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The impact of toxic masculinity on restrictive emotionality and mental health seeking support

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ABSTRACT

Many men struggle, at least occasionally, to talk about their feelings and to seek mental health support. Previous research has attributed this to gendered social norms requiring men to be tough and confident. In the present research, we investigate, across two studies, the role toxic masculinity, defined as the over-exaggeration of masculine social norms that perpetuate misogyny, plays in restrictive emotionality and intention to seek health support, as well as underlying mechanisms. Consistent with our predictions, we found that toxic masculinity, and associated variables such as aggression and dominance, were strongly linked to restrictive emotionality. Contrary to our predictions however, restrictive emotionality, but not toxic masculinity, predicted men's avoidance in seeking help for emotional problems and having suicidal thoughts. We discuss implications, limitations, and directions for future research to address issues surrounding men's mental health and improving service accessibility.

Research has consistently found that men are less likely than women to talk about their emotions (e.g., De Fruyt, 1997; Kring & Gordon, 1998) and seek help from mental health professionals when they experience symptoms (e.g., Lindinger-Sternart, 2015). This failure to seek treatment may underlie the documented higher rates of suicide in men (vs. women) (Berke et al., 2018). In 2021, death by suicide was three times higher in men (compared to women) in England and Wales, for instance (Baker, 2022). Popular discourse has recently begun to link the term "toxic masculinity" to men's reluctance to express their feelings and their resulting poorer mental health (e.g., Sheppard, 2025). The purpose of the present research, therefore, is to examine different facets of toxic masculinity's impact on restrictive emotionality and seeking support for mental health concerns, as well as investigate underlying mechanisms. We begin by briefly reviewing existing research on masculinity and men's mental health, before defining toxic masculinity and theorizing its role in perpetuating men's avoidance of help seeking for mental health concerns.

1. Masculinity and men's mental health

Existing research that examines the perpetuation of poor mental health in men (as well as men's reluctance to seek support for their mental health) has focused on the role of gendered social norms. Gendered social norms prescribe and proscribe different personality traits, behaviours, and roles that are deemed acceptable for men versus those acceptable of women. For example, men are expected to be tough, confident, and the household breadwinner whereas women are expected to be nurturing, kind, and the household caretaker (Bem, 1981; Fiske, 2012; Seager & Barry, 2019a, 2019b). Engrained from a young age, gender norms constantly influence people's attitudes and actions across their lifespan (Ashfield & Gouws, 2019; Ellemers, 2018; Ross & Mirowsky, 1984; Vogel et al., 2011). Social norms are accepted expectations that control social behaviours (Hechter & Opp, 2001) and lead men to behave in stereotypically masculine (sometimes hypermasculine) ways to be socially accepted (Berke et al., 2018; Ellemers, 2018). Such gendered social norms teach men not to show their emotions, which can lead to mental health difficulties, such as depression (Levant & Wong, 2017; Syzdek & Addis, 2010). Importantly, while men may feel particularly pressured to act in ways that display adherence to these norms, all people, regardless of gender identity, have the potential to endorse and enforce these norms. For example, research has shown that female health practitioners can unintentionally reinforce these masculine norms through their interactions with male patients (Seymour-Smith et al., 2002).

Symptoms of depression often manifest differently in men (vs. women). According to the Diagnostic and Statistical Manual of Mental

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Health Disorders (DSM-5), major depressive disorder is characterised by a person "appearing tearful" or as if they are "about to cry" (American Psychiatric Association, 2013, p. 160–163). Crying in men can be seen as an expression of weakness and is associated with femininity (Ross & Mirowsky, 1984); men appearing feminine is a violation of gendered social norms (Ellemers, 2018; Levant & Wong, 2017). As a result, emotions such as being upset or crying are then associated with feelings of shame and are commonly replaced by feelings of anger (Jakupcak et al., 2005; Magovcevic & Addis, 2008; Parent et al., 2019; Ross & Mirowsky, 1984; West & Zimmerman, 1987). As a result, different symptoms are commonly attributed to masculine depression including substance abuse, issues with anger management, and difficulties with interpersonal relationships (Bilsker et al., 2018; Cole & Davidson, 2018; Liddon et al., 2019). These hypermasculine symptoms, associated with masculine depression, may influence the diagnostic process with depression, leading men to get misdiagnosed or not being diagnosed at all (Mahalik & Rochlen, 2006; Ross & Mirowsky, 1984; Salk et al., 2017). The desire to restrict emotionality to appear masculine can also lead men to fail to seek out or reject mental health support and treatment (e.g., Addis & Mahalik, 2003; Lindinger-Sternart, 2015; see also Call & Shafer, 2018). Despite well documented statistics highlighting men's (vs. women's) poorer physical and mental health, examining the causes of this difference has remained undertheorized, perhaps because of the stigma associated with men's mental health that stems from societal gendered expectations discussed above (McKenzie et al., 2018; McKenzie et al., 2022).

2. Toxic Masculinity

Toxic masculinity is typically defined as the over-exaggeration of traits and characteristics associated with the socially defined norms of masculinity that perpetuate misogyny and heterosexism while reinforcing power over women by devaluing femininity (Harrington, 2021; Parent et al., 2019; Plant et al., 2000; Waling, 2019). Thus, the present research operationalizes toxic masculinity as a combination of beliefs that exaggerate winning, power over women, and heterosexual presentation as a means of exerting dominance over others and over femininity (Parent et al., 2019). Not all characteristics associated with masculinity norms are toxic. For example, wanting to be seen as athletic or independent would not be seen as toxic, but wanting to be seen as forceful or dominant has the potential to be toxic. Toxic masculinity denotes a harmful constellation of traditional masculinity that perpetuates male dominance over women and marginalized men and preserves the existing status quo (see Ingram et al., 2019).

Because toxic masculinity is associated with the over exaggeration of masculine social norms, men who score higher on measures of toxic masculinity will likely also score higher on measures of (a) dominance, (b) aggression, and (c) rejection of femininity (Harrington, 2021; Parent et al., 2019). Dominance comes in many forms, such as physical aggression, where a man uses physical force to appear traditionally masculine (Harrington et al., 2021). This manifestation of dominance is because aggression shows power, a form of dominance, which feeds into the social masculine norms (Harrington et al., 2021).

Stereotypes position men as violent and aggressive and men who promote traditional gender roles or are deemed 'hypermasculine' have augmented aggression (Hess et al., 2000; Jakupcak et al., 2005; Ross & Mirowsky, 1984; Rudman & Goodwin, 2004; Seager & Barry, 2019a, 2019b). This aggression may be due to the restrictive nature of the gender role norms (Aries, 1996; Cohn & Zeichner, 2006; Jakupcak et al., 2005; Malonda-Vidal et al., 2021). In turn, the adherence to gender norms can lead to men fearing or feeling guilty for being vulnerable, and thus suppressing their emotions (Jakupcak et al., 2005). Finally, given the element of both power over women (misogyny) and heterosexual presentation (heterosexism), men who score higher on toxic masculinity will feel the need to reject and distance from anything that would be considered feminine. Given gendered social norms, one way to reject femininity is to avoid showing emotions. Thus, toxic masculinity leads to men's restrictive emotionality (Cole & Davidson, 2019; Jakupcak et al., 2005; Syzdek & Addis, 2010) which, in turn, can decrease the likelihood of seeking help related to mental health (Vogel et al., 2011).

3. The present research

The present research aims to explore the link between toxic masculinity and its relation to restrictive emotionality and (mental) health help-seeking behaviours. Previous literature illustrates that men struggle with their restrictive emotionality due to the stigma and negative connotations surrounding mental health in men (Kingerlee et al., 2019; Levant & Wong, 2017; Parent et al., 2019; Ross & Mirowsky, 1984; Syzdek & Addis, 2010). These negative connotations are reinforced through the promotion of traditional gender roles and norms (Ellemers, 2018; Levant & Wong, 2017; Mahalik & Rochlen, 2006; Ross & Mirowsky, 1984). Toxic masculinity enforces these gender roles through imposing hypermasculine behaviours and social masculine norms such as aggression and dominance, which then can also lead to reduced help-seeking behaviours (cf. Mostoller & Mickelson, 2024).

It is important to note that previous research has shown that psychological measurements of different facets of masculinity are correlated (see, for example, Levant & Richmond, 2008). However, individual men may endorse some masculine norms more than others and experience different types of emotions following threats to their masculinity (Vescio et al., 2021). Additionally, men also have different motivations for conforming to societal expectations of masculinity (e.g., Stanaland & Gaither, 2021). Therefore, it is important that research measures men's conformity to and endorsement of a variety of masculine norms to better understand the combinations and patterns that may lead to negative outcomes, including refusal to seek mental health support.

We investigate three hypotheses which go beyond past research. First, we predict that toxic masculinity is positively associated with men's restrictive emotionality. Second, we predict toxic masculinity is negatively associated with mental health seeking intentions. Third, we predict the link between toxic masculinity and help seeking intentions is mediated by aggression, dominance, and restrictive emotionality. We operationalise difficulties of speaking about one's emotion through restrictive emotionality because it expresses the view that men should not express emotions, whether they are positive or negative (Levant et al., 2007).

We test Hypothesis 1 in Study 1 and Hypotheses 1–3 in Study 2. For Study 1 we recruited a sample of men and women, which allowed us to investigate whether women can also have internalised toxic masculinity and hence show the same response pattern as men. Study 2 only included men and focused on the key variables. Both Study 1 and Study 2 recruited participants from the United Kingdom where men's health has been called a "national concern" as men experience a disproportionate number of health issues – both mental and physical (Local Government Association, 2024). In fact, a parliamentary inquiry into the mental health experiences of men in the United Kingdom called for additional research on how gender stereotypes may underly men's disengagement for help-seeking (Women and Equalities Committee, 2019). The present research seeks to contribute to this appeal.

Thus, our research holds significance in the field of masculine psychology to identify barriers which may prohibit men from accessing mental health services and therefore have poorer health outcomes than women. The data and the online supplemental materials are available at https://osf.io/fwc9t/?view_only=d2907866e9f1442b8629f22abdb133c9

4. Study 1

4.1. Method

4.1.1. Participants

A power analysis revealed that to detect an effect size of $r = 0.30$ with a power of 0.95, we would need a sample size of at least 138 participants. Initially, 266 started the survey, but 46 were excluded for not completing any questions or optional withdrawal. The final sample size consisted of 220 participants, with ages ranging from 18 to 83 years ($M = 32.85$, $SD = 16.28$; 66 men, 152 women, and 2 participants who selected "Other" as their gender.) We also included women because, as we outline in more detail in the interim discussion below, women can and do endorse socially constructed prescriptions of masculinity and can even reinforce the more toxic elements of masculinity (Connell, 1995). Forty-six participants were students from a university in the East of England and received course credits in exchange of their participation. The remaining participants were recruited through social media and word of mouth; they were not compensated. Participants were required to be proficient in English and over the age of 18 years old. The participants undertook the experiment online via mobile phone or a computer or a laptop and accessed the survey hosted by Qualtrics through a link. Our local ethics committee approved both studies and participants provided informed consent before participating (see the online supplemental materials for the full survey including the Information Sheet and Consent Form https://osf.io/fwc9t/?view_only=d2907866e9f1442b8629f22abdb133c9).

4.1.2. Materials

Following Parent et al. (2019), we measured toxic masculinity by averaging three dimensions of the Conformity to Masculine Norms Inventory (CMNI, Levant et al., 2020): winning, power over women, and heterosexual presentation (α = 0.89). Example items include "I like to always get my way" (winning), "The women in my life should obey me" (power over women), and "It would be awful if people thought I was gay" (heterosexual presentation). Answers were given on a 4-point scale ranging from 1 (strongly disagree) to 4 (strongly agree).

We also measured a series of constructs that, as discussed above, are associated with toxic masculinity: aggression, dominance, avoidance of femininity, traditional values, and hostile sexism. To measure aggression and dominance, we used subscales of the Male Role Norms Inventory Revised (MRNI-R; Levant et al., 2007) using the same response scale. Example items include "If another man flirts with the women accompanying a man, this is a serious provocation and the man should respond with aggression" (aggression, α = 0.90) and "A man should always be the boss" (dominance, α = 0.91).

Avoidance of femininity was measured with the subscale from the MRNI-R (Levant et al., 2007). Using a 7-point Likert scale (1 = strongly disagree, 7 = strongly agree), example items include "Boys should play with action figures not dolls" and "A man should avoid holding his wife's purse at all times" (α = 0.92). Tradition values (Schwartz, 1992; Schwartz et al., 2001; 1 = not at all like me, 6 = very much like me) included statements such as "I think it's best to do things in traditional ways" (α = 0.71). We used the 11-item hostile sexism subscale from the Ambivalent Sexism Inventory (Glick & Fiske, 1997; 1 = disagree strongly, 6 = agree strongly) which includes items such as "Women are too easily offended" (α = 0.88).

We also included measures assessing the (un)willingness to express emotion and accept help from others. Restrictive emotionality, our main variable of interest, was measured with the subscale from the MRNI-R (Levant et al., 2007) using a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (Strongly agree). Example items include "A man should never admit when others hurt his feelings" and "Fathers should teach their sons to mask fear" (α = 0.92). Extreme self-reliance was also measured using the MRNI-L subscale (Levant et al., 2007) and included items that assessed masculine independence such as "A man should never count on someone else to get the job done" (α = 0.83).

Both self-reliance and emotional self-control were measured using the relevant subscales from the CMNI (Levant et al., 2020). Using 4-point scales (1 = strongly disagree, 4 = strongly agree), self-reliance included items such as "I never ask for help" (α = 0.85) while emotional control included items such as "I tend to keep my feelings to myself" (α = 0.93).

Political orientation was measured with a single item "What is your political orientation?" Responses were given on an 11-point scale ranging from 0 (very left-leaning), 5 (central/moderate) to 10 (very right-leaning). Religiosity was also measured with a single item "How religious are you?" Responses were given on an 11-point scale ranging from 0 (not religious at all) to 10 (very religious).

4.1.3. Procedure

The order in which each scale was presented was randomised, with demographic information collected first. The items in each scale were not randomised. The questionnaire took around 15 to 20 minutes to complete. On completion, participants were debriefed. In the debrief, more information was given, expanding on how these views may align with toxic masculinity and thus impact how they perceived restrictive emotionality in men. In addition, the main researchers' contact details were provided for any follow up questions regarding the research.

5. Results

Analyses were conducted using the Statistical Package for the Social Sciences (SPSS-27 and SPSS-28) software. As shown in Table 1, and in support of Hypothesis 1, toxic masculinity was positively correlated with restrictive emotionality, self-reliance, and extreme self-reliance. Toxic masculinity was also positively associated with aggression and dominance (common outcomes of toxic masculinity) as well as associated behaviours and attitudes (avoidance of femininity, tradition values and hostile sexism). Importantly, each of these related constructs were also associated with concealing emotions and refusing support. Men (vs. women) scored higher on all variables with the exception of traditional values and self-reliance (Table 1; for results of independent samples *t*-tests alongside descriptive statistics see Table S1). The relationships described above were, in general, stronger for men than women (see Table S2).

6. Discussion

The findings of Study 1 illustrate that those who score higher on toxic masculinity (and associated variables) are also more likely to conceal their emotions and avoid asking for help or support. Research has shown that women can and do endorse socially constructed prescriptions of masculinity and can even reinforce the more toxic elements of masculinity. More specifically, because masculinity (vs. femininity) is valued in society and men (vs. women) generally have more power in society (see Galinsky et al., 2024), women may reinforce cultural ideals of manhood even when it disadvantages them (Connell, 1995) and may also reinforce the belief that masculinity must be continually and publicly proven such as by showcasing emotional toughness (Bosson et al., 2021). Women's endorsement of cultural ideals of masculinity have led them to (a) support political candidates who oppose gender equality (e.g., Vescio & Schermerhorn, 2021), (b) feel less likely to succeed in stereotypically masculine careers (Oswald, 2008), and most relevant to the present research, (c) reinforce stereotypes about men's ability to talk about emotional issues which may further isolate them from seeking health (including mental health) support (Seymour-Smith et al., 2002).

Findings from Study 1 show that both men and women who endorse toxic masculinity also more strongly believe in men's restrictive emotionality through beliefs about men's dominance and aggression. However, the association was stronger for men than for women. This can be explained in two ways. First, research consistently shows that

Table 1
Correlations and descriptive statistics between all variables (Study 1).

		M	*SD*	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	Toxic masculinity	1.91	0.34														
2	Aggression	2.77	1.31	0.60***													
3	Dominance	1.72	0.96	0.62***	0.69***												
4	Avoidance of femininity	2.19	1.22	0.60***	0.70***	0.66***											
5	Tradition	3.71	0.94	0.28***	0.24***	0.21**	0.28***										
6	Hostile sexism	2.49	0.96	0.53***	0.51***	0.49***	0.53***	0.26***									
7	Restrictive emotionality	1.90	1.08	0.59***	0.73***	0.75***	0.72***	0.23**	0.52***								
8	Emotional control	2.43	0.61	0.17	0.32***	0.18	0.25***	0.17	0.21**	0.36***							
9	Self-reliance	2.39	0.42	0.19**	0.26***	0.22**	0.15	0.00	0.11	0.22**	0.38***						
10	Extreme self-reliance	2.98	1.16	0.42***	0.70***	0.53***	0.55***	0.16	0.33***	0.55***	0.17	0.27***					
11	Gender (1: Male, 0: Women)	1.70	0.46	0.33***	0.55***	0.41***	0.58***	0.14	0.36***	0.65***	0.28***	0.02	0.32***				
12	Age	32.85	16.28	0.14	0.14	0.09	0.29***	0.07	0.15	0.20**	0.07	0.07	0.16	0.18**			
13	Education level	2.53	1.39	−0.03	−0.01	0.10	0.09	−0.01	−0.02	0.09	−0.04	0.01	0.09	0.10	0.21**		
14	Political orientation	4.28	2.00	0.30***	0.25***	0.13	0.32***	0.21**	0.37***	0.29***	0.07	−0.04	0.19**	0.18	0.26***	0.06	
15	Religiosity	2.57	2.79	0.20**	0.15	0.21**	0.23**	0.70***	0.13	0.10	0.01	0.02	0.16	0.03	0.10	−0.01	0.14

Note. $^{**}p < .01$, $^{***}p < .001$. Results of all significance tests are two-tailed. Note that we only deem correlations significant with $^{**}p < .01$ to reduce the type-I error rate.

although women can endorse traditional notions of masculinity, typically men still score higher (e.g., Borgogna & McDermott, 2022; Levant et al., 2010; Vescio & Schermerhorn, 2021). Second, in hindsight, the wording of our toxic masculinity scale was more tailored for men (e.g., "I control the women in my life"). Therefore, we assume that women were more likely thinking about men when answering these questions as they would have been for the other measures used (e.g., "A man should never admit when others hurt his feelings").

Findings from Study 1 support our first hypothesis – that toxic masculinity is associated with restrictive emotions. This is significant because it suggests that not all people endorse the stereotype that men should conceal their emotions, but rather those that endorse a more toxic construction of masculine identity. This toxicity leads men to hide their feelings and adopt a masculine self-reliance that avoids help from others. This may, in turn, lead to the refusal to seek mental health support, a prediction we turn to in Study 2.

7. Study 2

Study 1 provided some initial evidence that toxic masculinity is linked with restrictive emotionality. While Study 1 included participants who did not identify as men to examine both men and women's endorsement of toxic masculinity and its relation with restrictive emotionality, our focus on health seeking behaviours is specific to men. Therefore, we only recruited men in Study 2 to test our additional hypotheses about whether toxic masculinity was also associated with lower intention for health seeking behaviour. We further tested whether this effect was mediated through aggression, dominance, and restrictive emotionality. We acknowledge the debate in the literature on the appropriateness of conducting mediation analyses with cross-sectional data. For example, some argue that cross-sectional data undermines the temporal order implied in a mediation model and hence should not be done (Maxwell & Cole, 2007). In contrast, others have argued that with a clear theoretical rationale using cross-sectional data for a mediation analysis is justifiable, even though longitudinal data are preferrable (Fairchild & McDaniel, 2017; Georgeson et al., 2023). In short, we used mediation analysis to get an understanding of *potential* mechanisms, which will need to be further investigated with experimental or longitudinal designs. We do not claim causality but use this as an initial investigation to extend existing findings and further understand the potential barriers to men seeking mental health support.

7.1. Method

7.1.1. Participants

Even though most of our effects in Study 1 were large, we decided to be conservative and recruit at least 250 participants as correlations tend to stabilise at the point (Schönbrodt & Perugini, 2013). Overall, we recruited 264 men from the United Kingdom from Prolific.co who were compensated £1.27 (or £9.35/h) for their participation. Participants were predominantly White (84.8 %) with a mean age of 39.97 (SD = 12.92); no participants were excluded. This study was also approved by our local ethics committee. Participants provided informed consent prior to taking part in this study.

7.1.2. Material

To measure toxic masculinity, we used a short 27-item version of the CMNI (Levant et al., 2020). As in Study 1, we averaged across the subdimensions winning, power over women, and heterosexual presentation ($\alpha = 0.91$). Additionally, we again measured self-reliance ($\alpha = 0.89$) and emotional control ($\alpha = 0.92$) using the CMNI.

As in Study 1, restrictive emotionality ($\alpha = 0.90$), aggression ($\alpha = 0.88$), dominance ($\alpha = 0.93$), and extreme self-reliance ($\alpha = 0.85$) were measured using the MRNI-R (Levant et al., 2007).

We measured intention to seek help with the General Help Seeking Questionnaire (Wilson et al., 2005), separately for personal or emotional

problems as well as for experiencing suicidal thoughts with 9 items respectively. Specifically, participants were asked to indicate how likely they would seek help from various sources such as a friend or doctor/GP. Responses were averaged across all sources, separately for each of the two dimensions (α = 0.79 for personal or emotional problems, α = 0.82 for suicidal thoughts).

Political orientation and religiosity were measured as in Study 1.

We did not randomise the order of scales but the order of items for the two longer scales (MRNI-R and CMNI) were randomised.

8. Results

Zero-order correlations between the relevant variables are reported in Table 2. Replicating the findings of Study 1 and further supporting Hypothesis 1, toxic masculinity was positively associated with restrictive emotionality, dominance, aggression, political orientation, and religiosity, as well as negatively associated with age. However, unexpectedly Hypotheses 2 was not supported: toxic masculinity was not significantly correlated with health seeking behaviour., However, restrictive emotionality, which is associated with toxic masculinity, was negative correlated with mental health-seeking behaviours. In other words, those who endorsed the idea that men should conceal their emotions and appear tough reported less intentions to seek help.

To explore the possibility that toxic masculinity is only associated with some of the health seeking behaviour items, but not with others, we computed 2 (dimensions of health seeking behaviour: personal or emotional problems vs suicidal thoughts) x 9 (sources) = 18 correlations. Because the tests were exploratory, we set our α-threshold to 0.001 to reduce the risk of false-positive findings. Toxic masculinity was negatively correlated with help seeking behaviour for personal and emotional problems with an intimate partner, $r = -0.22$, $p < .001$, and with a friend, $r = -0.21$, $p < .001$. Surprisingly, toxic masculinity was *positively* correlated with help seeking behaviour for personal and emotional problems with a minister or religious leader, $r = 0.29$, $p < .001$. We found a similar positive correlation between toxic masculinity and help seeking behaviour for suicidal thoughts with a minister or religious leader, $r = 0.26$, $p < .001$. No other correlations were significant at α = 0.001.

Finally, to test Hypothesis 3, we ran two mediation models with toxic masculinity as the predictor, aggression, dominance, and restrictive emotionality as mediators, and the two health seeking behaviours as dependent variables (Figs. 1 and 2). Regarding health seeking behaviour for personal problems, only the indirect effect through restrictive emotionality was significant, $B = -0.27$, 95 %-CI[−0.40, −0.14]. Regarding health seeking behaviour for suicidal thoughts, again only the indirect effect through restrictive emotionality was significant, $B = -0.33$, 95 %-CI[−0.47, −0.19]. Together, Hypothesis 3 was partially supported.

9. Discussion

In Study 2, we found further support for Hypothesis 1 - that toxic masculinity was positively related to restrictive emotionality. We also replicated results showing associations between toxic masculinity and related constructs (aggression, dominance) with other measures of emotion (emotional control, self-reliance, and extreme self-reliance).

In an exploratory set of analyses, higher levels of toxic masculinity predicted a lower likelihood of seeking help from an intimate partner. This finding aligns with previous research that men disengage from their partner following threats to their masculinity which may be because relationship interdependence is seen as stereotypically feminine (Lamarche et al., 2021). Thus, it is likely that men who more strongly endorse elements of toxic masculinity would also be less emotionally vulnerable with their romantic partner. In addition, masculinity has to be continually demonstrated (Vandello et al., 2008) particularly in front of other men. Therefore, men who highly endorse toxic masculinity would likely not want to show any vulnerability in front of their (male) friends for fear of being seen as unmanly.

Interestingly and unexpectedly, higher toxic masculinity was associated with a greater likelihood of seeking help from a minister or religious leader. Although we don't want to speculate beyond our data, one possible explanation for this finding is that religion offers a space to both reinforce men's traditional masculinity and promote emotional vulnerability through a focus on fatherhood (Burke & Hudec, 2015).

In contrast, we found no support for Hypothesis 2. Toxic masculinity was unrelated to health seeking behaviour for personal problems and suicidal thoughts. Nevertheless, two exploratory mediation analyses partly supported Hypothesis 3: Restrictive emotionality mediated the association between toxic masculinity and help seeking behaviours, whereas aggression and dominance did not.

Table 2
Correlations and descriptive statistics between all variables (Study 2).

	M	SD	1	2	3	4	5	6	7	8	9	10	11
1. Toxic masculinity	3.10	1.06											
2. Extreme self-reliance	3.69	1.21	0.55***										
3. Restrictive emotionality	2.71	1.20	0.63***	0.70***									
4. Dominance	2.47	1.30	0.75***	0.64***	0.72***								
5. Aggression	3.46	1.29	0.66***	0.74***	0.74***	0.79***							
6. Health seeking personal	4.00	0.98	−0.11	−0.28***	−0.30***	−0.11	−0.15*						
7. Health seeking suicidal	4.16	1.22	−0.03	−0.16**	−0.24***	−0.04	−0.09	0.81***					
8. Self-reliance	3.56	1.33	0.16*	0.27***	0.32***	0.17**	0.19**	−0.44***	−0.42***				
9. Emotional control	4.21	1.40	0.19**	0.35***	0.45***	0.20**	0.27***	−0.52***	−0.43***	0.59***			
10. Age	39.97	12.92	−0.13*	0.17**	0.16**	−0.07	0.01	−0.04	−0.02	0.02	0.12		
11. Political orientation	4.36	2.03	0.38***	0.39***	0.50***	0.45***	0.45***	−0.18**	−0.09	0.07	0.20**	0.15*	
12. Religiosity	2.09	2.83	0.39***	0.20**	0.21***	0.40***	0.33***	0.10	0.17**	−0.08	0.01	−0.02	0.27***

Note.
* $p < .05$.
** $p < .01$.
*** $p < .001$.

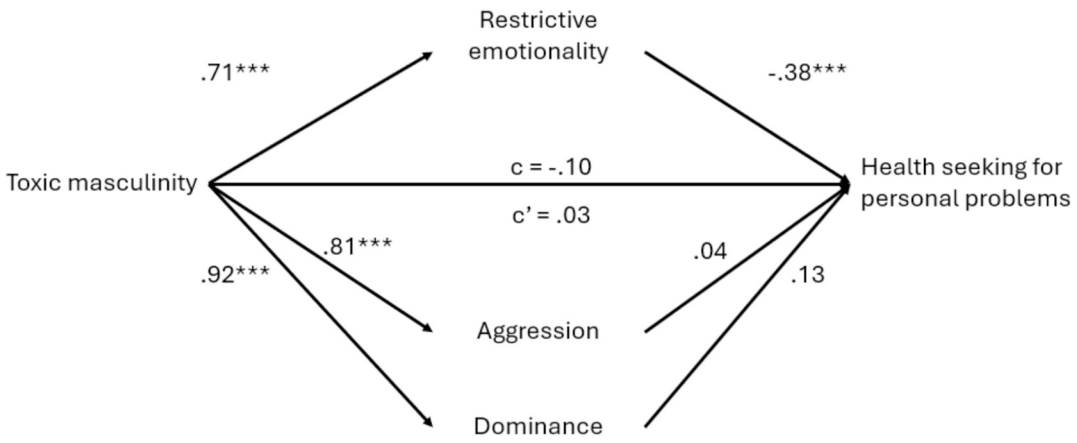

Fig. 1. Mediation model for aggression, dominance, and restrictive emotionality as mediators for health seeking for personal problems (Study 2).

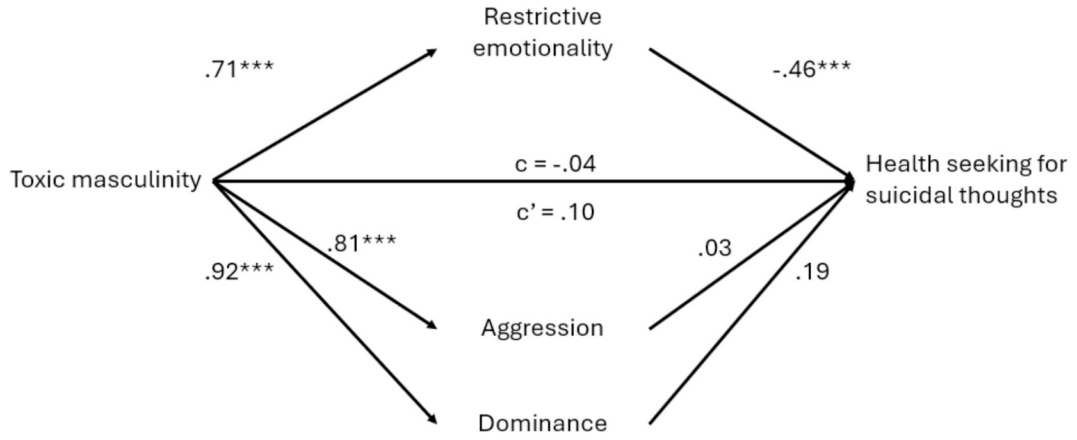

Fig. 2. Mediation model for aggression, dominance, and restrictive emotionality as mediators for health seeking for suicidal thoughts (Study 2).

10. General Discussion

In the present research we predicted and found consistently across two studies that toxic masculinity is positively associated with restrictive emotionality. Contrary to our predictions, toxic masculinity was largely unrelated to health seeking behaviours directly. Below, we discuss the findings and implications in more detail.

Toxic masculinity is reinforced through behaviours such as aggression and dominance (Parent et al., 2019; Plant et al., 2000), which in turn predict restrictive emotionality. Such reinforcement may be due to social masculine gender roles which suggest that men should not show emotions (Parent et al., 2019; Ross & Mirowsky, 1984). Masculine gender norms instead promote aggression, power over women, and being "tough" (Hess et al., 2000; Pedersen & Nielsen, 2020). This suggests that aggressive and dominant behaviours are enforced through societal and traditional gender norms which form the basis of more exaggerated, and toxic, embodiments of masculine identity.

Similarly, masculine gender norms are more strongly engrained in men due to fear of judgement and the need for adopting the groups' social identity (Levant & Wong, 2017; Pedersen & Nielsen, 2020; Turner & Oakes, 1986). This pattern might explain why, in our research, the effect of toxic masculinity on restrictive emotionality was stronger among men than women: masculine gender roles have a stronger effect on men, given that they constantly felt pressured to compromise their restrictive emotionality to align with societal norms. Such a dynamic aligns with social identity theory illustrating that men adopt these beliefs both publicly and in private (Levant & Wong, 2017). Overall, the present research is an important extension of previous research investigating how traditional gender norms and roles impact men's expression of emotion (Cole & Davidson, 2018; Jakupcak et al., 2005; Ross & Mirowsky, 1984; Syzdek & Addis, 2010).

Contrary to our expectations, toxic masculinity was only related to restrictive emotionality, but not to help seeking behaviour. We speculate that this surprising finding might be because men might understand "help seeking" differently. For some, it might be talking about their emotions, while for others it could just be hanging out with others without necessarily talking about their feelings. Indeed, people understand concepts such as helpfulness differently, even within the same culture (Hanel et al., 2018). It might also not be necessary to share one's feelings to feel better: previous research established that spending time with others is sufficient for increased well-being (Hudson et al., 2020). Men scoring higher on toxic masculinity might therefore be more likely to spend time with a friend or family member, for instance, without talking about their feelings, but still feel better afterwards.

However, our findings also reveal significant indirect effects of toxic masculinity on health-seeking behaviour through restrictive emotionality. Specifically, toxic masculinity was positively associated with restrictive emotionality, which, in turn, was associated with reduced health-seeking behaviours for both personal problems and suicidal thoughts. Such findings suggest that the restrictive emotionality associated with toxic masculinity may suppress the motivation to seek help, particularly for mental health issues. As noted above, the results of the mediation are not meant to suggest causality but provide a key possibility for why men may not seek out support for mental health, a pattern that should be further examined in longitudinal and/or experimental designs.

10.1. Limitations and future directions

Despite replicating the main findings across a convenient and a paid sample, our research has several limitations. All relations are correlational and thus causality cannot be determined. Further, it is unclear whether our findings replicate beyond the UK. Future research in this field should therefore consider that there are some cultural mean differences in depression and traditional gender standards (Hyde, 2014; Salk et al., 2017). However, Marshall (2008) argues that collectivist cultures endorse traditional values more than westernized cultures, suggesting that the results may also be replicable across other cultural contexts. In societies where traditional values and social gender roles are strongly reinforced, the effect may be even more pronounced, with women more actively supporting the prescribed roles of men. It may be useful in future research to better understand the differences in restrictive emotionality in cultures, to include both collectivist and westernized cultures. Similarly, in future research, it would be helpful to measure ethnicity within the demographics. Samples from non-WEIRD populations may produce different results due to their cultural beliefs, upbringings, or exposure to prejudice. Differences in ethnicity may lead to augmented likelihood of restrictive emotionality and self-dependence, and thus issues with mental health (Bhugra & McKenzie, 2003; Watkins et al., 2020).

Research in the future may also explore more predictors of aggression and dominance. As discussed above, previous literature on gender role norms may provide an explanation as to why aggression and dominance predict restrictive emotionality. However, future research into this topic may identify alternative predictors, such as influence from a role model or prolonged exposure to aggressive and dominant behaviours (Seager & Barry, 2019a, 2019b).

Future research may also consider a masculine-informed approach that does not aim to challenge entrenched hypermasculine norms (Liddon et al., 2019; Seager & Barry, 2019a, 2019b). Such a strategy could help channel masculinity into coping mechanisms that support men in addressing mental health difficulties. Another consideration is that mental health services are gender blind “favouring” women and children, for example, waiting rooms, which for men can be perceived as displaying vulnerability to others (Ashfield & Gouws, 2019).

10.2. Practice implications

Investigating predictors of restrictive emotionality in men has been demonstrated to be of great importance. Our results illustrate that the main predictors of restrictive emotionality in men are toxic masculinity, aggression, and dominance. In contrast, only restrictive emotionality was associated with lower health seeking behaviour. Therefore, mental health services can recognise restrictive emotionality as a key accessibility limitation for men and understand the role of stigma in men accessing support (Mostoller & Mickelson, 2024). Focus can remain on destigmatising stereotypes or gender norms surrounding toxic masculinity, which can lead to lower restrictive emotionality, and might eventually increase health seeking behaviour. By addressing these barriers, some men, who have been influenced across their lifespan and consistently been exposed to gender norms without holding these views themselves, may be more likely to access support (Sexton, 2019). In conjunction with previous literature, the present research can also demonstrate why men who have restrictive emotionality and self-reliance are more likely to suffer with mental health difficulties. These outcomes may result from the reinforcement of traditional gender roles but is clearly predicted by higher levels of aggression and dominance. The enforcing role of societal gender norms causes shame and guilt surrounding restrictive emotionality.

The implications of the present research can also address men who score higher in toxic masculinity. It is important to address men who are higher in toxic masculinity given that they have values which align with restrictive gender norms. These men, similarly, have higher levels of restrictive emotionality and emotional independence. Whilst toxic masculinity is not the exact predictor for the absence of restrictive emotionality, it is still important to breakdown these damaging hypermasculine ideologies to allow men to express their vulnerability without judgement. The reduction of judgement and stigma can assist with the likelihood of men accessing psychological help services. Such interventions may also be able to reduce suicide rates and provide men with an alternative way of coping with mental distress before suicide becomes an option.

The urgency of implementing such measures is highlighted by data from the British Department of Health and Social Care (2023), which show that men are three times more likely to die by suicide than women. In light of the NHS England (2025) five-year plan to improve mental health care, especially through prioritising crisis helplines that support suicide prevention, our research emphasises the need to particularly reach individuals with higher levels of toxic masculinity as they are less likely to engage in help-seeking behaviours. However, to effectively support men with higher levels of toxic masculinity, further research is needed to specifically explore approaches to mental health management in this group.

11. Conclusion

The present research supports previous literature demonstrating that an absence of restrictive emotionality can be due to a strong endorsement of masculine social norms. It provides a basis for potential future research surrounding men's restrictive emotionality, aggression, and dominance considering that men who adopt behaviours associated with toxic masculinity have an augmented likelihood of restrictive emotions and increased self-dependence. The results present new evidence demonstrating the role of hypermasculine behaviours and the influences that they have on expression of emotion in men. This topic is an important area of research due to a decreased likelihood of men accessing mental health support when facing mental distress and increased vulnerability of death by suicide. Addressing these challenges is crucial, given that death by suicide is often preventable with appropriate mental health intervention. By addressing aggression and dominance as predictive factors, due to social gender role, society can begin to destigmatise restrictive emotionality in men.

CRediT authorship contribution statement

Eva K.J. Horton: Writing – review & editing, Writing – original draft, Validation, Software, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Nathaniel E.C. Schermerhorn:** Writing – review & editing, Writing – original draft, Validation, Supervision, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Paul H.P. Hanel:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.paid.2025.113459.

Data availability

The data and the online supplemental materials are available at https://osf.io/fwc9t

References

Addis, M. E., & Mahalik, J. R. (Jan 2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*(1), 5–14.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing. https://doi.org/10.1176/appi.books.9780890425596

Aries, E. (1996). *Men and women in interaction reconsidering the differences*. Oxford University Press, Inc.

Ashfield, J. A., & Gouws, D. S. (2019). Dignifying Psychotherapy with Men: Developing Empathic and Evidence-Based Approaches That Suit the Real Needs of the Male Gender. In J. A. Barry, R. Kingerlee, M. Seager, & L. Sullivan (Eds.), *The Palgrave Handbook of Male Psychology and Mental Health*. Cham: Palgrave Macmillan. https://doi.org/10.1007/978-3-030-04384-1_30.

Baker, C. (2022). Suicide Statistics. House of Commons Library. https://commonslibrary.parliament.uk/research-briefings/cbp-7749/, 26/04/2023.

Bem, S. L. (1981). Gender schema theory: A cognitive account of sex typing. *Psychological Review, 88*(4), 354–364. https://doi.org/10.1037/0033-295X.88.4.354

Berke, D. S., Reidy, D., & Zeichner, A. (2018). Masculinity, emotion regulation, and psychopathology: A critical review and integrated model. *Clinical Psychology Review, 66*, 106–116. https://doi.org/10.1016/j.cpr.2018.01.004

Bhugra, D., & McKenzie, K. (2003). Expressed emotion across cultures. *Advances in Psychiatric Treatment, 9*(5), 342–348. https://doi.org/10.1192/apt.9.5.342

Bilsker, D., Fogarty, A. S., & Wakefield, M. A. (2018). Critical issues in men's mental health. *The Canadian Journal of Psychiatry, 63*(9), 590–596. https://doi.org/10.1177/0706743718766052

Borgogna, N. C., & McDermott, R. C. (2022). Is traditional masculinity ideology stable over time in men and women? *Psychology of Men & Masculinities, 23*(3), 347–352. https://doi.org/10.1037/men0000393

Bosson, J. K., Jurek, P., Vandello, J. A., Kosakowska-Berezecka, N., Olech, M., Besta, T., & Van Laar, C. (2021). Psychometric properties and correlates of precarious manhood beliefs in 62 nations. *Journal of Cross-Cultural Psychology, 52*(3), 231–258. https://doi.org/10.1177/0022022121997997

Burke, K., & Hudec, A. M. (2015). Sexual encounters and manhood acts: Evangelicals, Latter-Day Saints, and religious masculinities. *Journal for the Scientific Study of Religion, 54*(2), 330–344. https://doi.org/10.1111/jssr.12182

Call, J. B., & Shafer, K. (2018). Gendered manifestations of depression and help seeking among men. *American Journal of Men's Health, 12*(1), 41–51. https://doi.org/10.1177/1557988315623993

Cohn, A., & Zeichner, A. (2006). Effects of masculine identity and gender role stress on aggression in men. *Psychology of Men & Masculinity, 7*(4), 179–190. https://doi.org/10.1037/1524-9220.7.4.179

Cole, B. P., & Davidson, M. M. (2019). Exploring men's perceptions about male depression. *Psychology of Men & Masculinities, 20*(4), 459–466. https://doi.org/10.1037/men0000176

Connell, R. W. (1995). *Masculinities*. Berkley: University of California Press.

De Fruyt, F. (1997). Gender and individual differences in adult crying. *Personality and Individual Differences, 22*(6), 937–940. https://doi.org/10.1016/S0191-8869(96)00264-4

Department of Health & Social Care. (2023). *Suicide prevention in England: 5-year cross-sector strategy [Policy paper]*. GOV.UK. September 11 https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy.

Ellemers, N. (2018). Gender stereotypes. *Annual Review of Psychology, 69*, 275–298. https://doi.org/10.1146/annurev-psych-122216-011719

Fairchild, A. J., & McDaniel, H. L. (2017). Best (but oft-forgotten) practices: Mediation analysis1,2. *The American Journal of Clinical Nutrition, 105*(6), 1259–1271. https://doi.org/10.3945/ajcn.117.152546

Fiske, S. T. (2012). Managing ambivalent prejudices: Smart-but-cold and warm-but-dumb stereotypes. *The Annals of the American Academy of Political and Social Science, 639*(1), 33–48. https://doi.org/10.1177/0002716211418444

Galinsky, A. D., Turek, A., Agarwal, G., Anicich, E. M., Rucker, D. D., Bowles, H. R., … Magee, J. C. (2024). Are many sex/gender differences really power differences? *PNAS Nexus, 3*(2), Article pgae025. https://doi.org/10.1093/pnasnexus/pgae025

Georgeson, A. R., Alvarez-Bartolo, D., & MacKinnon, D. P. (2023). A sensitivity analysis for temporal bias in cross-sectional mediation. *Psychological Methods*. https://doi.org/10.1037/met0000628

Glick, P., & Fiske, S. T. (1997). Hostile and benevolent sexism: Measuring ambivalent sexist attitudes toward women. *Psychology of Women Quarterly, 21*(1), 119–135. https://doi.org/10.1111/j.1471-6402.1997.tb00104

Hanel, P. H. P., Maio, G. R., Soares, A. K. S., Vione, K. C., Coelho, d. H., L, G., & Manstead, A. S. R. (2018). Cross-cultural differences and similarities in human value instantiation. *Frontiers in Psychology. Personality and Social Psychology, 9*. https://doi.org/10.3389/fpsyg.2018.00849

Harrington, A. G., Overall, N. C., & Cross, E. J. (2021). Masculine gender role stress, low relationship power, and aggression toward intimate partners. *Psychology of Men & Masculinities, 22*(1), 48–62. https://doi.org/10.1037/men0000262

Harrington, C. (2021). What is "toxic masculinity" and why does it matter? *Men and Masculinities, 24*(2), 345–352. https://doi.org/10.1177/1097184X20943254

Hechter, M., & Opp, K. D. (2001). *Social norms*.

Hess, U., Senécal, S., Kirouac, G., Herrera, P., Philippot, P., & Kleck, R. E. (2000). Emotional expressivity in men and women: Stereotypes and self-perceptions. *Cognition & Emotion, 14*(5), 609–642. https://doi.org/10.1080/026999300501176 48

Hudson, N. W., Lucas, R. E., & Donnellan, M. B. (2020). Are we happier with others? An investigation of the links between spending time with others and subjective well-being. *Journal of Personality and Social Psychology, 119*(3), 672–694. https://doi.org/10.1037/pspp0000290

Hyde, J. S. (2014). Gender similarities and differences. *Annual Review of Psychology, 65*, 373–398. https://doi.org/10.1146/annurev-psych-010213-115057

Ingram, K. M., Davis, J. P., Espelage, D. L., Hatchel, T., Merrin, G. J., Valido, A., & Torgal, C. (2019). Longitudinal associations between features of toxic masculinity and bystander willingness to intervene in bullying among middle school boys. *Journal of School Psychology, 77*, 139–151. https://doi.org/10.1016/j.jsp.2019.10.007

Jakupcak, M., Tull, M. T., & Roemer, L. (2005). Masculinity, Shame, and Fear of Emotions as Predictors of Men's Expressions of Anger and Hostility. *Psychology of Men & Masculinity, 6*(4), 275–284. https://doi.org/10.1037/1524-9220.6.4.275

Kingerlee, R., Abotsie, G., Fisk, A., & Woodley, L. (2019). Reconnection: Designing Interventions and Services with Men in Mind. In J. A. Barry, R. Kingerlee, M. Seager, & L. Sullivan (Eds.), *The Palgrave Handbook of Male Psychology and Mental Health*. Cham: Palgrave Macmillan. https://doi.org/10.1007/978-3-030-04384-1_31.

Kring, A. M., & Gordon, A. H. (1998). Sex differences in emotion: Expression, experience, and physiology. *Journal of Personality and Social Psychology, 74*(3), 686–703. https://doi.org/10.1037/0022-3514.74.3.686

Lamarche, V. M., Atkinson, C., & Croft, A. (2021). A cognitive uncoupling: masculinity threats and the rejection of relationship interdependence. *Social Psychological and Personality Science, 12*(6), 920–929. https://doi.org/10.1177/1948550620961263

Levant, R., & Wong, Y. (2017). *The psychology of men and masculinities*. American Psychological Society. https://doi.org/10.1037/0000023-007

Levant, R. F., & Richmond, K. (2008). A review of research on masculinity ideologies using the Male Role Norms Inventory. *The Journal of Men's Studies, 15*(2), 130–146. https://doi.org/10.3149/jms.1502.130

Levant, R. F., Smalley, K. B., Aupont, M., House, A. T., Richmond, K., & Noronha, D. (2007). Initial validation of the male role norms inventory-revised (MRNI-R). *The Journal of men's Studies, 15*(1), 83–100. https://doi.org/10.3149/jms.1501.83

Levant, R. F., Rankin, T. J., Williams, C. M., Hasan, N. T., & Smalley, K. B. (2010). Evaluation of the factor structure and construct validity of scores on the Male Role Norms Inventory—Revised (MRNI-R). *Psychology of Men & Masculinity, 11*(1), 25–37. https://doi.org/10.1037/a0017637

Levant, R. F., McDermott, R., Parent, M. C., Alshabani, N., Mahalik, J. R., & Hammer, J. H. (2020). Development and evaluation of a new short form of the Conformity to Masculine Norms Inventory (CMNI-30). *Journal of Counseling Psychology, 67*(5), 622–636. https://doi.org/10.1037/cou0000414

Liddon, L., Kingerlee, R., Seager, M., & Barry, J. A. (2019). What Are the Factors That Make a Male-Friendly Therapy? In J. A. Barry, R. Kingerlee, M. Seager, & L. Sullivan (Eds.), *The Palgrave Handbook of Male Psychology and Mental Health*. Cham: Palgrave Macmillan. https://doi.org/10.1007/978-3-030-04384-1_32.

Lindinger-Sternart, S. (2015). Help-seeking behaviors of men for mental health and the impact of diverse cultural backgrounds. *International Journal of Social Science Studies, 3*(1), 1–6. https://doi.org/10.11114/ijsss.v3i1.519

Local Government Association. (2024). Men's health: 'Silent crisis' needs to be a 'national concern' – LGA. August 24 https://www.local.gov.uk/about/news/mens-health-silent-crisis-needs-be-national-concern-lga.

Magovcevic, M., & Addis, E. (2008). The masculine depression scale: Development & psychometric evaluation. *Psychology of Men & Masculinity, 7*, 191–202. https://doi.org/10.1037/1524-9220.4.1.3

Mahalik, J. R., & Rochlen, A. B. (2006). Men's likely responses to clinical depression: What are they and do masculinity norms predict them? *Sex Roles, 55*, 659–667. https://doi.org/10.1007/s11199-006-9121-0

Malonda-Vidal, E., Samper-García, P., Llorca-Mestre, A., Muñoz-Navarro, R., & Mestre-Escrivá, V. (2021). Traditional masculinity and aggression in adolescence: Its relationship with emotional processes. *International Journal of Environmental Research and Public Health, 18*(18), Article 9802. https://doi.org/10.3390/ijerph18189802

Marshall, T. C. (2008). Cultural differences in intimacy: The influence of gender-role ideology and individualism—collectivism. *Journal of Social and Personal Relationships, 25*(1), 143–168. https://doi.org/10.1177/0265407507086810

Maxwell, S. E., & Cole, D. A. (2007). Bias in cross-sectional analyses of longitudinal mediation. *Psychological Methods, 12*(1), 23–44. -989X.12.1.23"23.

McKenzie, S. K., Collings, S., Jenkin, G., & River, J. (2018). Masculinity, social connectedness, and mental health: Men's diverse patterns of practice. *American Journal of Men's Health, 12*(5), 1247–1261. https://doi.org/10.1177/1557988318772732

McKenzie, S. K., Oliffe, J. L., Black, A., & Collings, S. (2022). Men's experiences of mental illness stigma across the lifespan: A scoping review. *American Journal of Men's Health, 16*(1), Article 15579883221074789. https://doi.org/10.1177/15579883221074789 (https://files.digital.nhs.uk/99/3916C8/ment-heal-act-stat-eng-2019-20-summ-rep%20v1.1.pdf)

Mostoller, A. M., & Mickelson, K. D. (2024). Masculinity and Mental Well-Being: The Role of Stigma Attached to Help-Seeking Among Men. *Sex Roles, 90*(3), 353–362. https://doi.org/10.1007/s11199-024-01457-2

NHS England. (2025). *Life-changing outcomes for 9 in 10 men who complete NHS Talking Therapies in London [News release]*. NHS England. June 9 https://www.england.nhs.

uk/london/2025/06/09/life-changing-outcomes-for-9-in-10-men-who-complete-nhs-talking-therapies-in-london/.
Oswald, D. L. (2008). Gender stereotypes and women's reports of liking and ability in traditionally masculine and feminine occupations. *Psychology of Women Quarterly, 32*(2), 196–203. https://doi.org/10.1111/j.1471-6402.2008.00424.x
Parent, M. C., Gobble, T. D., & Rochlen, A. (2019). Social media behavior, toxic masculinity, and depression. *Psychology of Men & Masculinities, 20*(3), 277–287. https://doi.org/10.1037/men0000156
Pedersen, M. J., & Nielsen, V. L. (2020). Bureaucratic decision-making: A multi-method study of gender similarity bias and gender stereotype beliefs. *Public Administration, 98*(2), 424–440. https://doi.org/10.1111/padm.12622
Plant, E. A., Hyde, J. S., Keltner, D., & Devine, P. G. (2000). The gender stereotyping of emotions. *Psychology of Women Quarterly, 24*(1), 81–92. https://doi.org/10.1111/j.1471-6402.2000.tb01024.x
Ross, C. E., & Mirowsky, J. (1984). Men who cry. *Social Psychology Quarterly, 47*(2), 138–146. https://doi.org/10.2307/3033942
Rudman, L. A., & Goodwin, S. A. (2004). Gender Differences in Automatic In-Group Bias: Why Do Women Like Women More Than Men Like Men? *Journal of Personality and Social Psychology, 87*(4), 494–509. https://doi.org/10.1037/0022-3514.87.4.494
Salk, R. H., Hyde, J. S., & Abramson, L. Y. (2017). Gender differences in depression in representative national samples: Meta-analyses of diagnoses and symptoms. *Psychological Bulletin, 143*(8), 783–822. https://doi.org/10.1037/bul0000102
Schönbrodt, F. D., & Perugini, M. (2013). At what sample size do correlations stabilize? *Journal of Research in Personality, 47*(5), 609–612. https://doi.org/10.1016/j.jrp.2013.05.009
Schwartz, S. H. (1992). Universals in the content and structure of values: Theoretical advances and empirical tests in 20 countries. In *, 25. Advances in experimental social psychology* (pp. 1–65). Academic Press. https://doi.org/10.1016/S0065-2601(08)60281-6.
Schwartz, S. H., Melech, G., Lehmann, A., Burgess, S., Harris, M., & Owens, V. (2001). Extending the cross-cultural validity of the theory of basic human values with a different method of measurement. *Journal of Cross-Cultural Psychology, 32*(5), 519–542. https://doi.org/10.1177/0022022101032005001
Seager, M., & Barry, J. A. (2019a). Cognitive Distortion in Thinking About Gender Issues: Gamma Bias and the Gender Distortion Matrix. In J. A. Barry, R. Kingerlee, M. Seager, & L. Sullivan (Eds.), *The Palgrave Handbook of Male Psychology and Mental Health*. Cham: Palgrave Macmillan. https://doi.org/10.1007/978-3-030-04384-1_5.
Seager, M., & Barry, J. A. (2019b). Positive Masculinity: Including Masculinity as a Valued Aspect of Humanity. In J. A. Barry, R. Kingerlee, M. Seager, & L. Sullivan (Eds.), *The Palgrave Handbook of Male Psychology and Mental Health*. Cham: Palgrave Macmillan. https://doi.org/10.1007/978-3-030-04384-1_6.
Sexton, J. Y. (2019). *The man they wanted me to be: Toxic masculinity and a crisis of our own making.* Catapult.
Seymour-Smith, S., Wetherell, M., & Phoenix, A. (2002). 'My wife ordered me to come!': A discursive analysis of doctors' and nurses' accounts of men's use of general practitioners. *Journal of Health Psychology, 7*(3), 253–267. https://doi.org/10.1177/1359105302007003220
Sheppard, S. (2025, August 7). *The dangerous effects of toxic masculinity*. Verywell Mind. https://www.verywellmind.com/the-dangerous-mental-health-effects-of-toxic-masculinity-5073957.
Stanaland, A., & Gaither, S. (2021). "Be a man": The role of social pressure in eliciting men's aggressive cognition. *Personality and Social Psychology Bulletin, 47*(11), 1596–1611. https://doi.org/10.1177/0146167220984298
Syzdek, R., & Addis, E. (2010). Adherence to masculine norms and attributional processes predict depressive symptoms in recently unemployed men. *Cognitive Therapy and Research, 34*, 533–543. https://doi.org/10.1007/s10608-009-9290-6
Turner, J. C., & Oakes, P. J. (1986). The significance of the social identity concept for social psychology with reference to individualism, interactionism and social influence. *British Journal of Social Psychology, 25*(3), 237–252. https://doi.org/10.1111/j.2044-8309.1986.tb00732.x
Vandello, J. A., Bosson, J. K., Cohen, D., Burnaford, R. M., & Weaver, J. R. (2008). Precarious manhood. *Journal of Personality and Social Psychology, 95*(6). https://doi.org/10.1037/a0012453, 1325–1139.
Vescio, T. K., & Schermerhorn, N. E. (2021). Hegemonic masculinity predicts 2016 and 2020 voting and candidate evaluations. *Proceedings of the National Academy of Sciences of the United States of America, 118*(2), Article e2020589118. https://doi.org/10.1073/pnas.2020589118
Vescio, T. K., Schermerhorn, N. E., Gallegos, J. M., & Laubach, M. L. (2021). The affective consequences of threats to masculinity. *Journal of Experimental Social Psychology, 97*, Article 104195. https://doi.org/10.1016/j.jesp.2021.104195Vogel
Vogel, D. L., Heimerdinger-Edwards, S. R., Hammer, J. H., & Hubbard, A. (2011). "Boys don't cry": Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counseling Psychology, 58*(3), 368–382. https://doi.org/10.1037/a0023688
Waling, A. (2019). Problematising 'toxic' and 'healthy' masculinity for addressing gender inequalities. *Australian Feminist Studies, 34*(101), 362–375. https://doi.org/10.1080/08164649.2019.1679021
Watkins, D. C., Goodwill, J. R., Johnson, N. C., Casanova, A., Wei, T., Allen, J. O., & Abelson, J. M. (2020). An online behavioral health intervention promoting mental health, manhood, and social support for young black men: the YBMen project. *American Journal of Men's Health, 14*(4), Article 1557988320937215. https://doi.org/10.1177/1557988320937215
West, C., & Zimmerman, H. (1987). Doing gender. *Gender & Society, 1*, 125–151. https://doi.org/10.1177/0891243287001002002
Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. (2005). Measuring help-seeking intentions: Properties of the general help seeking questionnaire. *Canadian Journal of Counselling, 39*(1), 15–28. https://eric.ed.gov/?id=EJ719917.
Women and Equalities Committee. (2019). *Letter from the Chair to Nadine Dorries MP regarding the Mental Health of Men and Boys inquiry*. UK Parliament. October 30 https://committees.parliament.uk/publications/9188/documents/159775/default/.