aimed at encouraging help-seeking behaviors.

Although facilitators are still under-researched.[26] A growing interest in a more positive approach to supporting men's help-seeking, as identified facilitators suggest possible strategies wherein these key barriers may be addressed.[27] The facilitators investigated include the presence of trained practitioners, peer advocates and role models, and targeted awareness-raising in schools, universities, and work settings.[28] Among young men living in rural areas, the importance of mental health services being discreet and confidential was also reported.[22] Organizational factors identified by young men engaged in mental health services include initial contact, effective cross-sector partnerships, and availability of male practitioners.[27]

Some authors[29] argue that considering and responding to men's preferences would further incite help-seeking behaviors, leading to increased use of services. While this perspective encourages

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

services and professionals to tailor their support to people's needs, research has mainly focused on client preferences associated with nonpsychological variables such as race, ethnicity, gender, or drug treatment preference compared with psychotherapy.[30] Although the current study focuses more broadly on psychosocial interventions in the context of public services, parallels can be drawn with research on psychotherapy preferences in private practice. For example, studies have shown that women are known to mostly reject the prospect of taking medication for their mental health issues in favor of psychotherapy,[30,31] although this preference is less apparent among men.[32,33] Men seem to respond more positively to help from a psychotherapist, followed by help from a doctor and their significant other.[34] Others have suggested a preference for friends and family, particularly young men.[28] Although there is no consensus in the literature, some studies suggest that most men express no preference for their practitioner's gender and those who do express a preference for prefer female therapists.[35–37] Others suggest that men sometimes have a preference for women or men therapists.[38,39] Compared with women, men generally favor individual over group intervention.[33] Wanigaratne and Barker showed that most men seem to prefer a more "naïve" style of psychosocial intervention. Here the practitioner takes a friendly approach, reassures the client, and gives nonspecialist advice over other styles such as psychodynamic, humanistic, cognitive-behavioral, and external locus of control approaches.[40] Another study found a preference for positive-psychology/positive masculinity interventions[41] over cognitive-behavioral interventions.[20] Finally, men favor interventions that are more directive and focused on cognition rather than emotion,[42] possibly because disclosure of personal information, emotional expression, and vulnerability is perceived to be inconsistent with masculine norms.[41,43] Hence, many men are reluctant to use the services available since psychological interventions are often more emotion-focused than solution-focused.[36,44,45] However, once the process begins, the bond and perceived efficacy of the treatment is more crucial to help-seeking intentions in the future than a man's difficulty or discomfort with emotional expression,[46] reinforcing the importance and relevance of identifying men's preferences and tailoring services accordingly. Encouraging men to consult would require an adaptation of services whose orientation is still undetermined.

Although the literature on Quebec men is modest, consisting mainly of grey literature written in French, its contribution is significant as it provides the basis for our understanding of the current phenomenon. In Quebec, a lower proportion of men than women report being affiliated with a family physician in 2020 (77.2% vs. 81.4%).[47] In general, Quebec men are also less likely than women to consult a professional for their mental health. A governmental report shows that 9.5% of men and 15.1% of women consulted a professional for psychosocial services in 2010–2011 (in a community organization, public institution, or private practice).[48] In contrast with the international literature, data from a Quebec report shows that if they had personal or emotional problems, men would prefer asking for help from their spouse rather than their family doctor, family, psychosocial services/professionals, and friends. Almost half of them indicated that they would not ask for help from anyone.[49] Indeed, only 2.3% (3.8% of women) of the population reported needing to see a psychosocial professional but were unable to do so,[48] suggesting a lack of awareness or perceived usefulness of such professionals.

For men who desire to consult, some barriers to service users are still present. For example, group discussions with Quebec men have identified professionals' attitudes (i.e., indifference, lack of empathy, judgment, etc.), negative past experiences, and lack of accessibility of services.[50] Efforts are currently being made to address these barriers in the Quebec public system. Some organizational practices currently being encouraged in Quebec include the availability of flexible options such as the possibility of taking appointments online, the increased proximity

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

of services, the design of neutral and welcoming waiting rooms with men-oriented literature, among others.[51]

As research on men's preferences and facilitators to professional help-seeking remains limited, stakeholders concerned with men's health have increasingly been interested in possible organizational changes and improvement of services geared toward this population. This descriptive study aims to:

(i) Assess psychological distress and help-seeking behaviors among men.
(ii) Identify, from the men's point of view, the factors that would facilitate consultation with a psychosocial resource when needed.
(iii) Explore men's preferences in terms of intervention.

METHODS

Research design

The research design is a cross-sectional quantitative study using a self-administered online questionnaire operationalized by a specialized survey firm.

Study population

The population studied was adult men. To participate, respondents had to be men over 18 years of age and living in Quebec, Canada. No exclusion criterion was used. The description of participant characteristics is presented in Table 1.

TABLE 1. Participant Characteristics

Characteristics	n (%)
Language (n = 2095)	
French	1826 (87.2%)
English	269 (12.8%)
Age, years (n = 2095)	
18–24	78 (3.7%)
25–34	163 (7.8%)
35–44	291 (13.9%)
45–54	431 (20.6%)
55–64	586 (28.0%)
65+	546 (26.1%)
Education level (n = 2062)	
No high school	32 (1.5%)
High school/vocational	612 (29.2%)
College/CEGEP	486 (23.2%)
University	932 (44.5%)
Household income (n = 1884)	
<$35,000	235 (12.5%)
35,000 $ to $54,999	326 (17.3%)
50,000 $ to $74,999	286 (15.2%)
75,000 $ to $99,999	387 (20.5%)
≥$100,000	650 (34.5%)
Sexual orientation (n = 2067)	
Heterosexual	1906 (92.2%)
GBTQ+	161 (7.8%)
Marital status (n = 2095)	
Married or partnered	1510 (72.7%)
Separated or divorced	189 (9.1%)
Single	378 (18.2%)

GBTQ: Gay Bisexual Transgender and Questioning/Queer.

Recruitment and data collection

The study was commissioned by a coalition of community organizations dedicated to men's health and well-being. Respondents were recruited through two probability-based online panels (SOM and Delvinia). The second panel was used to supplement the data with English-speaking participants. An algorithm was used to achieve the best possible representativeness of the sample based on age, region, first language, education, landlord/tenant status, and household size. Data collection took place between October 4 and October 16, 2018, through SOM's online survey website. The questionnaire was sent by the two research companies to 6394 potential participants (4544 and 1850 men, respectively, with 37 reported inactive email addresses). They reported a response rate of 42.3 and 16.7%, respectively. This response rate was calculated by dividing the number of completed questionnaires

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

by the number of email addresses reached. English speakers were over-sampled to obtain at least 250 participants and be representative of the province's linguistic demographics. All survey responses were anonymous. Participants with unfinished questionnaires (n = 289) were excluded. The final sample consisted of 2095 men. The current secondary use of the data by the researchers was approved by the ethics board of the Université du Québec à Montréal, with an exemption from the use of informed consent as it was not initially sought by the coalition of community organizations.

Variables

A set of questions was designed to explore objective and subjective matters from previous work with Quebec men.[6,53] Variables of interest include: (i) sociodemographic characteristics, (ii) psychological distress, (iii) help-seeking behaviors, (iv) facilitators to help-seeking behaviors, and (v) preferences in intervention and practitioner. The questionnaire is provided in the Appendix section.

The questionnaire collected sociodemographic information (sexual orientation and marital status). Other sociodemographic data such as age, education level, and household income, were obtained from the panels' databases.

Psychological distress was measured with the Kessler psychological distress scale (K6), which reported a Cronbach's alpha of 0.88,[54] and is composed of six items answered by a Likert scale ranging from none of the time (0) to all the time (4), for a total score out of 24. Following guidelines from previous studies,[55] participants were divided into three categories according to their scores: low distress (≤7), moderate distress (8–12), and high distress (≥13). Reliability analysis was carried out on the K6 scale, with a Cronbach's alpha of 0.97 for the current sample.

Close-ended questions regarding consultation of varied health services and professionals in the past year (e.g., family doctor, specialist doctor, psychosocial professional in the private sector, psychosocial professional in a community organization, etc.) were included to investigate help-seeking behaviors.

Facilitators to help-seeking first included the self-reported likelihood of consulting psychosocial services during different situations. It was assessed with seven items answered on a 10-point scale ranging from not likely at all (1) to extremely likely (10), in which participants had to indicate the likelihood of consulting in the occurrence of seven different situations: lost libido, lost job, marital separation, feeling depressed, threats of separation, suicidal ideation, and situation with an impact on children. Reliability analysis was carried out on the seven items, with a Cronbach's alpha of 0.90 for the current sample.

Self-reported likelihood of consulting psychosocial services in the event of three different figures (i.e., a doctor, friend, or spouse) encouraging the participant to do so was also assessed with three items answered on a 10-point scale ranging from not likely at all (1) to extremely likely (10). Scores for each item consisted of the number selected out of 10. Reliability analysis was carried out on the three items, with a Cronbach's alpha of 0.84 for the current sample.

Participants were then asked to which degree, from not at all (1) to a lot (4), 12 different facilitators would increase help-seeking behaviors (i.e., someone takes the first appointment for them, someone accompanies them to the first appointment, the possibility of the professional coming over, a friend recommends a particular resource or professional, the possibility of appointment by internet, possibility of making first contact by phone, possibility of going without an appointment, knowing what to expect, services being discreet, convenient opening hours, information available online beforehand, and free or of low cost). Reliability analysis was carried out on the 12 items, with a Cronbach's alpha of 0.82 for the current sample. Men were also asked to choose the most important factor for them when consulting a psychosocial resource or professional, out of seven possible answers (proximity to your home, low risk of running into someone they know in the waiting room, the possibility of meeting a professional who was referred to you and whom you trust, free or of

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

low cost, knowing that the consultation process is short, feeling that the resource will be able to help, or no preference).

Finally, preferences in terms of intervention and practitioners were identified with close-ended questions. Men were asked what their preferred source of help would be between someone who has experienced the same thing as them, someone close to them (family member or friend), or a psychosocial professional. Participants were then asked whether they would prefer to consult a male practitioner, a female practitioner, or if they had no preference. To assess men's preferred role for a potential practitioner, they were asked to select what they would prefer their practitioner to do: listen to them without judging and letting them reflect on the situation by themselves, help them understand what they are experiencing without telling them what to do, give feedback, advice, and practical tools, or all these answers. Finally, to assess the preferred type of intervention, they were asked whether they would favor an intervention focused on helping them identify what they can do to resolve the situation, helping them understand the cause of the problem, or no preference.

The questionnaire was available in both French and English. Consent to participate in studies was given to the panels when signing up.

Data analysis

Sociodemographics were examined through descriptive analyses. The variables were stratified to present the distribution of men with distress for each group. Chi-square tests of independence were carried out to examine the relationship between psychological distress and consultation of psychosocial resources/professionals and medical resources/professionals in the last 12 months. One-way analysis of variance (ANOVA) was used to determine in which situations and following the advice of which figures men reported a greater likelihood of consulting psychosocial services. Descriptive analyses were also carried out to describe men's responses. IBM SPSS for Mac, version 26 (IBM Corp., Armonk, NY, USA) was used to perform the analyses.

RESULTS

This descriptive study plans to document psychological distress and help-seeking behaviors among men; identify, from the men's point of view, the factors that would facilitate consultation with a psychosocial resource when needed; and explore men's preferences in terms of intervention.

Distress and help-seeking among men

The K6 measure showed that 21.3% of men surveyed were experiencing moderate psychological distress, and 8.3% were experiencing high psychological distress. Men under 35 years of age, GBTQ+ men, single men, separated/divorced men, and men with a household income below $55,000 were proportionally more numerous in presenting psychological distress than men in other sociodemographic groups.

In the last 12 months, 85.4% of all respondents had consulted a health resource or professional, and 9.6% had consulted a psychosocial resource or professional. About 50.6% had consulted one in their life. Table 2 presents the distribution of men presenting at least moderate psychological distress according to sociodemographic group and number of these men who consulted psychosocial services in the last 12 months. Among these only 17.8% had taken a psychosocial service in the last 12 months.

About 75.7% of all men reported having consulted a family physician in the past year. Medical specialists (44.2%) and physicians in walk-in clinics or at the emergency (34%) were consulted less often than other health specialists such as dentists, naturopaths, and massage therapists (76.2%). The use of psychosocial resources and professionals was less widespread with only 5.9% of men having consulted practitioners in private practice, 4.5% in the public sector, 2.7% in specialized services, and 2.6% in community organizations. Table 3 shows the number of men who have consulted a psychosocial resource and a physician in the last 12 months according to level of psychological distress.

A chi-square test of independence showed an association between psychological distress and

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

TABLE 2. Percentage of Men Experiencing at Least Moderate Psychological Distress, and Those Who Have Consulted Psychosocial Services in the Last 12 months, Stratified by Various Sociodemographic Variables

	n	Men presenting at least moderate distress	Men presenting at least moderate distress and have consulted
All	2047	606 (29.6%)	108 (17.8%)
Age (years)			
18–34	232	110 (47.4%)	18 (16.4%)
35–54	710	243 (34.2%)	51 (21.0%)
55+	1105	253 (22.9%)	39 (15.4%)
Sexual orientation			
Heterosexual	1872	539 (28.8%)	93 (17.3%)
GBTQ+	153	60 (39.2%)	14 (23.3%)
Educational level			
No high school/ high school/ trade school	626	196 (31.3%)	36 (18.4%)
College	472	143 (30.3%)	19 (13.3%)
University	918	255 (27.8%)	52 (20.4%)
Household income			
<$ 55,000	539	199 (36.9%)	41 (20.6%)
≥$ 55,000	1305	353 (27.0%)	62 (17.6%)
Marital status			
Married or partnered	1488	384 (25.8%)	58 (15.1%)
Separated or divorced	184	68 (37.0%)	18 (26.5%)
Single	363	150 (41.3%)	32 (21.3%)

TABLE 3. Men Who Have Consulted a Psychosocial Resource and a Physician in the Last 12 Months According to the Level of Psychological Distress

Psychological distress	Psychosocial services		Physician	
	n	%	n	%
Low distress (n = 1441)	83	5.8	1228	85.2
Moderate distress (n = 437)	54	12.4	369	85.0
High distress (n = 169)	54	32.0	138	82.6

consultation of psychosocial services ($\chi^2 = 128.677$; $p < 0.001$). A Cramer's V test indicated a very strong association between the two variables (V = 0.251; Range, > 0.25).[52] A chi-square test of independence also showed an association between psychological distress and consultation of a physician ($\chi^2 = 6.708$; $p < 0.05$). However, Cramer's V test indicated that the association between the two variables was weak (V = 0.057; Range, 0.05 to 0.10).[52]

The sociodemographic variables (education, household income, and marital status) were combined to compare the two groups of participants

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

in terms of social and material deprivation. Single men with income lower than $25,000 and with or without a high school diploma or a trade diploma composed our highly vulnerable group (n = 92); those in a relationship, having an income higher than $100,000 and university education formed the privileged group (n = 578). Compared with the privileged group (24.2%), men in the vulnerable group (44.9%) were twice more likely to experience at least moderate distress. They were also four times more likely to experience high distress (20.2% vs. 5.1%). Men presenting at least moderate distress in the privileged group were 1.5 times more likely to have consulted psychosocial services in the last 12 months than those in the vulnerable group (23.1 % vs. 15.8%). Men with high distress in the privileged group were 1.17 times more likely to have consulted these services in the last 12 months than men in the vulnerable group (34.5% vs. 29.4%).

Factors facilitating help-seeking

The self-reported likelihood of consulting psychosocial services in the occurrence of different hypothetical situations was investigated. A one-way ANOVA was conducted to investigate possible differences between men's ratings of the different situations. Since the assumption of homogeneity of variance was not met for this data, the obtained Welch's adjusted F ratio of 227.61 was used, which was significant at an alpha level of 0.05, and was reported as Welch's F (6, 6173.32) = 227.61; $p < 0.001$; $\omega = 0.10$. A statistically significant effect of the type of situation was observed on the probability of consulting. Men rated the probability of consulting if they lost their job as significantly lower ($\bar{x} = 5.43$) than in the other situations. Noticing an impact of their problem on their children ($\bar{x} = 7.87$) and suicidal ideation ($\bar{x} = 7.54$) were rated the highest, with the other situations remaining somewhere in between (see Table 4).

TABLE 4. Mean Probability of Consulting When Facing Different Situations

Situation	n	Mean[a]	SD
Impact on children	1926	7.87	2.32
Suicidal ideation	2020	7.54	2.74
Threats of separation	1986	6.30	2.80
Feeling depressed	2055	6.20	2.54
Marital separation	1973	6.17	2.71
Loss of libido	2014	6.01	2.66
Losing job	1936	5.43	2.84
Total	13,910	6.50	2.78

[a]The mean scores represent the average likelihood ratings assessed from 1–10.

The effect of different types of known figures hypothetically encouraging men to consult (spouse, doctor, and friend) on men's self-reported likelihood of consulting psychosocial services was also investigated. A one-way ANOVA was conducted to investigate the possible differences between men's ratings of the different figures. Since the assumption of homogeneity of variance was unmet for this data, the obtained Welch's adjusted F ratio of 4079.37 was used, which was significant at the alpha level of 0.05 and was reported as Welch's F (2, 4079.37) = 227.61; $p < 0.001$; $\omega = 0.08$. There was a statistically significant effect on the type of figure on the probability of consulting. A Games-Howell post hoc test revealed that the probability of consulting psychosocial services/professionals was highly statistically significant if their doctor recommended them to ($\bar{x} = 7.93 \pm 2.057$; $p < 0.001$) than if a partner ($\bar{x} = 6.94 \pm 2.323$; $p < 0.001$) or a friend ($\bar{x} = 6.10 \pm 2.228$; $p < 0.001$) were to tell them to. Also, the probability of consulting if a partner were to tell them was highly statistically significant ($\bar{x} = 6.94 \pm 2.323$; $p < 0.001$) than if a friend ($\bar{x} = 6.10 \pm 2.228$; $p < 0.001$) were to do so.

Figure 1 illustrates participant ratings of different possible facilitators to consulting psychosocial services. The majority of men (53.6%) indicated that services being "free or of low cost" would be very helpful in their decision to consult, followed by "convenient opening hours" (51.3%) and "the possibility of getting information about the services online beforehand" (48.9%). Other facilitators

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

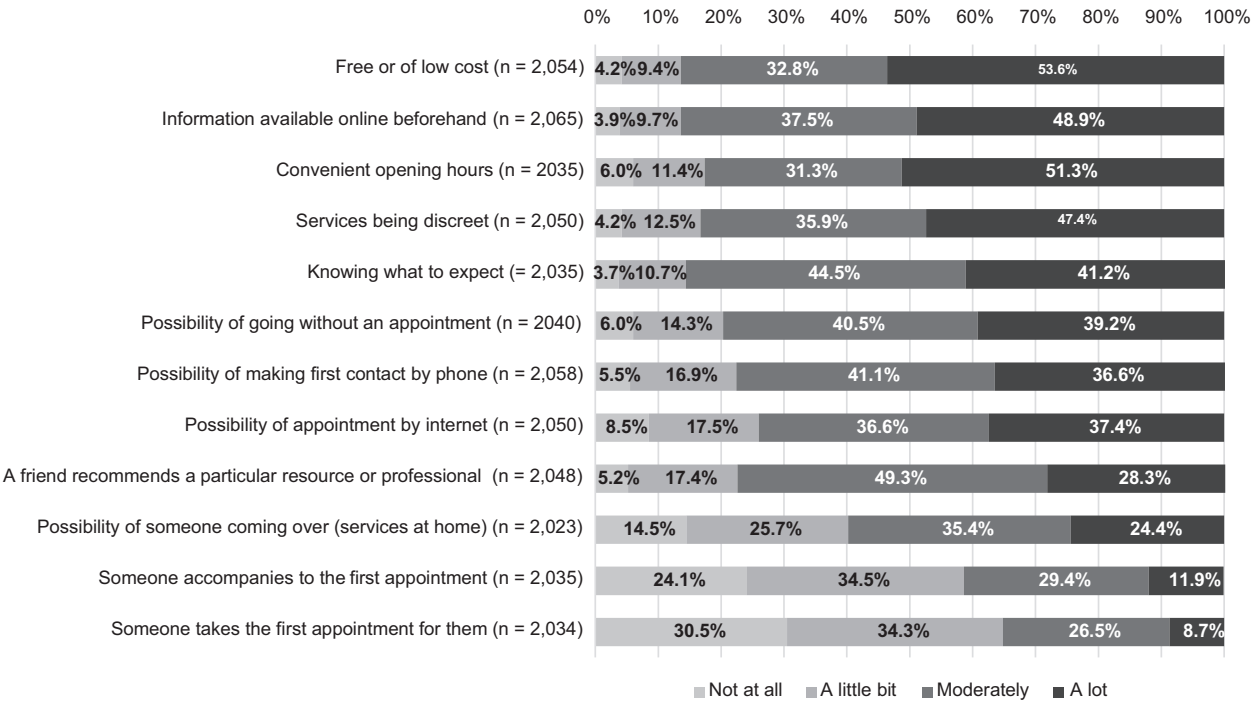

FIGURE 1. Participant ratings of factors that would help them in their decision to reach out for a psychosocial resource or a professional.

such as "services being discreet" (47.4%), "knowing what to expect" (39.2%), and "the possibility of going without an appointment" (39.2%) were also believed to be helpful. Although rated lower, factors related to outside help from family and friends such as "that someone close to you accompany you to the first appointment" and "that someone close to you take the first appointment for you" were still perceived as being moderately or very helpful to more than one-third of men.

When asked about the most important factor to consult a psychosocial resource or professional, most men (52.4%) chose the response "feeling that the professional will be able to help with my problem." Other popular answers included "free or of low cost" again (10.5%) and "proximity to home" (10.4%). Also, 10% chose "the possibility of meeting a professional who was referred to you and whom you trust," and 8.3% picked "the low risk that you run into someone you know in the waiting room." Finally, 3.4% chose "knowing that the consultation process will be short term," and 5% had no preference. The proportion of men who preferred "free or of low cost" and "proximity to home" was higher among younger men under the age of 35 years (17.5% and 16.2%, respectively). More men with at least moderate psychological distress chose "proximity to home" (17.1%), and fewer chose "feeling that the professional will be able to help with my problem" (41.8%). Finally, more single men preferred "free or of low cost" (16.8%) compared with men with a high education level (8.7%).

Preferences in terms of intervention and professional services

If they were to experience significant difficulties, men would feel more comfortable discussing them with a professional (74%) compared with someone who has gone through the same situation (17.1%) or a friend/family member (8.9%).

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

Descriptive analyses show that the proportion of men aged 55 years and older who preferred a professional was slightly higher (79.3%) than other groups, and more younger men under the age of 35 chose someone who has gone through the same situation (21.3%) or a friend/family member (20.4%). The proportion of men who would choose someone who has gone through the same situation was also higher among single men (22.7%) and men with at least moderate psychological distress (22.6%).

Most men did not have a preference in their practitioner's gender (67.2%), although 17.9% preferred a woman, and 14.9% preferred a man. The proportion of men who chose a male practitioner was higher among GBTQ+ men (33.3%), and those wanting a female practitioner were higher among men aged under 35 (32.8%). The lack of preference for the practitioner's gender was higher among retired men (71.1%) and men with low psychological distress (70.7%).

Men majorly preferred to receive feedback, advice, and concrete tools (34.3%) rather than receiving help to understand what they are experiencing without being given instructions on what to do (12.2%) or being listened to without any judgment and being free to reason on their own (3.7%) when seeking professional help. However, 47.5% of men preferred an intervention that included all three aspects. The proportion of men who would prefer to be listened to without any judgment and wanted to be free to reason on their own was slightly higher among men under 35 years of age (7.6%) than other groups. Men seemed to overwhelmingly prefer intervention focused on helping them identify what they could do to resolve the situation (54.9%) rather than helping them understand the cause of the problem (31.4%), and 13.7% had no preference.

DISCUSSION

The current study assessed psychological distress and help-seeking behaviors among men, factors that would facilitate consultation with a psychosocial resource when needed, and preferences in terms of intervention. Deviating from the individual level of analysis of help-seeking, this article proposes ways to support help-seeking through organizational changes and the adaptation of services to men's preferences.

Results of the present study indicate that a large proportion of men present signs of recent psychological distress, with nearly one in three men surveyed showing at least moderate psychological distress. This survey finding is not surprising as middle-aged men are one of the groups most likely to experience psychological distress compared to other age and gender groups.[56] In our study, a higher percentage of younger men and GBQT+ men presented psychological distress, reflecting the high rates of psychological distress in these groups already reported in the literature.[57,58] Moreover, single men and men with lower household incomes were also proportionally highly represented. These findings are in line with the literature on the higher prevalence of psychological distress in single men[59] and lower-income men.[60] However, the naturally high co-occurrence of these two groups in our sample (61.4% of single men had a household income of less than $55,000 vs. 18.6% of married/partnered men) does not allow us to comment on the effect of household income as a measure of socioeconomic status. However, the results of this study suggest that men with higher levels of psychological distress are significantly more likely to have consulted psychosocial services in the last year over 68% of men with high psychological distress. This finding is consistent with the literature suggesting low use of sources of help among men experiencing mental health difficulties[61,62] and young men's preference for informal sources of help such as friends and family.[22,28] Although statistical analyses would be needed to analyze the differences in psychological distress. The exploratory stratification of the data does show any major differences between the different sociodemographic groups in terms of help-seeking when differences in psychological distress are accounted for. For example, while it was expected that fewer men with lower household incomes would consult

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

psychosocial services, they were proportionally more likely to do so. Further research is needed to accurately assess how these sociodemographic variables impact help-seeking when accounting for the significant influence of psychological distress.

Fortunately, the results suggest that some facilitators might encourage help-seeking behaviors, given that different figures in men's lives could incite help-seeking behavior. Indeed, these results indicate that men are more likely to consult if their doctor tells them to vs. a spouse or a friend. It is possible that the relationship Quebecers have with their family doctor is influenced by the universal health care system, although other factors appear to be involved.[63] This emphasizes the role of general practitioners in the screening and referral of their male patients as most men surveyed have had contact with a physician in the last year, which is an encouraging finding. Quebec's universal health care and the high percentage of the population with a family physician put the province in a good position to act on this finding. Indeed, Quebec men, especially at-risk men, may be expected to visit their physicians more frequently than men in countries with single-payer systems. Although we found a weak negative relationship between levels of psychological distress and physician consultation in the last year, the literature on suicidology shows that men consulted a general practitioner when they feel severely distressed, as a good proportion of men consult shortly before committing suicide.[64-67] This outcome is in line with the current results showing that men would feel more comfortable discussing their difficulties with a professional rather than someone who has gone through the same situation or a friend/family member, which varies somewhat between age groups. Adults with symptoms of psychological distress also highly endorse general practitioners as their primary source of help,[68,69] which puts them in a very good position to act as gatekeepers, especially for men with greater and more urgent needs. This approach is particularly true for older men since young adults might not yet see general practitioners as a source of help for mental disorders or distress.[3,26] They are also less likely to need medical care in general and are therefore less likely to encounter medical professionals. For men experiencing distress, general practitioners play a limited but useful role since they can listen, prescribe medication, and make referrals to specialized resources. Psychosocial resources such as psychologists and social workers also play an important role in helping men. Their part is, however, less well known among the population.[53,70] Such services might benefit from the increased promotion of their expertise, role, and availability.

The results of this study show that men reported a higher likelihood of turning to psychosocial services in certain circumstances, for instance, if their situation affected their children or if they were experiencing suicidal ideation. The strong protective effect of marriage for men has long been known and could also potentially extend to parents of dependent children.[71] However, the protective effect of having dependent children is limited in men and is influenced by other factors such as the number of children, their age, and men's marital status. Interestingly, separation and threats of separation were rated somewhat in between other situations, even though they can potentially affect children. In cases of loss of libido or job, the need for psychological support is less explicit and they were rated significantly lower by men. Studies have indicated that while men present signs of psychological distress, they tend to reach a higher threshold of symptom severity before seeking help than women.[72] Men might not recognize their problems,[9] may believe they can cope with their situation,[4] ignore them,[73] or express their distress with externalizing behaviors.[74] Outcomes of such private coping methods for mental health and well-being are unclear, as psychological distress has been found to interfere with people's lives.[56] Inversely, the negative impact of paternal psychological distress on children is scientifically clear[75] and is a very apparent concern for parents with mental illness.[76] Professionals and family members may therefore find it advantageous to suggest to distressed men that getting help would be beneficial for the well-being of their children.

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

The results also show that men generally report a high likelihood of consulting in certain serious circumstances and feel more comfortable discussing their issues with a professional. They also report low formal help-seeking (only 17.8% of men with at least moderate distress have consulted in the last year). It is thus possible that many Quebec men, including those in need of psychosocial help, hesitate to seek help. These results suggest the possible importance of external barriers to men's help-seeking. Some structural factors such as services being free or of low cost, being discreet, and information on services being available beforehand could be facilitators to men's help-seeking behaviors. Most organizational items proposed in the questionnaire were rated as hypothetically very helpful or at least moderately, for seeking help. However, information on the actual influence of said facilitators is needed. Previous research not specific to men reported numerous structural reasons that explain the underutilization of mental health services in the United States. These include lack of health insurance coverage and cost,[77-80] lack of culturally and linguistically appropriate services,[81] and location of services.[79,82] Some of these factors can also be associated with many sociodemographic variables such as socioeconomic status. Hence, some authors argue that strategies to increase accessibility,[21] and awareness[79,83] of already existing and adequate mental health services, should be prioritized. In the context of available public psychosocial services, the cost of services may be less of an issue for some. However, the current long waiting lists for these services may discourage others. In this case, it is expected that the focus would be on improving accessibility in terms of wait times while still providing quality services.

Although less valued by the majority of men surveyed, factors involving someone lending assistance with the help-seeking behavior like taking the first appointment or accompanying the person to their first appointment and having the professional come over could also be helpful to some. While the involvement of family members in help-seeking behaviors may be difficult or even contraindicated in some cases,[84,85] as family members are seen as potential allies by primary care providers.[86] Prior research has found that more than one-third of older adults coming to primary care settings were accompanied by family members,[87,88] and men often rely on their wives and daughters for assistance for their health management.[89-92] In the past, physicians have noticed a trend where young came in on their own with their partners close behind.[93] These findings are also supported by a survey of Quebec men.[53] This trend may be consistent with research suggesting that older men might prefer treatments for depression involving the family.[94] It is clear that friends and relatives of distressed men can be a precious source of information to professionals and effectively assist men in their help-seeking behaviors.[95-98] This also suggests that partner support could significantly influence help-seeking behaviors in younger men while providing possible explanations for the results of older men of the sample.

Since men are more likely to seek professional help when they have previously sought some form of help,[73,99,100] one can assume that they will engage in further help-seeking behaviors if accompanied by a loved one to relevant and adequate services. While research on the effect of partner and family support on mental health help-seeking behaviors is limited, it offers some insights into how men can be encouraged for seeking help for the first time. A previous study has shown that couples tend to collectively address and cope with their mental health concerns.[101] Partners can influence help-seeking behavior by increasing confidence in treatment or the perceived effectiveness of treatment through conversational tactics.[102] However, there is a current need to better equip partners and relatives as they are unprepared to handle distressed individuals.[103] This is illustrated by the high number of calls received by suicide prevention centres regarding distressed individuals, especially middle-aged men, from concerned friends and family.[104] Providing training and support to the people close to distressed men is therefore encouraged to diminish their exhaustion, reinforce the safety net of men in distress,

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

and prevent social fragmentation.[53,104] However, it is critical not to rely exclusively on men's relatives for their health, especially women, as this also creates additional pressure and contributes to their mental burden. Actions should be taken to reduce the gender-related social stigma in help-seeking and to encourage men to take responsibility for their health.

Finally, the results indicate that most men do not have a preference for the gender of their practitioner, which is consistent with some of the studies reviewed.[35-37] However, among men who preferred either male or female practitioners, gender preferences were evenly split. Men in one of the previously mentioned studies overwhelmingly preferred female practitioners. As previously stated, the availability of male practitioners is a critical factor for mental health service providers for young men,[27] The lack of male practitioners is a systematic barrier to care.[94] While research in adults is inconclusive,[105-108] adolescent-practitioner dyads matched on gender result in higher alliances and increased probability of finishing treatments,[107,109] suggesting more serious implications of gender-matching in young men. Compatible with other studies,[110,111] most surveyed men also preferred solution-focused interventions over problem-identification interventions, and a majority preferred a combination of both. Men also preferred receiving feedback, advice, and concrete tools, rather than help understanding what they were experiencing or being listened to, although a combination of these three approaches was also appreciated. The results also suggest that the working alliance is pivotal for men and continuity in services is appreciated. In summary, the results highlight some preferences that should be taken into account by professionals working with men, as this can influence intervention outcomes.[112] Studies show that clients engaging in treatment that is more congruent with their preferences are more likely to pursue their treatment and develop a stronger working alliance, experiencing more positive treatment outcomes.[20,112-114] Interestingly, some authors indicate that these preferences may be linked to the influence of gender roles and suggest more male-friendly intervention alternatives by using "male-sensitive therapeutic styles" focused on strengths[115] or preferences[116] associated with traditional male socialization. Although the current results show that men have some specific preferences in terms of intervention, a "one size fits all" gendered approach to mental health intervention should not be applied. Other important factors like the quality of the client-practitioner alliance have been found to predict positive clinical outcomes,[117] and need to be considered. Thus, future research should concentrate on multiple dispositional variables such as personality traits,[30,118-120] individual preferences[112] and individual attitudes,[20] and remain gender-sensitive.[121,122]

LIMITATIONS

This study has limitations that need to be considered for accurate interpretation of the results. First, although this descriptive study enabled us to explore Quebec men's preferences and help-seeking facilitators, its cross-sectional design does not allow us to infer a causal relationship between the different variables. Several sociodemographic variables have already been linked to psychological distress and subjective mental health. Some interactions also emerged through our analyses, although our sample size could not support the results. The interaction between sociodemographic variables and help-seeking behaviors must be tested with robust multivariate models for controlling confounding factors. Although the recruitment of marginalized groups and at-risk communities (e.g., GBTQ+ men and low-income men) causes methodological difficulties in survey research, these groups report higher psychological distress and possible differences in facilitators to help-seeking, warranting further study.

Second, the sample was composed of older, highly educated, and high-earning participants. It is difficult to know whether this affected the results. As a reference, Statistics Canada[123] indicates that 26.1% of the Quebec male population

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

aged 25–64 years have a university degree vs. 44.5% in the sample aged ≥18 years, and 42.9% of the Quebec male population aged ≥15 years report an income of at least $50,000 vs. 70.2% in the sample aged ≥18 years. It is critical to recognize that methodologies such as online surveys are prone to nonresponse bias. In this study, the two panels used to reach participants reported response rates of 42.3% and 16.7%, respectively, with no comparative analyses of key characteristics between respondents and nonrespondents that explain these discrepancies.

Despite these limitations, this descriptive study has helped explore facilitators of help-seeking behaviors in a population that has yet to be investigated for potential positive change.

CONCLUSION

Although efforts to remove barriers to help-seeking are made, the proportion of men who consult psychosocial resources remains low. A facilitator-focused approach to help-seeking suggests that encouraging help-seeking behavior in men is also possible by fostering supportive conditions considering men's preferences. Psychosocial services and professionals are in the best position to effectively integrate these findings as they can modify organizational structures that impede men's help-seeking behaviors. Reduced costs, convenient opening hours, private facilities, and other factors should therefore be encouraged in mental health services geared toward men. Furthermore, mental health services should view general practitioners as essential allies and gatekeepers, as they hold a considerable power of influence over men and are often consulted by those in distress. Providing continuous professional training and fostering strong cooperation with general practitioners should be encouraged. Lastly, while general practitioners are well-trusted by men, a lack of awareness exists surrounding psychosocial professionals and services. Further efforts should be directed towards responding to this current need.

ACKNOWLEDGEMENTS

The authors would like to thank Hélène Gaudreau, Isabelle Lapointe, Kadia Saint-Onge, and Stephanie Radziszewski (Université du Québec à Montréal) for reviewing the manuscript and providing support.

FUNDING

The use of a specialized survey firm for data collection was funded by the Regroupement provincial en santé et bien-être des hommes.

REFERENCES

1. Schomerus G, Angermeyer MC. Stigma and its impact on help-seeking for mental disorders: What do we know? Epidemiol Psychiatr Soc. 2008;17(1):31–7. http://dx.doi.org/10.1017/S1121189X00002669
2. Barney LJ, Griffiths KM, Jorm AF, Christensen H. Stigma about depression and its impact on help-seeking intentions. Aust N Z J Psychiatry. 2006;40(1):51–4. http://dx.doi.org/10.1080/j.1440-1614.2006.01741.x
3. Biddle L, Donovan JL, Gunnell D, Sharp D. Young adults' perceptions of GPs as a help source for mental distress: A qualitative study. Br J Gen Pract. 2006;56(533):924–31.
4. McKenzie SK, Collings S, Jenkin G, River J. Masculinity, social connectedness, and mental health: Men's diverse patterns of practice. Am J Mens Health. 2018;12(5):1247–61. http://dx.doi.org/10.1177/1557988318772732
5. Nam SK, Chu HJ, Lee MK, Lee JH, Kim N, Lee SM. A meta-analysis of gender differences in attitudes toward seeking professional psychological help. J Am Coll Health. 2010;59(2):110–16. http://dx.doi.org/10.1080/07448481.2010.483714
6. Tremblay G, Roy J, de Montigny F, et al. Où en sont les hommes québécois en 2014? sondage sur les rôles sociaux, les valeurs et sur le rapport des hommes québécois aux services – rapport de recherche. [Internet]; 2015 [cited 2021 July 1]. Available from: https://cerif.uqo.ca/sites/cerif.uqo.ca/files/sondageprojet_perceptions_version_finale.pdf

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

7. Courtenay WH. College men's health: An overview and a call to action. J Am Coll Health. 1998;46(6):279–90. http://dx.doi.org/10.1080/07448489809596004
8. Courtenay WH. Dying to be men: Psychosocial, environmental, and biobehavioral directions in promoting the health of men and boys. England: Routledge; 2011.
9. Möller-Leimkühler AM. Barriers to help-seeking by men: A review of sociocultural and clinical literature with particular reference to depression. J Affect Disord. 2002;71(1–3):1–9. http://dx.doi.org/10.1016/S0165-0327(01)00379-2
10. Arsenault-Lapierre G, Kim C, Turecki G. Psychiatric diagnoses in 3275 suicides: A meta-analysis. BMC Psychiatry. 2004;4(1):1–11. http://dx.doi.org/10.1186/1471-244X-4-37
11. World Health Organization. Preventing suicide: A global imperative. Report No.: 9241564776. Geneva, Switzerland: World Health Organization; 2014.
12. Magaard JL, Seeralan T, Schulz H, Brütt AL. Factors associated with help-seeking behaviour among individuals with major depression: A systematic review. PLoS One. 2017;12(5):e0176730. http://dx.doi.org/10.1371/journal.pone.0176730
13. Biddle L, Donovan J, Sharp D, Gunnell D. Explaining non-help-seeking amongst young adults with mental distress: A dynamic interpretive model of illness behaviour. Sociol Health Illn. 2007;29(7):983–1002. http://dx.doi.org/10.1111/j.1467-9566.2007.01030.x
14. Clement S, Schauman O, Graham T, Maggioni F, Evans-Lacko S, Bezborodovs N, et al. What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychol Med. 2015;45(1):11–27. http://dx.doi.org/10.1017/S0033291714000129
15. Addis ME, Mahalik JR. Men, masculinity, and the contexts of help seeking. Am Psychol. 2003;58(1):5. http://dx.doi.org/10.1037/0003-066X.58.1.5
16. Galdas PM, Cheater F, Marshall P. Men and health help-seeking behaviour: Literature review. J Adv Nurs. 2005;49(6):616–23. http://dx.doi.org/10.1111/j.1365-2648.2004.03331.x
17. Levant RF, Wimer DJ, Williams CM, Smalley KB, Noronha D. The relationships between masculinity variables, health risk behaviors and attitudes toward seeking psychological help. Int J Mens Health. 2009;8(1):3. http://dx.doi.org/10.3149/jmh.0801.3
18. Switzer JF, Wittink MN, Karsch BB, Barg FK. "Pull yourself up by your bootstraps": A response to depression in older adults. Qual Health Res. 2006;16(9):1207–16. http://dx.doi.org/10.1177/1049732306290148
19. Zivin K, Kales HC. Adherence to depression treatment in older adults. Drugs Aging. 2008;25(7):559–71. http://dx.doi.org/10.2165/00002512-200825070-00003
20. Cole BP, Petronzi GJ, Singley DB, Baglieri M. Predictors of men's psychotherapy preferences. Couns Psychother Res. 2019;19(1):45–56. http://dx.doi.org/10.1002/capr.12201
21. Seidler ZE, Dawes AJ, Rice SM, Oliffe JL, Dhillon HM. The role of masculinity in men's help-seeking for depression: A systematic review. Clin Psychol Rev. 2016;49:106–18. http://dx.doi.org/10.1016/j.cpr.2016.09.002
22. Rickwood DJ, Deane FP, Wilson CJ. When and how do young people seek professional help for mental health problems? Med J Aust. 2007;187(S7):S35–9. http://dx.doi.org/10.5694/j.1326-5377.2007.tb01334.x
23. Rickwood DJ, Deane FP, Wilson CJ, Ciarrochi JV. Young people's help-seeking for mental health problems. Aust e-J Adv Ment Health. 2005;4(3):218–51. http://dx.doi.org/10.5172/jamh.4.3.218
24. Davies J, McCrae BP, Frank J, Dochnahl A, Pickering T, Harrison B, et al. Identifying male college students' perceived health needs, barriers to seeking help, and recommendations to help men adopt healthier lifestyles. J Am Coll Health. 2000;48(6):259–67. http://dx.doi.org/10.1080/07448480009596267
25. Yousaf O, Grunfeld EA, Hunter MS. A systematic review of the factors associated with delays in medical and psychological help-seeking among men. Health Psychol Rev. 2015;9(2):264–76. http://dx.doi.org/10.1080/17437199.2013.840954
26. Gulliver A, Griffiths KM, Christensen H. Perceived barriers and facilitators to mental health help-seeking in young people: A systematic

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

review. BMC Psychiatry. 2010;10(1):1–9. http://dx.doi.org/10.1186/1471-244X-10-113
27. Rice SM, Telford NR, Rickwood DJ, Parker AG. Young men's access to community-based mental health care: Qualitative analysis of barriers and facilitators. J Ment Health. 2018;27(1):59–65. http://dx.doi.org/10.1080/09638237.2016.1276528
28. Russell V, Gaffney P, Collins K, Bergin A, Bedford D. Problems experienced by young men and attitudes to help-seeking in a rural Irish Community. Ir J Psychol Med. 2004;21(1):6–10. http://dx.doi.org/10.1017/S0790966700008065
29. Lynch L, Long M, Moorhead A. Young men, help-seeking, and mental health services: Exploring barriers and solutions. Am J Mens Health. 2018;12(1):138–49. http://dx.doi.org/10.1177/1557988315619469
30. Petronzi GJ, Masciale JN. Using personality traits and attachment styles to predict people's preference of psychotherapeutic orientation. Couns Psychother Res. 2015;15(4):298–308. http://dx.doi.org/10.1002/capr.12036
31. McHugh RK, Whitton SW, Peckham AD, Welge JA, Otto MW. Patient preference for psychological vs pharmacologic treatment of psychiatric disorders: A meta-analytic review. J Clin Psychiatry. 2013;74(6):595–602. http://dx.doi.org/10.4088/JCP.12r07757
32. Houle J, Villaggi B, Beaulieu M-D, L'espérance, F, Rondeau, G, Lambert, J. Treatment Preferences in Patients with First Episode Depression. J Affect Disord. 2013;147(1-3):94-100. https://doi.org/10.1016/j.jad.2012.10.016
33. Sierra Hernandez CA, Oliffe JL, Joyce AS, Söchting I, Ogrodniczuk JS. Treatment preferences among men attending outpatient psychiatric services. J Ment Health. 2014;23(2):83–7. http://dx.doi.org/10.3109/09638237.2013.869573
34. Berger JL, Addis ME, Green JD, Mackowiak C, Goldberg V. Men's reactions to mental health labels, forms of help-seeking, and sources of help-seeking advice. Psychol Men Masc. 2013;14(4):433. http://dx.doi.org/10.1037/a0030175
35. Højgaard A, Laursen B. What Danish patients want: Gender, profession and age of therapist. Sexologies. 2017;26(3):e21–5. http://dx.doi.org/10.1016/j.sexol.2017.04.003
36. Liddon L, Kingerlee R, Barry JA. Gender differences in preferences for psychological treatment, coping strategies, and triggers to help-seeking. Br J Clin Psychol. 2018;57(1):42–58. http://dx.doi.org/10.1111/bjc.12147
37. Black SC, Gringart E. The relationship between clients' preferences of therapists' sex and mental health support seeking: An exploratory study. Aust Psychol. 2019;54(4):322–35. http://dx.doi.org/10.1111/ap.12370
38. Anderson J. Client perception of counselor characteristics. Salt Lake City, UT: University of Utah; 2005.
39. Furnham A, Swami V. Patient preferences for psychological counsellors: Evidence of a similarity effect. Couns Psychol Q. 2008;21(4):361–70. http://dx.doi.org/10.1080/09515070802602146
40. Wanigaratne S, Barker C. Clients' preferences for styles of therapy. Br J Clin Psychol. 1995;34(2):215–22. http://dx.doi.org/10.1111/j.2044-8260.1995.tb01455.x
41. Kiselica MS, Englar-Carlson M. Identifying, affirming, and building upon male strengths: The positive psychology/positive masculinity model of psychotherapy with boys and men. Psychother Theor Res Pract Train. 2010;47(3):276. http://dx.doi.org/10.1037/a0021159
42. Cooper M, Norcross JC, Raymond-Barker B, Hogan TP. Psychotherapy preferences of laypersons and mental health professionals: Whose therapy is it? Psychotherapy. 2019;56(2):205. http://dx.doi.org/10.1037/pst0000226
43. Mahalik JR, Good GE, Englar-Carlson M. Masculinity scripts, presenting concerns, and help seeking: Implications for practice and training. Prof Psychol Res Pract. 2003;34(2):123. http://dx.doi.org/10.1037/0735-7028.34.2.123
44. Kingerlee R, Precious D, Sullivan L, Barry J. Engaging with the emotional lives of men. Psychology. 2014;27(6):418–21.
45. Wilkins D. Untold problems: A review of the essential issues in the mental health of men and boys. England: Men's Health Forum; 2010.
46. Cusack J, Deane FP, Wilson CJ, Ciarrochi J. Emotional expression, perceptions of therapy, and help-seeking intentions in men attending therapy

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

services. Psychol Men Masc. 2006;7(2):69. http://dx.doi.org/10.1037/1524-9220.7.2.69

47. Institut de la statistique du Québec. Les indicateurs de l'occupation et de la vitalité des territoires. Inscriptions auprès d'un médecin de famille au 31 décembre de chaque année. editor. Banque de données des statistiques officielles sur le Québec [Quebec Institute of Statistics. Indicators of the occupation and vitality of the territories. Registration with a family doctor on December 31 of each year. editor. Database of official statistics on Quebec]; 2021. French
48. Lecours C, Pomey MP, Tremblay ME, Enquête québécoise sur l'expérience de soins 2010-2011. la consultation pour des services sociaux : regard sur l'expérience vécue par les québécois. [Internet]: Institut de la statistique du Québec; 2013 [cited 2021 July 1]. Available from: https://bdso.gouv.qc.ca/docs-ken/multimedia/PB01671FR_EnqSante_exp_soin_Vol4_H00F00.pdf
49. Roy J, Tremblay G, Guilmette D. Perceptions des hommes québécois de leurs besoins psychosociaux et de santé ainsi que leur rapport aux services. méta-synthèse. [Internet]: Équipe de recherche Masculinités et Société, Université Laval; 2014 [cited 2021 July 1]. Contract No.: 978-2-924418-01-7. Available from: http://www.rohim.net/doc/perceptions-des-hommes.pdf
50. Tremblay G, Roy J, Beaudet L, Chamberland L. Les hommes et les services sociaux et de santé. analyse qualitative d'entrevues de groupe focalisées tenues auprès d'hommes québécois. [Internet]: Équipe de recherche Masculinités et Société, Université Laval; 2016 [cited 2021 July 1]. Contract No.: 978-2-924418-18-5. Available from: http://www.perceptions.svs.ulaval.ca/sites/perceptions.svs.ulaval.ca/files/rapportgroupesdediscussionavecisbn_1fevrier2016.pdf
51. Massuart M, St-Martin K, Côté I, L'Heureux PT. Guide de pratiques de gestion pour adapter les services de première ligne à la clientèle masculine [Internet]. [cited 2021 July 1]. Available from: https://publications.msss.gouv.qc.ca/msss/fichiers/2017/17-729-03W.pdf
52. Akoglu H. User's guide to correlation coefficients. Turk J Emerg Med. 2018; 18: 91–93. https://doi.org/10.1016/j.tjem.2018.08.001
53. Tremblay G. Perceptions des hommes québécois de leurs besoins psychosociaux et de santé ainsi que de leur rapport aux services. [Internet] Université Laval; 2016 [cited 2021 July 1]. Available from: http://www.cps02.org/media/Perceptionsdeshommesquebecoisdeleursbesoinspsychosociaux-2016.pdf
54. Cornelius BL, Groothoff JW, van der Klink JJ, Brouwer S. The performance of the K10, K6 and Ghq-12 to screen for present state Dsm-Iv disorders among disability claimants. BMC Public Health. 2013;13(1):1–8. http://dx.doi.org/10.1186/1471-2458-13-128
55. Hilton MF, Whiteford HA. Interacting with the public as a risk factor for employee psychological distress. BMC Public Health. 2010;10(1):1–7. http://dx.doi.org/10.1186/1471-2458-10-435
56. Watkins DC, Johnson NC. Age and gender differences in psychological distress among African Americans and Whites: Findings from the 2016 National Health Interview Survey. Healthcare (Basel). 2018 Mar; 6(1): 6. http://dx.doi.org/10.3390/healthcare6010006
57. Cochran SD, Sullivan JG, Mays VM. Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. J Consult Clin Psychol. 2003;71(1):53. http://dx.doi.org/10.1037/0022-006X.71.1.53
58. Drapeau A, Marchand A, Forest C. Gender differences in the age-cohort distribution of psychological distress in Canadian adults: Findings from a National Longitudinal Survey. BMC Psychol. 2014;2(1):1–13. http://dx.doi.org/10.1186/s40359-014-0025-4
59. Willitts M, Benzeval M, Stansfeld S. Partnership history and mental health over time. J Epidemiol Community Health. 2004;58(1):53–8. http://dx.doi.org/10.1136/jech.58.1.53
60. Orpana HM, Lemyre L, Gravel R. Income and psychological distress: The role of the social environment. Health Rep. 2009;20(1):21. Available from: https://pubmed.ncbi.nlm.nih.gov/19388365/
61. Australian Bureau of Statistics. National survey of mental health and wellbeing: Summary of results, 2007. Canberra: Commonwealth of Australia; 2008.

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

62. Bland RC, Newman SC, Orn H. Help-seeking for psychiatric disorders. Can J Psychiatry. 1997;42(9):935–42. http://dx.doi.org/10.1177/070674379704200904
63. Commissaire à la santé et au bien-être. Perceptions et expériences de la population: Le Québec comparé. Résultats de l'enquête internationale sur les politiques de santé du Commonwealth Fund de 2016 (Health and Welfare Commissioner. Perceptions and experiences of the population: Compared Quebec. Results of the 2016 Commonwealth Fund International Health Policy Survey) [Internet]. [cited 2021 July 1]. French. Available from: https://www.csbe.gouv.qc.ca/fileadmin/www/2016/CWF/CSBE_CWF_2016_Rapport_Resultats.pdf
64. Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: A review of the evidence. Am J Psychiatry. 2002;159(6):909–16. http://dx.doi.org/10.1176/appi.ajp.159.6.909
65. Pearson A, Saini P, Da Cruz D, Miles C, While D, Swinson N, et al. Primary care contact prior to suicide in individuals with mental illness. Br J Gen Pract. 2009;59(568):825–32. http://dx.doi.org/10.3399/bjgp09X472881
66. Pirkis J, Burgess P. Suicide and recency of health care contacts: A systematic review. Br J Psychiatry. 1998;173(6):462–74. http://dx.doi.org/10.1192/bjp.173.6.462
67. Séguin M, Leage A, Turecki G, et al. Projet de recherche sur les décès par suicide au nouveau-brunswick entre avril 2002 et mai 2003. [Internet] : Douglas Hospital Research Centre; 2007 [cited 2021 July 1]. Available from: https://www.gnb.ca/0055/pdf/3182-f.pdf
68. Lauber C, Nordt C, Falcato L, Rössler W. Lay recommendations on how to treat mental disorders. Soc Psychiatry Psychiatr Epidemiol. 2001;36(11):553–6. http://dx.doi.org/10.1007/s001270170006
69. Rogers CM, Dianne Oliver A. Experiencing depression, experiencing the depressed: The separate worlds of patients and doctors. J Ment Health. 2001;10(3):317–33. http://dx.doi.org/10.1080/09638230125545
70. Murstein BI, Fontaine PA. The public's knowledge about psychologists and other mental health professionals. Am Psychol. 1993;48(7):839. http://dx.doi.org/10.1037/0003-066X.48.7.839
71. Qin P, Mortensen PB. The impact of parental status on the risk of completed suicide. Arch Gen Psychiatry. 2003;60(8):797–802. http://dx.doi.org/10.1001/archpsyc.60.8.797
72. Biddle L, Gunnell D, Sharp D, Donovan JL. Factors influencing help seeking in mentally distressed young adults: A cross-sectional survey. Br J Gen Pract. 2004;54(501):248–53.
73. Sheu H-B, Sedlacek WH. An exploratory study of help-seeking attitudes and coping strategies among college students by race and gender. Meas Eval Couns Dev. 2004;37(3):130–43. http://dx.doi.org/10.1080/07481756.2004.11909755
74. Magovcevic M, Addis ME. The masculine depression scale: Development and psychometric evaluation. Psychol Men Masc. 2008;9(3):117. http://dx.doi.org/10.1037/1524-9220.9.3.117
75. Flouri E, Sarmadi Z, Francesconi M. Paternal psychological distress and child problem behavior from early childhood to middle adolescence. J Am Acad Child Adolesc Psychiatry. 2019;58(4):453–8. http://dx.doi.org/10.1016/j.jaac.2018.06.041
76. Stallard P, Norman P, Huline-Dickens S, Salter E, Cribb J. The effects of parental mental illness upon children: A descriptive study of the views of parents and children. Clin Child Psychol Psychiatry. 2004;9(1):39–52. http://dx.doi.org/10.1177/1359104504039767
77. Snowden LR, Thomas K. Medicaid and African American outpatient mental health treatment. Mental Health Serv Res. 2000;2(2):115–20. http://dx.doi.org/10.1023/A:1010161222515
78. Eisenberg D, Hunt J, Speer N, Zivin K. Mental health service utilization among college students in the United States. J Nerv Ment Dis. 2011;199(5):301–8. http://dx.doi.org/10.1097/NMD.0b013e3182175123
79. Owens PL, Hoagwood K, Horwitz SM, Leaf PJ, Poduska JM, Kellam SG, et al. Barriers to children's mental health services. J Am Acad Child Adolesc Psychiatry. 2002;41(6):731–8. http://dx.doi.org/10.1097/00004583-200206000-00013
80. Woodward AM, Dwinell AD, Arons BS. Barriers to mental health care for hispanic Americans: A literature review and discussion. J Ment

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

Health Admin. 1992;19(3):224–36. http://dx.doi.org/10.1007/BF02518988
81. Barr DA, Wanat SF. Listening to patients: Cultural and linguistic barriers to health care access. Fam Med. 2005;37(3):199–204.
82. Alegria M, Canino G, Ríos R, Vera M, Calderón J, Rusch D, et al. Mental health care for Latinos: Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino Whites. Psychiatr Serv. 2002;53(12):1547–55. http://dx.doi.org/10.1176/appi.ps.53.12.1547
83. Eaton J, Nwefoh E, Okafor G, Onyeonoro U, Nwaubani K, Henderson C. Interventions to increase use of services; mental health awareness in Nigeria. Int J Ment Health Syst. 2017;11(1):1–6. http://dx.doi.org/10.1186/s13033-017-0173-z
84. Hinton L, Apesoa-Varano EC, Unützer J, Dwight-Johnson M, Park M, Barker JC. A descriptive qualitative study of the roles of family members in older men's depression treatment from the perspectives of older men and primary care providers. Int J Geriatr Psychiatry. 2015;30(5):514–22. http://dx.doi.org/10.1002/gps.4175
85. Hinton L, Sciolla AF, Unützer J, Elizarraras E, Kravitz RL, Apesoa-Varano EC. Family-centered depression treatment for older men in primary care: A qualitative study of stakeholder perspectives. BMC Fam Pract. 2017;18(1):1–9. http://dx.doi.org/10.1186/s12875-017-0659-4
86. Apesoa-Varano EC, Hinton L, Barker JC, Unützer J. Clinician approaches and strategies for engaging older men in depression care. Am J Geriatr Psychiatry. 2010;18(7):586–95. http://dx.doi.org/10.1097/JGP.0b013e3181d145ea
87. Sayers SL, White T, Zubritsky C, Oslin DW. Family involvement in the care of healthy medical outpatients. Fam Pract. 2006;23(3):317–24. http://dx.doi.org/10.1093/fampra/cmi114
88. Wolff JL, Roter DL. Hidden in plain sight: Medical visit companions as a resource for vulnerable older adults. Arch Intern Med. 2008;168(13):1409–15. http://dx.doi.org/10.1001/archinte.168.13.1409
89. Compton MT, Esterberg ML. Treatment delay in first-episode nonaffective psychosis: A pilot study with African American family members and the theory of planned behavior. Compr Psychiatry. 2005;46(4):291–5. http://dx.doi.org/10.1016/j.comppsych.2004.10.006
90. Dentinger E, Clarkberg M. Informal caregiving and retirement timing among men and women: Gender and caregiving relationships in Late Midlife. J Fam Issues. 2002;23(7):857–79. http://dx.doi.org/10.1177/019251302236598
91. Lima JC, Allen SM, Goldscheider F, Intrator O. Spousal caregiving in late midlife versus older ages: Implications of work and family obligations. J Gerontol Ser B Psychol Sci Soc Sci. 2008;63(4):S229–38. http://dx.doi.org/10.1093/geronb/63.4.S229
92. Maly RC, Umezawa Y, Ratliff CT, Leake B. Racial/ethnic group differences in treatment decision-making and treatment received among older breast carcinoma patients. Cancer. 2006;106(4):957–65. http://dx.doi.org/10.1002/cncr.21680
93. Tudiver F, Talbot Y. Why don't men seek help? Family physicians' perspectives on help-seeking behavior in men. J Fam Pract. 1999;48:47–52.
94. Dwight-Johnson M, Apesoa-Varano C, Hay J, Unutzer J, Hinton L. Depression treatment preferences of older white and Mexican origin men. Gen Hosp Psychiatry. 2013;35(1):59–65. http://dx.doi.org/10.1016/j.genhosppsych.2012.08.003
95. Cabassa LJ, Lester R, Zayas LH. "It's like being in a labyrinth": Hispanic immigrants' perceptions of depression and attitudes toward treatments. J Immigr Minor Health. 2007;9(1):1. http://dx.doi.org/10.1007/s10903-006-9010-1
96. Hinton L, Zweifach M, Oishi S, Tang L, Unützer J. Gender disparities in the treatment of late-life depression: Qualitative and quantitative findings from the impact trial. Am J Geriatr Psychiatry. 2006;14(10):884–92. http://dx.doi.org/10.1097/01.JGP.0000219282.32915.a4
97. Murray J, Banerjee S, Byng R, Tylee A, Bhugra D, Macdonald A. Primary care professionals' perceptions of depression in older people: A qualitative study. Soc Sci Med. 2006;63(5):1363–73. http://dx.doi.org/10.1016/j.socscimed.2006.03.037
98. Owens C, Lambert H, Donovan J, Lloyd KR. A qualitative study of help seeking and primary care consultation prior to suicide. Br J Gen Pract. 2005;55(516):503–9.

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

99. Blais RK, Renshaw KD. Stigma and demographic correlates of help-seeking intentions in returning service members. J Trauma Stress. 2013;26(1):77–85. http://dx.doi.org/10.1002/jts.21772
100. Turcotte D, Dulac G, Lindsay J, Rondeau G, Turcotte P. Centre de recherche interdisciplinaire sur la violence familiale et la violence faite aux femmes. Les Trajectoires De Demande D'aide Des Hommes En Difficulté. Montreal: CRI-VIFF; 2002. French.
101. Colman E, Missinne S, Bracke P. The role of perceived helpfulness in predicting subjective unmet need and the frequency of health care use. Arch Psychiatr Nurs. 2014;28(1):43–9. http://dx.doi.org/10.1016/j.apnu.2013.10.007
102. Muscari EC, Fleming C. Help-seeking for mental health concerns: The role of partner influence. Couple Fam Psychol Res Pract. 2019;8(4):181. http://dx.doi.org/10.1037/cfp0000125
103. Janevic MR, Rosland A-M, Wiitala W, Connell CM, Piette JD. Providing support to relatives and friends managing both chronic physical illness and depression: The views of a national sample of US adults. Patient Educ Couns. 2012;89(1):191–8. http://dx.doi.org/10.1016/j.pec.2012.05.009
104. Mishara BL, Houle J, Lavoie B. Comparison of the effects of four suicide prevention programs for family and friends of high-risk suicidal men who do not seek help themselves. Suicide Life Threat Behav. 2005;35(3):329-42. https://doi.org/10.1521/suli.2005.35.3.329
105. Bhati KS. Effect of client-therapist gender match on the therapeutic relationship: An exploratory analysis. Psychol Rep. 2014;115(2):565–83. http://dx.doi.org/10.2466/21.02.PR0.115c23z1
106. Behn A, Davanzo A, Errázuriz P. Client and therapist match on gender, age, and income: Does match within the therapeutic dyad predict early growth in the therapeutic alliance? J Clin Psychol. 2018;74(9):1403–21. http://dx.doi.org/10.1002/jclp.22616
107. Blow AJ, Timm TM, Cox R. The role of the therapist in therapeutic change: Does therapist gender matter? J Fem Fam Ther. 2008;20(1):66–86. http://dx.doi.org/10.1080/0895280801907150
108. Shiner B, Westgate CL, Harik JM, Watts BV, Schnurr PP. Effect of patient-therapist gender match on psychotherapy retention among United States veterans with posttraumatic stress disorder. Adm Policy Ment Health Ment Health Serv Res. 2017;44(5):642–50. http://dx.doi.org/10.1007/s10488-016-0761-2
109. Wintersteen MB, Mensinger JL, Diamond GS. Do gender and racial differences between patient and therapist affect therapeutic alliance and treatment retention in adolescents? Prof Psychol Res Pract. 2005;36(4):400. http://dx.doi.org/10.1037/0735-7028.36.4.400
110. Rochlen AB, O'Brien KM. The relation of male gender role conflict and attitudes toward career counseling to interest in and preferences for different career counseling styles. Psychol Men Masc. 2002;3(1):9. http://dx.doi.org/10.1037/1524-9220.3.1.9
111. Wisch AF, Mahalik JR, Hayes JA, Nutt EA. The impact of gender role conflict and counseling technique on psychological help seeking in men. Sex Roles. 1995;33(1):77–89. http://dx.doi.org/10.1007/BF01547936
112. Berg AL, Sandahl C, Clinton D. The relationship of treatment preferences and experiences to outcome in generalized anxiety disorder (Gad). Psychol Psychother Theor Res Pract. 2008;81(3):247–59. http://dx.doi.org/10.1348/147608308X297113
113. Elkin I, Yamaguchi J, Arnkoff D, et al. "Patient-treatment fit" and early engagement in therapy. Psychother Res. 1999;9(4):437–51. http://dx.doi.org/10.1080/10503309912331332851
114. Swift JK, Callahan JL. A comparison of client preferences for intervention empirical support versus common therapy variables. J Clin Psychol. 2010;66(12):1217–31. http://dx.doi.org/10.1002/jclp.20720
115. Englar-Carlson M, Stevens MA, Scholz R. Psychotherapy with men. In: Chrisler JC, McCreary DR, editors. Handbook of gender research in psychology. London: Springer; 2010. p. 221–51.
116. Syzdek MR, Addis ME, Green JD, Whorley MR, Berger J. A pilot trial of gender-based motivational interviewing for help-seeking and internalizing symptoms in men. Psychol Men Masc. 2014;15(1):90. http://dx.doi.org/10.1037/a0030950
117. Ardito RB, Rabellino D. Therapeutic alliance and outcome of psychotherapy: Historical excursus,

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

measurements, and prospects for research. Front Psychol. 2011;2:270. http://dx.doi.org/10.3389/fpsyg.2011.00270

118. Cabral RR, Smith TB. Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. J Couns Psychol. 2011;58(4):537. http://dx.doi.org/10.1037/a0025266
119. Holler TR. The importance of client personality in the prediction of preference for a counseling approach. The University of Memphis; 2006.
120. Ogunfowora B, Drapeau M. A study of the relationship between personality traits and theoretical orientation preferences. Couns Psychother Res. 2008;8(3):151–9. http://dx.doi.org/10.1080/14733140802193218
121. American Psychological Association. APA guidelines for psychological practice with boys and men. Washington:APA; 2018.
122. Englar-Carlson M, Kiselica MS. Affirming the strengths in men: A positive masculinity approach to assisting male clients. J Counsel Dev. 2013;91(4):399–409. http://dx.doi.org/10.1002/j.1556-6676.2013.00111.x
123. Statistics Canada. Census profile, 2016 census. Catologue No. 98-316-X2016001 [Internet]. [Cited 2017 Feb 8]. Available from: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

APPENDIX
QUESTIONNAIRE

For the purpose of the survey, the term "psychosocial professional" refers to any person who has received technical or professional training to provide psychological or social assistance. It can be someone who works in the health and social services network or in a community organization. For example, psychologists and social workers are considered psychosocial professionals

Section 1: Factors facilitating the consultation of psychological resources or professionals

Q1. In Quebec, there are various services intended for men, but many of them are not well known by the population. What would be the three most effective strategies, among the following, to help you know what services are available? Indicate your first three choices.

a) A website specializing in resources intended form men
b) A mobile application
c) A flyer delivered in your mailbox
d) TV advertisements
e) Radio advertisements
f) Targeted 15-second spots on the Internet (e.g. on sites about motorcycles, sports, etc.)
g) Promotion by community organizations
h) Other (specify): _____

I don't know/I prefer not to answer

Q2. On a 1 to 10 scale, how likely would you be to consult a psychosocial professional if...?

	Not at all likely									**Very likely**	
Q2a. Your doctor told you to consult one	1	2	3	4	5	6	7	8	9	10	Prefer not to answer
Q2b. Your spouse told you to consult one	1	2	3	4	5	6	7	8	9	10	Prefer not to answer
Q2c: One of your friends told you to consult one	1	2	3	4	5	6	7	8	9	10	Prefer not to answer

Q3. On a 1 to 10 scale, how likely would you be to consult a psychosocial professional if…?

	Not at all likely									**Very likely**	
Q3a. You were going through a marital separation	1	2	3	4	5	6	7	8	9	10	Prefer not to answer
Q3b. Your spouse was threatening to leave you	1	2	3	4	5	6	7	8	9	10	Prefer not to answer
Q3c. You realized that a problem you had was having an impact on your child or children	1	2	3	4	5	6	7	8	9	10	Prefer not to answer
Q3d. You were contemplating suicide	1	2	3	4	5	6	7	8	9	10	Prefer not to answer
Q3e. You lost your job	1	2	3	4	5	6	7	8	9	10	Prefer not to answer
Q3f. You lost your libido	1	2	3	4	5	6	7	8	9	10	Prefer not to answer
Q3g. You felt depressed	1	2	3	4	5	6	7	8	9	10	Prefer not to answer

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

Q4. If you were experiencing significant emotional difficulties, would the following possibilities help you reach for a resource or a professional?

	Would not help at all				**Would help a lot**	
Q4a. That someone close to you take the first appointment for you	1	2	3	4	5	Prefer not to answer
Q4b. That a friend recommends a particular resource or professional	1	2	3	4	5	Prefer not to answer
Q4c. That someone close to you accompany you to the first appointment	1	2	3	4	5	Prefer not to answer
Q4d. That you be able to make a first contact with the resource directly	1	2	3	4	5	Prefer not to answer
Q4e. That you be able to make an appointment by Internet	1	2	3	4	5	Prefer not to answer
Q4f. That you be able to find information on the resource by Internet before consulting them	1	2	3	4	5	Prefer not to answer
Q4g. That you know what to expect	1	2	3	4	5	Prefer not to answer
Q4h. That you be able to go in person without an appointment	1	2	3	4	5	Prefer not to answer
Q4i. That the business hours simplify your life (outside regular working hours, including nights and weekends)	1	2	3	4	5	Prefer not to answer
Q4j. That it be discreet (waiting room, office)	1	2	3	4	5	Prefer not to answer
Q4k. That someone come visit you at home	1	2	3	4	5	Prefer not to answer
Q4l. That it be free or low cost	1	2	3	4	5	Prefer not to answer
Q4m. That the service be available in English	1	2	3	4	5	Prefer not to answer

Q5. What would make the waiting room of a psychosocial assistance resource welcoming FOR MEN in your opinion

I don't know, I prefer not to answer

Section 2: Preferences in terms of intervention

Q6. If you contacted a resource because you needed assistance and reached their voice mail, would you...?

a) Leave a message asking to call you back as soon as possible
b) Give up
c) Try elsewhere
d) Call later
e) I don't know, I prefer not to answer

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

Q7. If your request were put on a waiting list, would you like someone to call you back regularly to check on your situation?
- a) Yes
- b) No
- c) I don't have a preference
- d) I don't know, I prefer not to answer

Q8. If you were given the choice, what type of intervention would you prefer?
- a) An intervention to help you understand the causes of your problem
- b) An intervention to help you identify what you can do to get over the situation, regardless of the causes
- c) I don't have a preference
- d) I don't know, I prefer not to answer

Q9. Among the following factors, which one do you find the most important?
- a) That there be an ongoing relationship with the same psychosocial professional (even if you have to wait longer before the intervention starts)
- b) That you be able to see a psychosocial professional quickly when you need to (even if a different person provides the follow-up)
- c) That the psychosocial professional (social worker, psychologist, therapist) speaks English
- d) I don't have any preference
- e) I don't know, I prefer not to answer

Q10. If you were experiencing significant difficulties, would you feel more comfortable discussing with…?
- a) A male psychosocial professional
- b) A female psychosocial professional
- c) I don't have a preference
- d) I don't' know, I prefer not to answer

Q11. If you were experiencing significant difficulties, would you feel more comfortable discussing with…?
- a) Someone who has experienced the same thing as you
- b) Someone close to you (family member or friend)
- c) A psychosocial professional
- d) I don't know, I prefer not to answer

Q12. If you needed to consult a psychosocial professional, would you prefer that the professional…?
- a) Listen to you without judging and let you reflect on the situation by yourself
- b) Help you understand what you are experiencing without telling you what to do
- c) Give you feedback, advice and practical tools
- d) All of these answers
- e) I don't have a preference
- f) I don't know, I prefer not to answer

Q13. What would be the most important factor for you when consulting a psychosocial resource or professional
- a) The proximity to your home
- b) The low risk that you run into someone you know in the waiting room

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

c) The possibility of meeting a professional who was referred to you and whom you trust
d) That it's free or small cost (not too expensive)
e) Knowing that the consulting process is short (not long term)
f) Feeling that the resource will really be able to help solve your problem
g) I don't have a preference
h) I don't know, I prefer not to answer

Section 3: Health status and consultation on the last year

Q14. Generally speaking, would you say that your physical health is…?
a) Excellent
b) Very good
c) Good
d) Fair
e) Poor
f) I don't know, I prefer not to answer

Q15. Generally speaking, would you say that your mental health is…?
a) Excellent
b) Very good
c) Good
d) Fair
e) Poor
f) I don't know, I prefer not to answer

Q16. Generally speaking, how do you find your social life, in other words, the relationships that you have with the people around you (family members, friends, acquaintances, etc.)?
a) Very satisfying
b) Somewhat satisfying
c) Somewhat unsatisfying
d) Very unsatisfying
e) I don't know, I prefer not to answer

Q17. In the last month, how often have you felt…?

		Never				**Always**	
Q17a.	Nervous	1	2	3	4	5	Prefer not to answer
Q17b.	Desperate	1	2	3	4	5	Prefer not to answer
Q17c.	Agitated or restless	1	2	3	4	5	Prefer not to answer
Q17d.	Depressed	1	2	3	4	5	Prefer not to answer
Q17e.	Tired to the point where everything was an effort	1	2	3	4	5	Prefer not to answer
Q17f.	Worthless	1	2	3	4	5	Prefer not to answer

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.

Q18. When was the last time you consulted a psychosocial resource or professional?

a) Less than a month ago
b) From 1 to 3 months ago
c) From 4 to 12 months ago
d) More than 12 months but less than 3 years ago
e) From 3 to less than 5 years ago
f) 5 years ago, or longer than that
g) I have never consulted any psychosocial resource or professional
h) I don't know, I prefer not to answer

Q19. In the past year, have you consulted…?

Q19a.	Your family doctor	Yes	No	Prefer not to answer
Q19b.	A doctor in a walk-in clinic or emergency room	Yes	No	Prefer not to answer
Q19c.	A specialist doctor	Yes	No	Prefer not to answer
Q19d.	Another health care specialist (e.g. dentist, chiropractor, naturopath, massage therapist, etc.)	Yes	No	Prefer not to answer
Q19e.	A psychosocial professional from a CLSC or medical clinic	Yes	No	Prefer not to answer
Q19f.	A psychosocial professional from a specialized service (e.g. addiction recovery clinic)	Yes	No	Prefer not to answer
Q19g.	A psychosocial professional in a private cabinet	Yes	No	Prefer not to answer
Q19h.	A psychosocial professional in a community organization	Yes	No	Prefer not to answer

Q20. Which of the following statements best applies to your current situation?

a) I am married or in a common-law relationship
b) I am separate or divorced
c) I am single
d) I prefer not to answer

Q21. Among the following choices, which one best defines your sexual orientation?

a) Heterosexual (attracted by people of the opposite sex)
b) Homosexual (attracted by people the same sex)
c) Bisexual (attracted by both men and women)
d) Pansexual (attracted by people independently of their gender)
e) Asexual (not attracted by other people)
f) I prefer not to answer

DOI: http://dx.doi.org/10.22374/ijmsch.v5i1.57
Int J Mens Com Soc Health Vol 5(1):1–26; 12 January 2022.