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

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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
INTRODUCTION

Research has shown that individuals living with mental health disorders or experiencing psychological distress are often reluctant to seek professional help. 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; though more recent data have shown changes in this trend. 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. 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. 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. 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. A recent systematic review identified other sociodemographic determinants related to help-seeking. 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. 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, perceived stigma, gender socialization, familial and personal attitudes, use of alternative coping mechanisms, and previous negative or unhelpful 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. 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. Other frequently reported barriers in another recent systematic review included limited hours of operation, and poor communication with health professionals. 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, 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. The facilitators investigated include the presence of trained practitioners, peer advocates and role models, and targeted awareness-raising in schools, universities, and work settings. Among young men living in rural areas, the importance of mental health services being discreet and confidential was also reported. Organizational factors identified by young men engaged in mental health services include initial contact, effective cross-sector partnerships, and availability of male practitioners.

Some authors 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
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. 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, although this preference is less apparent among men. Men seem to respond more positively to help from a psychotherapist, followed by help from a doctor and their significant other. Others have suggested a preference for friends and family, particularly young men. 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. Others suggest that men sometimes have a preference for women or men therapists. Compared with women, men generally favor individual over group intervention. 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. Another study found a preference for positive-psychology/positive masculinity interventions over cognitive-behavioral interventions. Finally, men favor interventions that are more directive and focused on cognition rather than emotion, possibly because disclosure of personal information, emotional expression, and vulnerability is perceived to be inconsistent with masculine norms. Hence, many men are reluctant to use the services available since psychological interventions are often more emotion-focused than solution-focused. 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, 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%). 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). 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. Indeed, only 2.3% (3.8% of women) of the population reported needing to see a psychosocial professional but were unable to do so, 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. 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

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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.

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

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

GBTQ: Gay Bisexual Transgender and Questioning/Queer.
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. 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, 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, 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
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, helping 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
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

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

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

<table>
<thead>
<tr>
<th>Psychological distress</th>
<th>Psychosocial services</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Low distress (n = 1441)</td>
<td>83</td>
<td>5.8</td>
</tr>
<tr>
<td>Moderate distress (n = 437)</td>
<td>54</td>
<td>12.4</td>
</tr>
<tr>
<td>High distress (n = 169)</td>
<td>54</td>
<td>32.0</td>
</tr>
</tbody>
</table>

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).\(^{32}\) 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).\(^{32}\)

The sociodemographic variables (education, household income, and marital status) were combined to compare the two groups of participants
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; ω = 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 (x̄ = 5.43) than in the other situations. Noticing an impact of their problem on their children (x̄ = 7.87) and suicidal ideation (x̄ = 7.54) were rated the highest, with the other situations remaining somewhere in between (see Table 4).

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; ω = 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 (x̄ = 7.93 ± 2.057; p < 0.001) than if a partner (x̄ = 6.94 ± 2.323; p < 0.001) or a friend (x̄ = 6.10 ± 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 (x̄ = 6.94 ± 2.323; p < 0.001) than if a friend (x̄ = 6.10 ± 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

### Table 4. Mean Probability of Consulting When Facing Different Situations

<table>
<thead>
<tr>
<th>Situation</th>
<th>n</th>
<th>Mean±</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact on children</td>
<td>1926</td>
<td>7.87</td>
<td>2.32</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>2020</td>
<td>7.54</td>
<td>2.74</td>
</tr>
<tr>
<td>Threats of separation</td>
<td>1986</td>
<td>6.30</td>
<td>2.80</td>
</tr>
<tr>
<td>Feeling depressed</td>
<td>2055</td>
<td>6.20</td>
<td>2.54</td>
</tr>
<tr>
<td>Marital separation</td>
<td>1973</td>
<td>6.17</td>
<td>2.71</td>
</tr>
<tr>
<td>Loss of libido</td>
<td>2014</td>
<td>6.01</td>
<td>2.66</td>
</tr>
<tr>
<td>Losing job</td>
<td>1936</td>
<td>5.43</td>
<td>2.84</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>13,910</td>
<td>6.50</td>
<td>2.78</td>
</tr>
</tbody>
</table>

*aThe mean scores represent the average likelihood ratings assessed from 1–10.*
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%).
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 GBQT+ 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. 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. 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 and lower-income men. 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 and young men’s preference for informal sources of help such as friends and family. 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
Psychological distress and help-seeking facilitators

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 Quebeckers 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 clear75 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.

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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, lack of culturally and linguistically appropriate services, and location of services. 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 and awareness 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, as family members are seen as potential allies by primary care providers. Prior research has found that more than one-third of older adults coming to primary care settings were accompanied by family members, and men often rely on their wives and daughters for assistance for their health management. In the past, physicians have noticed a trend where young came in on their own with their partners close behind. These findings are also supported by a survey of Quebec men. This trend may be consistent with research suggesting that older men might prefer treatments for depression involving the family. 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. 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, 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. Partners can influence help-seeking behavior by increasing confidence in treatment or the perceived effectiveness of treatment through conversational tactics. However, there is a current need to better equip partners and relatives as they are unprepared to handle distressed individuals. 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. 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.
and prevent social fragmentation. 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. 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. The lack of male practitioners is a systematic barrier to care. While research in adults is inconclusive, adolescent-practitioner dyads matched on gender result in higher alliances and increased probability of finishing treatments, suggesting more serious implications of gender-matching in young men. Compatible with other studies, 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. 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.

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 or preferences 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, and need to be considered. Thus, future research should concentrate on multiple dispositional variables such as personality traits and individual preferences and individual attitudes, and remain gender-sensitive.

**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 indicates that 26.1% of the Quebec male population...
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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**

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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 for 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...?

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all likely</th>
<th>Very likely</th>
<th>Prefer not to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2a.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2b.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2c.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all likely</th>
<th>Very likely</th>
<th>Prefer not to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3a. You were going through a marital separation</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3b. Your spouse was threatening to leave you</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3c. You realized that a problem you had was having an impact on your child or children</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3d. You were contemplating suicide</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3e. You lost your job</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3f. You lost your libido</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3g. You felt depressed</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q4. If you were experiencing significant emotional difficulties, would the following possibilities help you reach for a resource or a professional?

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

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
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
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...

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Always</th>
<th>Prefer not to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q17a.</td>
<td>1</td>
<td>2</td>
<td>3 4 5</td>
</tr>
<tr>
<td>Q17b.</td>
<td>1</td>
<td>2</td>
<td>3 4 5</td>
</tr>
<tr>
<td>Q17c.</td>
<td>1</td>
<td>2</td>
<td>3 4 5</td>
</tr>
<tr>
<td>Q17d.</td>
<td>1</td>
<td>2</td>
<td>3 4 5</td>
</tr>
<tr>
<td>Q17e.</td>
<td>1</td>
<td>2</td>
<td>3 4 5</td>
</tr>
<tr>
<td>Q17f.</td>
<td>1</td>
<td>2</td>
<td>3 4 5</td>
</tr>
</tbody>
</table>
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…?

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

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