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Meta-Analyses of the Relationship Between Conformity to Masculine Norms and Mental Health-Related Outcomes

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Despite theoretical postulations that individuals' conformity to masculine norms is differentially related to mental health-related outcomes depending on a variety of contexts, there has not been any systematic synthesis of the empirical research on this topic. Therefore, the authors of this study conducted meta-analyses of the relationships between conformity to masculine norms (as measured by the Conformity to Masculine Norms Inventory-94 and other versions of this scale) and mental health-related outcomes using 78 samples and 19,453 participants. Conformity to masculine norms was modestly and unfavorably associated with mental health as well as moderately and unfavorably related to psychological help seeking. The authors also identified several moderation effects. Conformity to masculine norms was more strongly correlated with negative social functioning than with psychological indicators of negative mental health. Conformity to the specific masculine norms of self-reliance, power over women, and playboy were unfavorably, robustly, and consistently related to mental health-related outcomes, whereas conformity to the masculine norm of primacy of work was not significantly related to any mental health-related outcome. These findings highlight the need for researchers to disaggregate the generic construct of conformity to masculine norms and to focus instead on specific dimensions of masculine norms and their differential associations with other outcomes.

Public Significance Statement
This study synthesized findings from 19,453 participants across 78 samples regarding the relationships between conformity to masculine norms and mental health-related outcomes. In general, individuals who conformed strongly to masculine norms tended to have poorer mental health and less favorable attitudes toward seeking psychological help, although the results differed depending on specific types of masculine norms.

Keywords: conformity to masculine norms, meta-analysis, masculinities, mental health

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The question of how masculinity-related constructs are associated with mental health-related outcomes has been a key focus of gender-related counseling psychology research as well as the psychology of men over the past three decades (Wong, Steinfeldt, Speight, & Hickman, 2010). In a narrative review of 249 studies, O'Neil (2012) found strong evidence that masculinity-related constructs were positively associated with psychological problems across diverse samples of men and women. On the other hand, there has been growing recognition over the past decade that the relationship between masculinity-related constructs and mental health-related outcomes is probably more nuanced and may depend on the manner in which "masculinity" is operationalized (Wong et al., 2015), the specific dimensions of masculinities (Levant, Wimer, & Williams, 2011), types of outcomes (e.g., Hammer & Good, 2010), and types of populations being studied (e.g., Levant, Wong, Karakis, & Welsh, 2015).

The gender role norms model, which focuses on individuals' conformity to dominant masculine norms in society (Mahalik et al., 2003), might provide an ideal forum for studying the differential effects of masculinities on mental health-related outcomes. Grounded in the psychology of social norms, Mahalik et al. defined conformity to masculine norms as "meeting societal expectations of what constitutes masculinity in one's public or private life (p. 3)." Unlike other conceptual paradigms that focus on the negative consequences associated with masculinities (e.g., O'Neil,

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2008), the gender role norms model proposes that conformity to masculine norms can be beneficial or problematic depending on different contexts (Mahalik et al., 2003). Hence, the theoretical basis of this model aligns well with the notion that masculinities may have differential relationships with mental health-related outcomes.

Furthermore, the Conformity to Masculine Norms Inventory-94 (CMNI-94; Mahalik et al., 2003), which was developed to measure individuals' adherence to masculine norms, encompasses 11 subscales corresponding to 11 distinct dimensions of masculine norms—winning, emotional control, risk-taking, violence, dominance, playboy, self-reliance, primacy of work, power over women, disdain for homosexuals, and pursuit of status. Several factor analytic studies have provided support for the hypothesized factor structure of the CMNI-94 and the CMNI-46 (a briefer version of the CMNI-96) that corresponds to its subscales (Levant, Hall, Weigold, & McCurdy, 2015; Mahalik et al., 2003; Parent & Moradi, 2009, 2011). The sheer number of subscales makes this measure an ideal assessment tool to address differential effects of conformity to masculine norms on mental health-related outcomes. It is therefore entirely conceivable that conformity to some masculine norms might be associated with psychological distress, whereas conformity to other norms might not (Mahalik, Talmadge, Locke, & Scott, 2005).

Since the development of the CMNI-94 (Mahalik et al., 2003), research on conformity to masculine norms has burgeoned. A recent reliability generalization study of research from 2003 through 2013 identified 69 studies that used the CMNI[1] (Kivisalu, King, Phillips, & O'Toole, 2015). Aligning with Mahalik et al.'s postulation that conformity to masculine norms has both benefits and costs, research on the CMNI has identified complex and differential associations with mental health-related outcomes. For example, overall conformity to masculine norms as well as conformity to the specific masculine norms of self-reliance, emotional control, violence, dominance, risk-taking, and power over women were inversely associated with attitudes toward seeking professional psychological help in a predominantly White American male college sample (Mahalik et al., 2003). On the other hand, conformity to masculine norms may also be beneficial, as evidenced by a negative association between adherence to the masculine norm of winning and substance use in a mainly White American male college sample (Levant et al., 2011) and between conformity to the masculine norm of emotional control and alcohol use among Asian American male college students (Liu & Iwamoto, 2007).

In making sense of this mixed body of evidence, Wong, Owen, and Shea (2012) proposed two conceptual perspectives that explain how conformity to masculine norms might be differentially related to other outcomes. The variable-centered perspective, hereafter known as the predictor-centered perspective[2], proposes that the relationship between men's conformity to masculine norms and other outcomes varies as a function of the types of masculine norms—conformity to some masculine norms may be maladaptive, whereas conformity to other norms are adaptive. To illustrate, Mahalik et al. (2005) posited that men who conform to the masculine norms of self-reliance and emotional control might have difficulty with interpersonal relationships, whereas conformity to the masculine norms of primacy work, pursuit of status, and winning might endow men with a sense of identity and purpose derived from work.

In contrast, the person-centered perspective (Wong et al., 2012) suggests that the consequences of conformity to masculine norms differ for diverse groups of individuals; because of cultural and gender differences, diverse groups of individuals may experience varying levels of rewards and sanctions associated with conformity and nonconformity to masculine norms. This perspective also dovetails with recent advances in intersectionality scholarship as applied to men of color (Levant & Wong, 2013; Wong, Liu, & Klann, in press). For instance, the negative consequences of conforming to the masculine norm of emotional control might be less severe for Asian American men than for Latino American men because emotional control is congruent with Asian cultural values that promote emotional restraint but less so with the Latino masculinity ideology of caballerismo (Levant et al., 2015). Accordingly, the person-centered perspective predicts that conformity to masculine norms will be differentially related to mental health-related outcomes depending on the culture of the individuals.

In a test of differential associations between men's conformity to masculine norms and psychological distress, Wong et al. (2012) found support for both the predictor-centered and person-centered perspectives in a U.S. mixed sample of college and noncollege male adults. A latent class regression model identified a two-class solution: in Class 1, conformity to the masculine norm of risk-taking was negatively associated with psychological distress. However, in Class 2, men's conformity to the masculine norms of playboy, self-reliance, and risk-taking was positively associated with psychological distress, while conformity to the masculine norm of violence was negatively related to psychological distress. These findings provide support for the predictor-centered perspective. Moreover, Asian American men and younger men had greater odds of being classified in Class 2 than in Class 1, thus also providing support for the person-centered perspective.

Nonetheless, several issues in the Wong et al. (2012) study should be noted. For one, in addition to the predictor-centered and person-centered perspectives, a third perspective that was not considered in their study is the possibility that the link between conformity to masculine norms and mental health-related outcomes varies as a function of the type of outcomes. We label this perspective the *outcome-centered perspective*. Support for this idea can be found in Mahalik et al.'s (2003) original scale development study—the CMNI-94 total score was significantly and positively associated with two of the six subscales of the Brief Symptom Inventory—hostility and lack of social comfort—but not with depression, somatization, obsessive-compulsiveness, and phobic anxiety. These findings potentially suggest that conformity to masculine norms might be more strongly associated with interpersonal than with intrapersonal dimensions of mental health. Additionally, it is not possible to draw definitive conclusions from one study on the link between conformity to masculine norms and

[1] Given that there are several shorter versions of the CMNI-94, we use the term CMNI in this article to refer collectively and generically to all versions of the CMNI.

[2] Although Wong et al. used the term "variable-centered framework," we use the term "predictor-centered perspective" in this article to provide a sharper contrast with another perspective, the outcome-centered perspective, which is discussed in a subsequent section of this article.

mental health-related outcomes. Therefore, what is needed and perhaps overdue is a systematic statistical synthesis of findings on this topic.

Present Study

Against this backdrop, we sought to conduct a series of meta-analyses on the relationships between conformity to masculine norms (as measured by the CMNI) and mental health-related outcomes. We focused on the CMNI because it is currently the only published measure of conformity to masculine norms written in English. There are several advantages afforded by the use of meta-analysis in analyzing masculinity-related constructs (Wong & Horn, 2016). First, meta-analysis allows researchers to amalgamate findings from a large body of studies using a common metric, thus increasing statistical power as well as the confidence with which researchers can draw conclusions about the relations between masculinity-related constructs and mental health-related outcomes (Lipsey & Wilson, 2001). Second, although a recent book chapter provided a narrative review of research on conformity to masculine norms (Addis, Reigeluth, & Schwab, 2016), a meta-analysis provides a more systematic process for aggregating research that focuses on the magnitude of effect sizes rather than on simply counting the number of studies with significant findings (Quintana & Minami, 2006). Third, given the aforementioned mixed findings on the CMNI, meta-analyses would enable researchers to identify moderators of the link between conformity to masculine norms and mental health-related outcomes across a wide range of dimensions, outcomes, and demographic characteristics.

We focused on mental health-related outcomes in this study because they are the most widely studied topic in the psychology of men and masculinities (Wong et al., 2010) and also have important practical implications for clinical practice and for individuals' well-being. To ensure that a broad spectrum of studies were included in our meta-analyses, we adopted Keyes's (2007) conceptualization of complete mental health, which does not equate the absence of mental illness with the presence of mental health. Keyes also included psychological well-being (e.g., self-esteem) and social well-being (e.g., social connectedness with others) under the conceptual rubric of mental health. In support of this conceptualization, a factor analysis of positive indicators of mental health (e.g., life satisfaction, psychological well-being, and social well-being) and indicators of mental illness (e.g., depressive symptoms) in a national study of U.S. adults identified a two-factor model reflecting the latent variables of positive mental health and mental illness (Keyes, 2005). Therefore, following Keyes (2005, 2007) as well as previous counseling psychology meta-analyses involving mental health (Yoon et al., 2013), we treated positive mental health and negative mental health as orthogonal constructs. Furthermore, we included psychological help seeking as an outcome in our meta-analyses because it is also a mental health-related outcome and one of the most widely studied constructs in the psychology of men (Addis, Mansfield, & Syzdek, 2010). In sum, we had three broad sets of outcomes in this study: positive mental health, negative mental health, and psychological help seeking. The predictor variable in our meta-analyses was conformity to masculine norms, as measured by one of the versions of the CMNI. Given prior evidence for the bifactor structure of the CMNI-46 in a U.S. mixed sample of college and noncollege male adults (Levant, Hall, et al., 2015), we examined both the total score as well as subscale scores of the CMNI in our meta-analyses.

We had four main goals in this study, reflecting our interest in the overall as well as differential effects of conformity to masculine norms based on the aforementioned three perspectives. Although we used the three perspectives as a framework to guide our research questions on moderation effects, these perspectives are not competing hypotheses; therefore, evidence for one perspective does not imply a lack of support for another. First, we estimated the direction and magnitude of the relationships between conformity to masculine norms and our three sets of mental health-related outcomes. Based on the broad empirical literature on masculinities and mental health (O'Neil, 2012), we expected conformity to masculine norms to be unfavorably associated with mental health and psychological help seeking.

Second, based on the outcome-centered perspective, we tested moderation effects of conformity to masculine norms using specific types of positive and negative mental health outcomes (e.g., depression, substance use, body image problems, etc.). We focused only on heterogeneity in negative and positive mental health outcomes, but not in psychological help seeking, because the types of outcomes for the latter are relatively homogenous unlike the varied dimensions of positive and negative mental health. On the basis of the aforementioned findings of Mahalik et al. (2003), we hypothesized that conformity to masculine norms would be more strongly associated with negative social functioning and positive social well-being than with psychological dimensions of mental health.

Third, guided by the person-centered perspective (Wong et al., 2012), we examined moderation effects of gender, race, age, developmental characteristics (e.g., college student status), and sexual orientation that might modify the relations between conformity to masculine norms and mental health-related outcomes. We hypothesized that the magnitude of the relationships between conformity to masculine norms and mental health-related outcomes would be stronger for male samples than for female samples because masculine norms are perceived by individuals to be more relevant and consequential for men than for women (Wong, Ho, Wang, & Fisher, 2016). Additionally, we predicted that effect sizes would be weaker as the proportion of sexual minority individuals in the samples increase. This hypothesis is premised on prior research showing a weaker direct link between conformity to masculine norms and attitudes toward seeking psychological help for gay men than for heterosexual men in a U.S. community sample of adults (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). We did not provide directional hypotheses for the moderation effects of race (given the mixed evidence on these effects; Levant et al., 2015; Vogel et al., 2011) as well as for age and college student status because of the lack of prior research evidence.

Fourth, as recommended by the predictor-centered perspective (Wong et al., 2012), we tested the relationship between each of the 11 dimensions of conformity to masculine norms and mental health-related outcomes to identify potential differential effects as a function of the type of masculine norm. No directional hypotheses were provided, given the aforementioned mixed evidence in the extant empirical literature and the lack of prior theory in this area of research.

In addition to these four main goals, we also had several secondary aims. Because there are several versions of the CMNI, we examined whether the link between conformity to masculine norms and mental health-related outcomes varied as a function of the CMNI version. Additionally, given that the meaning of masculine norms might change over time, we also tested whether the relationships between conformity to masculine norms and the three sets of mental health-related outcomes differed as a function of the year of publication. No directional hypotheses were provided because of the lack of prior theory or research in this area.

Method

Literature Search and Inclusion/Exclusion Criteria

A member of our research team (a counseling psychology doctoral student) identified empirical studies that examined the CMNI and mental health-related outcomes to be included in our dataset. First, this member conducted a preliminary literature search for both journal articles and dissertations/theses in four electronic databases: Google Scholar, PsycINFO, PubMed, and Medline, using the key words *conformity to masculine norms*. The exact phrase "conformity to masculine norms" was used for the Google Scholar search because of the large number of hits the search yielded without the use of quotations. Using this exact phrase in Google Scholar likely did not compromise the quality of our search—because all quantitative studies that examine conformity to masculine norms are based on versions of the same measure, namely, the CMNI, the words "Conformity to Masculine Norms Inventory" would appear in the method section of such studies. This preliminary search uncovered 173 studies, from which the researcher reviewed the abstracts and obtained copies of identified studies to determine their eligibility. The first author (a counseling psychology professor) was consulted when the research team member was unsure about how to interpret the criteria for including studies in our dataset. For example, we did not include studies that focused exclusively on coping strategies (e.g., disengagement coping) because they could not be unambiguously classified as either positive or negative mental health outcomes. As a result, the original pool of studies was narrowed to the final data set of 78 samples found in 74 studies (13 dissertations and 61 journal articles) with a combined sample size of 19,453. A list of these studies is found in an online supplement to this article. Specifically, we included studies that (a) were written in English; (b) published between 2003 and by the end of the year 2013; (c) used one of the CMNI versions: CMNI-94 (11 subscales; Mahalik et al., 2003), CMNI-55 (11 subscales; Owen, 2011), CMNI-46 (nine subscales; Parent & Moradi, 2009), or CMNI-22 (Rochlen, McKelley, Suizzo, & Scaringi, 2008) or one or more of their subscales (note that the CMNI-22 does not have subscales); (d) reported at least one of three mental health-related outcomes—positive mental health, negative mental health, and/or psychological help seeking; and (e) reported the effect size (ES) of a bivariate correlation coefficient (r) between at least one of the predictors and outcomes described in (c) and (d). ESs that used other statistics (e.g., means and standard deviations for two groups) were converted to r. If a dissertation was later published as a journal article, only the journal article was included. ESs that only tested nonpsychological help seeking (e.g., academic help seeking) were not included in our meta-analyses. Also, following Cooper (2017), we did not include ESs from analyses involving multiple predictor variables (e.g., multiple regression) because ESs that take into account a third variable other than a predictor and an outcome are systematically different from those that do not.

Data Coding

The first author created a coding manual based on the aforementioned theoretical conceptualization of mental health-related outcomes. The following variables were coded: (a) publication outlet (e.g., journal article vs. dissertation/thesis), (b) publication year, (c) sample size, (d) gender, developmental characteristics, mean age, U.S. race[3], and sexual orientation[4] (see Table 1), (e) CMNI measures, including the version of CMNI that was used (see Table 1), (f) the dimensions of conformity to masculine norms that were used (e.g., overall construct, winning, emotional control, etc.), and (g) outcome variables. Following in part the coding scheme used by previous meta-analyses on mental health (Smith & Silva, 2011; Yoon et al., 2013), the outcome variables were categorized as (a) negative mental health: depression, psychological distress/stress, substance use, body image problems, other psychological problems, and negative social functioning (e.g., loneliness), (b) positive mental health: life satisfaction, self-esteem, other indicators of psychological well-being, and social well-being, and (c) psychological help seeking (e.g., attitudes toward seeking professional psychological help); ESs for negative dimensions of psychological help seeking (e.g., stigma) were reverse-scored.

A 2-hr training session was held by the first author to familiarize two doctoral students in counseling psychology with the coding manual, demonstrate how to perform coding for approximately 10% of the articles from the final data set, and clarify questions from the two students. The two coders then independently coded 15 studies, met with the first author again for about 1.5 hr to check interrater agreement, and resolved discrepancies by discussion and consensus. The rest of the studies were coded by the two coders using the same procedure, with consultations with the first author on an as-needed basis. The final coding results from the two coders were then compared with one another and disagreements were identified. The two coders met for 1 hr to discuss the rationale for their respective codes, leaving the unresolved disagreements for the first author to review. Finally, a meeting was held to reach consensus among the three. Cohen's Kappa revealed a moderate to almost perfect agreement between the coders (Kappas = .74–.98, average = .88, all ps $< .001$; McHugh, 2012).

Data Analytic Plan

The meta-analyses were conducted using SPSS macros developed by Wilson (2005). The Pearson correlation was used as our measure of ES. With the exception of our analyses involving specific dimensions of conformity to masculine norms, we used

[3] We focused only on U.S. samples for moderation analyses involving race because the concept of race and racial categorizations (e.g., Latino/Hispanic) are quite different between U.S. and non-U.S. countries.

[4] Although race and sexual orientation are reported as categorical variables in Table 1, we coded these as continuous variables based on the percentages of self-reported Asian Americans, African Americans, Latino Americans, and sexual minorities (anyone who did not identify as heterosexual).

Table 1
Overall Sample Characteristics (N = 78)

Sample	Number of samples
Gender	
Female	4
Male	71
Mixed[a] (female and male)	3
U.S. race[b] (n = 65)	
Predominantly African American	9
Predominantly Asian American	3
Predominantly Latino American	0
Predominantly White American	45
Multiracial (no racial group > 50%)	3
Race not reported	5
Developmental characteristics:	
Adolescents (mean age < 18 years and ≥ 12 years)	6
College students	25
Adults (non-college students; mean age < 65 years old)	27
Adults (mean age > 65 years old)	1
Mixed[a] (college students and adults non-college samples)	19
Sexual orientation[b]	
Predominantly heterosexual	23
Predominantly gay	3
Sexual orientation not reported	52
CMNI version	
CMNI-94	49
CMNI-55	2
CMNI-46	10
CMNI-22	17

Note. CMNI = Conformity to Masculine Norms Inventory.
[a] Samples were classified as mixed if the authors did not report separate effect sizes for female and male students or for college students and non-college adults. [b] For U.S. race and sexual orientation, predominantly = at least 50%.

the CMNI total score to represent the construct of conformity to masculine norms in our analyses. If the CMNI total score was not reported, we then computed the average of CMNI subscale ESs, weighted by the number of items in each subscale. However, some studies did not use all the subscales of the CMNI. In determining whether to average the ESs from such subscales, we sought to strike a balance between the need for CMNI subscales to adequately represent the overall construct of conformity to masculine norms versus the need to preserve as many ESs as possible in our meta-analyses. Thus, we used the average of CMNI subscales scores to represent the overall construct of conformity to masculine norms only if the researchers reported ESs for at least six CMNI subscales (given that the CMNI-94 consists of 11 subscales, six subscales would constitute a majority of subscales). For example, if a study reported ESs for only five CMNI subscales, the average of these ESs were not used for analyses involving the overall construct of conformity to masculine norms, but the subscales were used for analyses for specific dimensions of conformity to masculine norms (our fourth research question).

We used samples as the unit of analysis because it allowed us to analyze subgroup differences (Cooper, 2017). That is, if a study reported separate ESs for two groups of participants representing different demographic categories (e.g., women and men), these ESs were computed separately and weighed according to the respective sample sizes. Some studies reported multiple correlations between conformity to masculine norms and mental health-related outcomes within one sample. This occurred because researchers tested the associations between several dimensions of conformity to masculine norms (e.g., emotional control and self-reliance) and mental health-related outcomes, and/or multiple mental health-related outcomes were used (e.g., depression and stress). To avoid violating the assumption of independent samples and favoring samples that reported multiple ESs, we averaged the correlations to obtain only one effect size per sample for each of our three sets of outcomes (Cooper, 2017). There were two exceptions to this rule. Multiple ESs from the same sample were allowed when we tested moderation effects based on the type of positive (e.g., self-esteem) and negative mental health outcomes (e.g., depression) and when the focus of our analysis was on assessing the link between specific dimensions of conformity to masculine norms (e.g., self-reliance) and mental health-related outcomes.

Each r ES was converted to Fisher's transformed z before aggregating ESs across studies. ESs were weighted by the inverse variance method with larger samples given more weight. We then back-transformed mean ESs to r. We used a random-effects model for our meta-analyses because our goal was to draw inferences about a population of studies beyond the current sample of studies (Lipsey & Wilson, 2001). The Q-statistic was used to probe for moderation effects. Moderation analyses were conducted using metaregression for continuous moderating variables (z-scored mean age, year of publication, as well as the percentages of Asian Americans, Black Americans, Latino Americans, and sexual minorities based on self-reports) and an analog to a one-way analysis of variance for categorical moderators (all other moderators; Quintana & Minami, 2006). We followed Fu et al.'s (2011) recommendation to require at least 10 ESs for continuous moderation variables and to include a subgroup for categorical moderation analyses only if it had a minimum of four ESs.

Results

Sample and Study Characteristics

Demographic information about the sample characteristics are provided in Table 1. The majority of the samples (n = 65; 83%) were from the United States, with the remainder from Australia (n = 4), Canada (n = 3), and other countries.

Preliminary Analyses

We examined the presence of publication bias as a function of the type of publication for negative mental health, positive mental health, and psychological help seeking. No differences in ESs were detected between articles and dissertations/theses for negative mental health, $Q_b(1) = 3.54$, positive mental health, $Q_b(1) = 0.05$, and psychological help seeking, $Q_b(1) = 2.06$, $ps > .05$. Furthermore, an examination of the funnel plots (see supplementary materials) exhibited a distribution resembling an approximately symmetrical inverted funnel for all three outcomes, suggesting that publication bias did not adversely influence the meta-analytic findings.

Because extreme ESs may distort meta-analytic findings, we explored the presence of outliers. Using the criterion of three standard deviations away from the mean (Cooper, 2017), we found

only one outlier for the relation between conformity to masculine norms and psychological help seeking and no outliers for the other outcomes. However, after contacting the author of the study with this outlier ES, he clarified that there was an error (a missing negative sign) in the correlation reported. After correcting the error, there were no other outliers. Using metaregression, we also tested whether ESs for positive mental health, negative mental health, and psychological help seeking varied as a function of the reliability (alpha coefficient) of the CMNI measure reported. Across all outcomes, we found no evidence that measurement precision based on CMNI alpha coefficients affected the magnitude of ESs, *p*s $> .05$.

Main Analyses

Omnibus tests. Cohen's (1988) guidelines were used to categorize the magnitude of ESs, with *r* values of .1, .3, and .5 reflecting small, medium, and large ESs, respectively. To address our first research question, we used omnibus tests to examine the overall relations between conformity to masculine norms and each of the three sets of mental health-related outcomes. As shown in Table 2, conformity to masculine norms was significantly and positively related to negative mental health, as well as significantly and negatively related to positive mental health. ESs for both analyses were small. Conformity to masculine norms was also significantly and inversely related to psychological help seeking, with this relationship exhibiting a medium ES. The *Q*-statistic was significant for negative and positive mental health and for psychological help seeking. We also computed the I^2 test, which quantifies the percentage of the total variability in all studies attributed to between-studies heterogeneity rather than to chance (Higgins, Thompson, Deeks, & Altman, 2003). $I^2 = 100\% \times (Q\text{- }df)/Q$, with larger values signifying higher percentage of heterogeneity. I^2 values of 25%, 50%, and 75% correspond to low, medium, and high degrees of heterogeneity, respectively (Higgins et al., 2003). The I^2 values were generally in the medium to large range. Collectively, these findings point to the value of investigating moderation effects for the three sets of outcomes.

Outcome-centered perspective. To address our second research question based on the outcome-centered perspective, we tested moderation effects of conformity to masculine norms based on specific types of positive and negative mental health outcomes. The *Q*-statistic was significant for negative mental health (see Table 3), implying differences in ESs as a function of the type of negative mental health. Given our hypothesis that the ES for negative social functioning would be stronger than that for psychological indicators of negative mental health, we reanalyzed the results by comparing negative social functioning with negative psychological health (consisting of all other negative mental health outcomes). In support of our hypothesis ($Q_b(1) = 5.06$, $p = .025$), the link between conformity to masculine norms and negative social functioning ($r = .27$, 95% CI = **[**.16, .37**]**, $p < .001$) was significantly stronger than that between conformity to masculine norms and negative psychological health ($r = .14$, 95% CI = **[**.11, .17**]**, $p < .001$). In contrast, the *Q*-statistic was not significant for positive mental health. This nonsignificant finding remained in a reanalysis in which positive mental health outcomes were classified as social well-being versus psychological well-being (consisting of all other positive mental health outcomes).

Person-centered perspective. To examine our third research question on the person-centered perspective, we tested moderation effects based on gender, mean age, developmental characteristics, race, and sexual orientation (see Table 3). With regard to gender, there were insufficient ESs for moderation analyses for positive mental health (there were only two nonmale samples) and psychological help seeking (all samples were male). As for negative mental health, there were two ESs for female samples and three ESs for mixed (female/male) samples. To satisfy the minimum threshold of four ESs per subgroup, we merged the categories of female and mixed (female/male) samples to obtain five ESs. A comparison of ESs from female and mixed samples with those from exclusively male samples yielded a nonsignificant moderation effect.

With regard to developmental characteristics, we compared the ESs for exclusively college student samples versus noncollege adult (including older adults), and mixed (college/noncollege adult) samples (there were too few ESs for adolescent samples pertaining to each outcome). We combined noncollege adult samples and mixed samples into one group because there were fewer than four ESs for noncollege adult samples pertaining to psychological help seeking. As shown in Table 3, conformity to masculine norms was significantly associated with mental health-related outcomes for both sample subgroups, except for college students in relation to positive mental health. The *Q*-statistic was not significant for negative mental health but was significant for positive mental health and psychological help. The negative relationships between conformity to masculine norms and positive mental health

Table 2
Omnibus Tests: Correlations Between Conformity to Masculine Norms and Mental Health-Related Outcomes

Outcomes and Predictors	*k*	*r*	95% CI	*Q*	I^2
Negative mental health					
Conformity to masculine norms	37	.16***	[.13, .19]	75.62***	52.39%
Conformity to specific dimensions of masculine norms	156	.11***	[.09, .13]	592.57***	73.84%
Positive mental health					
Conformity to masculine norms	27	−.12***	[−.18, −.05]	110.69***	76.51%
Conformity to specific dimensions of masculine norms	127	−.06***	[−.09, −.02]	441.13***	71.44%
Psychological help seeking					
Conformity to masculine norms	14	−.31***	[−.39, −.23]	103.12***	87.39%
Conformity to specific dimensions of masculine norms	56	−.20***	[−.23, −.16]	137.64***	60.04%

*** $p < .001$.

Table 3
Categorical Moderation Analyses for Type of Outcomes, Gender, Developmental Characteristics, and CMNI Version

Moderator	Negative Mental Health				Positive Mental Health				Psychological Help Seeking			
	Q_b	*k*	*r*	95% CI	Q_b	*k*	*r*	95% CI	Q_b	*k*	*r*	95% CI
Type of negative mental health	12.71*				—	—	—	—	—	—	—	—
Depression		14	.13***	[.09, .17]								
Psychological distress/stress		4	.21***	[.12, .30]								
Substance use		10	.09**	[.04, .15]								
Body image problems		4	.14***	[.06, .23]								
Other psychological problems		8	.19***	[.11, .26]								
Negative social functioning		5	.27***	[.17, .36]								
Type of positive mental health	—	—	—	—	.69				—	—	—	—
Life satisfaction						6	−.13	[−.31, .05]				
Self-esteem						5	−.16	[−.33, .02]				
Other indicators of positive psychological well-being						14	−.11*	[−.22, −.003]				
Social well-being						10	−.07	[−.20, .05]				
Gender	2.00				—	—	—	—	—	—	—	—
Male		31	.17***	[.13, .20]								
Female and mixed (male/female)		6	.11**	[.04, .18]								
Developmental characteristics	3.73				4.32*				6.23*			
College		13	.12***	[.06, .17]		7	−.01	[−.13, .12]		7	−.22***	[−.33, −.10]
Non-college adult and mixed[a]		24	.18***	[.14, .22]		20	−.16***	[−.24, −.09]		7	−.41***	[−.51, −.30]
CMNI version	2.39				1.19				—	—	—	—
CMNI-94		20	.18***	[.13, .23]		16	−.12*	[−.21, −.02]				
CMNI-46		7	.12**	[.05, .19]		5	−.06	[−.22, .11]				
CMNI-22		9	.14***	[.08, .19]		6	−.17*	[−.30, −.04]				

[a] mixed = sample with college students and non-college adults.
* $p < .05$. ** $p < .01$. *** $p < .001$.

as well as between conformity to masculine norms and psychological help seeking were stronger in noncollege adult and mixed college/noncollege adult samples than in exclusively college samples.

Metaregression showed that the mean age, race (percentages of Asian, Black, and Latino Americans), and sexual orientation (percentage of sexual minorities) did not significant moderate the link between conformity to masculine norms and negative mental health, positive mental health, and psychological help seeking (see Table 4). Metaregression was not conducted for the effect of percentage of Latino Americans pertaining to psychological help seeking because we had too few ESs ($k < 10$). We also conducted several post hoc moderation analyses for race and sexual orientation. First, we explored the possibility that excessive skewness and kurtosis might be responsible for these nonsignificant findings. Only three variables—percentages of Asian, Black, and Latino Americans for negative mental health—exhibited skewness and/or kurtosis exceeding 2.0. A Rankit transformation (Bishara & Hittner, 2012) reduced skewness and kurtosis to less than 1.0 for these three variables. Second, we created a new variable, namely, the

Table 4
Moderation Analyses: Meta-Regression Models Examining Continuous Variables Associated With Effect Sizes

Variable	Negative Mental Health			Positive Mental Health			Psychological Help Seeking		
	β	*B* (*SE*)	*k*	β	*B* (*SE*)	*k*	β	*B* (*SE*)	*k*
Mean age	.17	.02 (.02)	33	−.03	−.004 (.03)	23	−.24	−.07 (.07)	14
Publication year	−.18	−.02 (.02)	37	.02	.004 (.03)	27	−.06	−.01 (.06)	14
Asian American	−.06	−.01 (.02)	20	−.15	−.03 (.04)	16	−.07	−.01 (.06)	11
Black American	.33	.05 (.03)	18	−.20	−.03 (.04)	15	.45	.08 (.05)	11
Latino American	.11	.01 (.02)	20	.14	.02 (.03)	16	—	—	—
Sexual minority	−.01	−.001 (.03)	13	−.28	−.05 (.05)	11	−.05	−.01 (.07)	11

Note. None of the variables was significantly associated with the effect sizes; *Q*-statistics were not significant for all analyses, *p*s > .05. The variables, Asian American, Black American, Latino American, and sexual minority, reflect the percentage of samples that pertain to these demographic groups. Sexual minority = percentage that did not identify as heterosexual.

percentage of racial minorities based on the proportion of participants who did not identify as White American. Third, we disaggregated sexual orientation by creating two new variables—the percentage of gay individuals and the percentage of bisexual individuals. However, none of our reanalyses using these new variables yielded significant moderation effects, *p*s $> .05$.

Predictor-centered perspective. Our fourth research question, guided by the predictor-centered perspective, focused on specific dimensions of conformity to masculine norms and mental health-related outcomes. We began by conducting omnibus tests for the weighted average ESs for specific dimensions of conformity to masculine norms. As shown in Table 2, overall, the specific dimensions of conformity to masculine norms were significantly and positively related to negative mental health as well as significantly and inversely related to positive mental health and psychological help seeking. The *Q*-statistic was significant for all three outcomes. I^2 values were in the medium range for negative and positive mental health and for psychological help seeking. Therefore, we proceeded with moderation analyses for these outcomes. As reflected in Table 5, nine dimensions of conformity to masculine norms were significantly and positively related to negative mental health, whereas two dimensions—primacy of work and disdain for homosexuals—were not significantly related to negative mental health. The *r* ESs for the associations between the 11 dimensions and negative mental health ranged from $<.01$ for primacy of work to .19 for self-reliance.

In contrast to negative mental health, only four of the 11 dimensions of conformity to masculine norms were significantly and inversely related to positive mental health: emotional control, playboy, self-reliance, and power over women, whereas winning, violence, dominance, primacy of work, disdain for homosexuals, and pursuit of status did not exhibit significant effects (see Table 5). Interestingly, risk-taking was favorably and significantly associated with positive mental health. Similar to negative mental health, self-reliance exhibited the largest ES in its association with positive mental health. The ESs for the association between the 11 dimensions and positive mental health ranged from .12 for risk-taking to $-.23$ for self-reliance.

As for psychological help seeking, there were insufficient ESs to analyze dimension differences for risk-taking and dominance. However, all but two of the remaining nine dimensions of conformity to masculine norms (primacy of work and pursuit of status) were significantly and inversely associated with psychological help seeking. The ESs ranged from $< .01$ for pursuit of status to $-.30$ for emotional control, which was the only dimension to attain a medium ES. Overall, these findings provide strong support

Table 5
Moderation Analyses Based on Specific Dimensions of Conformity to Masculine Norms

Variable	Outcome	*k*	*r*	95% CI
Winning	NM	15	.10**	[.04, .17]
	PM	10	.06	[−.03, .14]
	PH	5	−.20***	[−.30, −.09]
Emotional control	NM	20	.08**	[.03, .14]
	PM	18	−.16***	[−.22, −.10]
	PH	10	−.30***	[−.37, −.23]
Risk-taking	NM	13	.15***	[.08, .22]
	PM	10	.12**	[.03, .20]
	PH	—	—	—
Violence	NM	12	.10**	[.03, .17]
	PM	10	.00	[−.08, .09]
	PH	5	−.19***	[−.29, −.08]
Dominance	NM	12	.13***	[.05, .20]
	PM	12	−.05	[−.13, .03]
	PH	—	—	—
Playboy	NM	16	.18***	[.12, .24]
	PM	11	−.19***	[−.27, −.11]
	PH	4	−.16*	[−.28, −.03]
Self-reliance	NM	18	.19***	[.13, .25]
	PM	15	−.23***	[−.29, −.16]
	PH	10	−.20***	[−.27, −.12]
Primacy of work	NM	14	−.004	[−.07, .06]
	PM	13	.05	[−.03, .12]
	PH	4	−.12	[−.24, .01]
Power over women	NM	12	.12**	[.05, .19]
	PM	9	−.16***	[−.25, −.07]
	PH	4	−.28***	[−.38, −.17]
Disdain for homosexuals	NM	15	.03	[−.03, .10]
	PM	10	−.003	[−.09, .08]
	PH	4	−.24***	[−.34, −.13]
Pursuit of status	NM	9	.10*	[.01, .18]
	PM	9	.09	[−.00, .18]
	PH	4	−.002	[−.13, .13]

Note. NM = negative mental health ($Q_b = 31.05$, $p < .001$); PM = positive mental health ($Q_b = 94.04$, $p < .001$); PH = psychological help seeking ($Q_b = 21.32$, $p = .006$).
* $p < .05$. ** $p < .01$. *** $p < .001$.

for the predictor-centered perspective—namely, the link between conformity to masculine norms and mental health-related outcomes differed as a function of conformity to specific types of masculine norms.

Other analyses. Finally, using metaregression, we tested whether the relations between conformity to masculine norms and mental health-related outcomes varied as a function of the CMNI version and year of publication. As shown in Table 4, we found no significant moderation effects for CMNI version and year of publication.

Discussion

Although several recent literature reviews have summarized research on the relationship between masculinities and mental health-related outcomes (Addis et al., 2016; O'Neil, 2012), our study is the first to provide a meta-analytic synthesis of research focusing on conformity to masculine norms based on a combined sample of 19,453 participants. Our meta-analytic findings reveal that conformity to masculine norms was positively associated with negative mental health as well as inversely related to positive mental health and psychological help seeking. These findings support previous assertions on the deleterious consequences associated with masculinities (O'Neil, 2012). However, the small ESs for positive and negative mental health ($r \geq [.10]$) contrast with the medium ES for psychological help seeking ($r \geq -.30$), suggesting that individuals' conformity to masculine norms had potentially a greater impact on psychological help seeking than on mental health. These findings underscore the importance of utilizing innovative strategies to improve the psychological help seeking attitudes of individuals who conform strongly to masculine norms (Rochlen, Whilde, & Hoyer, 2005).

In addition to main effects, we also tested several moderators based on three conceptual perspectives that might account for differential associations between conformity to masculine norms and mental health-related outcomes (Wong et al., 2012). Our analyses based on the outcome-centered perspective identified a significant moderation effect for negative mental health but not for positive mental health. Supporting our hypothesis and previous findings (Mahalik et al., 2003), conformity to masculine norms was more strongly and unfavorably related to negative social functioning than to psychological indicators of negative mental health. This finding makes sense given that most of the subscales in the CMNI address interpersonal concerns (e.g., winning, emotional control, violence, dominance, self-reliance, playboy, power over women, and disdain for homosexuals) rather than exclusively intrapersonal concerns.[5] In sum, this finding, coupled with our earlier finding on the medium ES for psychological help seeking, highlights the negative interpersonal consequences of conformity to masculine norms.

Our analyses guided by the person-centered perspective found few differential associations between conformity to masculine norms and mental health-related outcomes as a function of demographic variables. Among the variables of gender, developmental characteristics, race, sexual orientation, and age, we only found significant moderating effects associated with developmental characteristics. The negative association between conformity to masculine norms and positive mental health and between conformity to masculine norms and psychological help seeking was stronger in noncollege adult and mixed college/noncollege adult samples than in exclusively college student samples. Although one might be tempted to infer from this finding that the negative impact of conformity to masculine norms was stronger for older individuals, this conclusion is premature because age was not a significant moderator of the link between conformity to masculine norms and psychological help seeking. One possible explanation is that college students may tend to be individuals from a higher socioeconomic status (SES) than noncollege adults (Oyserman, Coon, & Kemmelmeier, 2002). High SES tends to be positively associated with better mental health as well as seeking mental health services (e.g., Cummings, 2014), which might also have attenuated the association between conformity to masculine norms and mental health-related outcomes. Admittedly, this suggestion is speculative because the focus of our moderation analyses was on demographic variables rather than on underlying social and psychological processes. We elaborate on this issue in our discussion of study limitations below.

Our analyses based on the predictor-centered perspective found strong and unambiguous evidence that the link between conformity to masculine norms and mental health-related outcomes differed depending on the specific types of masculine norms (Wong et al., 2012). Only four of 11 dimensions of conformity to masculine norms had significant ESs indicating unfavorable relations with positive mental health as compared to nine ESs for negative mental health and psychological help seeking. Moderation effects based on the dimensions of conformity to masculine norms were significant for negative and positive mental health and for psychological help seeking. Across the 11 dimensions of conformity to masculine norms, the ESs were quite varied. For instance, the ESs ranged from $< .01$ (primacy of work) to .19 (self-reliance) for negative mental health, .12 (risk-taking) to $-.23$ (self-reliance) for positive mental health, and $< .01$ (pursuit of status) to $-.30$ (emotional control) for psychological help seeking.

The moderation findings pertaining to the dimensions of conformity to masculine norms represent our study's most substantive contribution to the literature on masculine norms and mental health. Although the notion that conformity to certain masculine norms may be maladaptive whereas conformity to other norms might be beneficial has been well-established in the theoretical and empirical literature (Liu & Iwamoto, 2007; Mahalik et al., 2005), our meta-analyses provide the first systematic account of the *specific* dimensions of masculine norms that may have the most deleterious mental health-related consequences, null effects, or favorable outcomes. Our meta-analyses demonstrated that three specific dimensions were significantly, robustly ($r \geq [.1]$), consistently, and unfavorably associated with negative mental health, positive mental health, and psychological help seeking—self-reliance, playboy, and power over women. The masculine norms of playboy and power over women are the norms most closely associated with sexist attitudes (although the masculine norm of playboy can apply to both heterosexuals and sexual minorities). The robust and unfavorable association between conformity to these two norms and mental health-related outcomes underscores the idea that sexism is not merely a social injustice, but also has deleterious mental health-related consequences for those who em-

[5] We are grateful to Ronald Levant for this insight.

brace such attitudes. For instance, heterosexual men who adhere strongly to norms associated with sexism might struggle in their relationships with women, leading to poorer mental health (Wong, Klann, Bijelić, & Aguayo, 2016).

The findings pertaining to two other dimensions—primacy of work and risk-taking—are in stark contrast to these results. Primacy of work was not significantly associated with any of the mental health-related outcomes. Perhaps this null finding reflects the complexity of work and its implications for well-being. Although an excessive focus on work can be problematic for one's health and interpersonal relationships, work and career can also be an important source of meaning in life (Dik, Byrne, & Steger, 2013). Our findings on risk-taking were interesting in that they were positively associated with *both* negative and positive mental health. Indeed, across all findings in our study, conformity to the masculine norm of risk-taking was the only dimension that demonstrated a favorable association with a mental health outcome. This paradoxical finding regarding risk-taking is not in itself unusual—research on positive psychological constructs, such as optimism and benevolent attributions, has also demonstrated positive correlations with both favorable and deleterious outcomes (McNulty & Fincham, 2012). On the one hand, individuals who conform strongly to the masculine norm of risk-taking might engage in risky health behavior that might predispose them to psychological problems; on the other hand, risk-takers might also be more willing to seek out opportunities to stretch themselves beyond their comfort zone (e.g., by trying out new hobbies) that provide opportunities for self-actualization (Lupton & Tulloch, 2002).

Further moderation analyses revealed that the link between conformity to masculine norms and mental health-related outcomes did not vary as a function of the version of CMNI used in the study or the year of the study's publication.

Limitations and Implications for Research and Practice

Despite the contributions of our findings, we acknowledge several limitations in our study. First, our meta-analyses focused only on conformity to masculine norms and mental health-related outcomes and do not generalize to other masculinity constructs and outcomes such as health behavior (e.g., physical exercise). Second, because our meta-analyses consisted only of studies written in English, it is possible that we might have excluded studies written in non-English languages. Third, the studies in our meta-analyses were based on correlational data; none of them involved the experimental manipulation of variables that would enable researchers to draw causal conclusions about the contingent effects of masculinities on mental health-related outcomes (see Addis et al., 2010, for similar criticisms). Additionally, given the paucity of longitudinal studies in the psychology of men and masculinities (Wong & Horn, 2016), we could not test whether ESs differed as a function of the temporal sequence of conformity to masculine norms and mental health-related outcomes.

Fourth, some of our moderation analyses were hampered by sampling inadequacy. Because our samples consisted mostly of men from the United States, our findings are not necessarily generalizable to women and to non-U.S. countries. Similarly, across all outcomes, our moderation analyses could not address comparisons involving adolescents and older adults because there were insufficient samples for these groups. The majority of studies did not report participants' sexual orientation, which drastically reduced the number of studies available for moderation analyses. Collectively, these concerns point to the need for more research on conformity to masculine norms among individuals from diverse groups and countries.

Fifth, our significant moderation effects involving demographic variables have to be interpreted cautiously because they do not explain the underlying psychosocial mechanisms that might account for the varying impact of conformity to masculine norms on mental health-related outcomes. Beyond demographic categories, future research should address how variables associated with social identities (e.g., racial/sexual identity, perceived racism, acculturation, and social class) interact with conformity to masculine norms to predict other outcomes among individuals from diverse backgrounds (Wong et al., in press). For instance, researchers can address whether experiences of racism accentuate the link between conformity to masculine norms and mental health outcomes among men of color.

Sixth, we focused only on one masculinity construct—conformity to masculine norms—measured by several versions of one scale (CMNI). Hence, there was a lack of methodological triangulation. Moreover, as a self-report measure, the CMNI has been shown to be correlated with social desirability (Mahalik et al., 2003). Future research could examine the use of implicit measures of masculinities that are less susceptible to social desirability concerns (e.g., Wong, Burkley, Bell, Wang, & Klann, 2017).

On the basis of our robust findings on moderation effects for specific dimensions of conformity to masculine norms, we argue that it is not particularly meaningful to discuss individuals' conformity to masculine norms in a generic sense; rather, it is more useful to focus on men's conformity to specific dimensions of masculine norms. Although Levant et al. (2015) did identify a bifactor structure for the CMNI-46, they also noted several weaknesses in this bifactor model. That is, the general factor in their model for the CMNI-46 explained only 22% of the common variance in the items, and nine of the 46 CMNI-46 item factor loadings on the general factor were nonsignificant. In the same vein, Parent and Moradi (2011) raised concerns about interpreting the total score of the CMNI based on low intercorrelations among the subscales of this measure. Therefore, we question whether it would ever be appropriate to use the total score of the CMNI in research on individuals' conformity to masculine norms. Instead, we recommend that researchers should routinely use the subscales of the CMNI to explore differential associations between specific dimensions of conformity to masculine norms and other outcomes.

With regard to clinical practice, several implications can be gleaned from our findings. Given that conformity to the masculine norms of emotional control, self-reliance, power over women, and playboy were consistently and unfavorably associated with mental health-related outcomes, clinicians could invite their clients to explore the negative psychosocial consequences of enacting these norms (Mahalik et al., 2005). For instance, men who are extremely self-reliant and emotionally controlled might potentially struggle with seeking help and developing intimate relationships with others. Additionally, clinicians should guard against pathologizing individuals who adhere strongly to the masculine norm of primacy of work (e.g., by labeling them "workaholics"), given our finding that this norm was not significantly associated with any of the

mental health-related outcomes in our study. Instead, clinicians could explore how the importance of work can be both a source of stress as well as a source of meaning in one's life (Dik et al., 2013).

Conclusion

In conclusion, our meta-analyses of 78 samples and 19,453 participants provide greater breadth of coverage and depth of analysis of the relations between conformity to masculine norms and mental health-related outcomes than any previous single study or literature review on this topic. Overall, conformity to masculine norms was significantly and unfavorably associated with mental health and psychological help seeking. Nevertheless the substantial degree of heterogeneity in the ESs for these relationships highlights the need to disaggregate the generic construct of masculine norms and focus instead on specific dimensions of conformity to masculine norms and their differential associations with other outcomes.

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