Masculinity and Men's Mental health

Allen Elias Babu

Completed under the guidance of

Fr. Dean Fernandes S.J.

Psychology Seminar 2021,

St. Xavier's College, Mumbai.

Preface

This research paper has been prepared for the Psychology Seminar 2021 at St. Xavier's College, Mumbai. The reasons behind choosing this theme are various and personal. However, the research paper has been prepared with an attempt to shed light on themes which are not frequently explored, or themes which are constantly unexplored.

A dialogue on mental health in males is seldom encountered in the popular discourse. The negligible instances which do find its mention are usually responses to, or supplementary statements to women's issues or the general feminist discourse. The casually and liberally used 'toxic masculinity' is frequently laden with connotations of blame, which imply a sense of absolute agency of the concerned individuals with regard to the expression of their masculine gender identity.

This research paper has been undertaken as an attempt to seek an honest, critical and objective view of the various factors influencing the mental health of males, wherein masculinity is assumed to be encompassing all such factors.

Through the paper, the author seeks to delve deeper into these themes, to ask questions, to present multiple perspectives but most importantly to initiate a dialogue on *Masculinity and Men's Mental Health* which would pervade classrooms, playgrounds, light talk and the solitude of homes.

Acknowledgements

This research paper has come to fruition owing to the timely, eager and constant contributions by certain individuals. I am indebted to them and all of them deserve an acknowledgement. Foremost, my guide and professor Fr. Dean S.J. for his constant support and unwavering faith in me. Secondly, Prof. Mayur More for his unflinching patience in guiding me through the course of my primary analysis. Thirdly, Abhishek Balgude and Jessica Singh for timely instances of rescue. Fourthly, to my family for their ceaseless patience. Lastly, I would like to thank myself for believing in me and seeing this project through to its end.

I am highly indebted to St. Xavier's College Autonomous, Mumbai for providing me this opportunity and to the Psychology Department with its professors - Linda Dhakul, Ruby Pavri and Asst. Vidita Save - for their faith and support in guiding me to complete this research paper.

Contents

1. Introduction.....	1
2. Understanding Masculinity.....	3
2.1. Definition	
2.2. Measuring Masculinity	
2.2.1. Traditional Masculinity Ideology (TMI)	
2.2.2. Scales	
2.3. Theoretical Approaches	
2.3.1. Gender Role Strain Paradigm (GRSP)	
2.3.2. Gender Role Conflict (GRC)	
2.3.3. Theories of Male Development and Identity Formation	
3. Relevance.....	11
3.1. Male Suicide Statistics	
3.2. Male Mental Health and Violence	
4. Masculinity and Mental Health.....	14
4.1. Masculinity and Well-being	
4.1.1. Physical Health	
4.1.2. Stress	
4.1.3. Self-Esteem and Self-Acceptance	
4.1.4. Intimacy	
4.1.5. Shame	
4.1.6. Alexithymia	

4.2. Masculinity and Mental Illness.....	20
4.2.1. Depression	
4.2.2. Anxiety Disorders	
4.2.3. Eating Disorders and Body Image Concerns	
4.2.4. Post-traumatic Stress Disorder (PTSD)	
4.2.5. Help-seeking	
4.2.6. Meta-Analysis	
4.3. Acquired Capability for Suicide (ACS).....	25
5. Towards Newer Schemas.....	27
5.1. Interpersonal Trauma	
5.1.1. Female Perpetrated Intimate Partner Violence	
5.1.1.1. Physical Aggression	
5.1.1.2. Psychological Aggression	
5.1.1.3. Legal and Administrative Aggression (LA Aggression)	
5.1.2. Sexual Violence	
5.1.3. Observations on Male Victims	
6. Positive Psychology/Positive Masculinity (PPPM).....	34
7. Primary Research.....	40
7.1. Sample	
7.2. Methodology	

7.3. Tools

7.4. Analysis

7.4.1. Section 1

7.4.2. Section 2

7.4.3. Section 3 – Emotionally Active

7.4.3.1. Mental Health

7.4.3.2. Help-Seeking

7.4.4. Section 4 – Visual Representation of Significant Responses

8. Conclusion.....	57
9. References	59

1. Introduction

“The most dangerous man is not one with power but one who feels powerless.”

-Michael Gurian

‘Masculinity and Men’s Mental Health’ is a broad theme encompassing numerous theories, perspectives and interrelationships associating masculinity with the mental health of males. An attempt has been made to do justice to this theme in this research paper.

In order to provide the essential context, the paper begins defining the concept of ‘masculinity’ as it is understood in the psychological discourse, followed by an inspection of the various psychological theories and constructions of ‘masculinity’ along with a brief discussion of its scales. Theoretical perspectives have then been combined with statistics to highlight the need and relevance for any research or dialogue thereof in these fields. This is followed by an investigation of the impact of Traditional Masculinity Ideology (TMI) on the overall well-being of men and on mental health in particular. Thereafter, the relation of TMI and various mental disorders in males has been examined. Furthermore, research has been provided to shed light on the incidence and helplessness of male victims of interpersonal trauma and systemic failures thereof. The newly emerging theoretical framework of Positive Psychology/Positive Masculinity (PPPM) Model has been discussed along with an exploration of its implications and its scope.

The primary research undertaken within this paper has been presented which has been divided into 4 sections. Firstly, a rudimentary analysis has been conducted to test the validity and relevance of the Brannon Masculinity Scale (BMS). Thereafter, the relation of masculinity ratings with mental Health and help-seeking behaviours has been explored. The third section

involves the introduction of a construct by the author, referred to as the *Emotionally Active* factor; its relation with mental Health and help-seeking behaviours has been analyzed. The relevance of the *Emotionally Active* factor has been highlighted, followed by a discussion on its implication and scope. The final section presents the visual representation of significant responses to the questionnaire administered in the primary research.

Efforts have been taken to include only the most relevant research; wherein recent studies have been given a preference. Older studies have been included only in instances of uncontested relevance or to present a trend or development which has been observed over the years.

Lastly, all material presented in the paper have due citations, references and acknowledgment of its authors and sources, barring the primary analysis and those opinions which are solely the author's.

2. Understanding Masculinity

2.1. Definition

In order to comprehend masculinity as it is understood in the psychological discourse, it is imperative to seek its definition within the domain. However, this definition is predicated on an important distinction within psychology (which is now being adopted commonly): sex and gender. Sex is considered biological (male, female or intersex) and gender is psycho-social (masculine, feminine and various non binary identities) (Bohan, 1997). Similarly, in the *APA College Dictionary of Psychology*, the distinction has been highlighted: “Sex usually refers to the biological aspects of maleness or femaleness, whereas gender implies the psychological, behavioral, social, and cultural aspects of being male or female (i.e., masculinity or femininity” (VandenBos, 2015). Therefore, in his book *The Tough Standard: The Hard Truths About Masculinity and Violence*, Ronald Levant defines masculinity:

In this vein, we define masculinity as a set of thoughts, feelings, and behaviors that are generally considered to be appropriate for boys and men; importantly, it also includes those that are considered inappropriate for boys and men, against which it has drawn a bright line. (Levant & Pryor, 2020, p. 3)

This definition is particularly important for two reasons. Firstly, Ronald Levant, the former president of the American Psychological Association (APA) is among the most significant figures in masculinity studies in psychology, having devised and evaluated 15 scales measuring gender constructs (Levant & Pryor, 2020). More importantly, this definition makes the important inclusion of the ‘forbidden’ aspect of masculinity. The sex roles laid down for men are more narrowly stipulated than women. Moreover, men face harsher penalties for engaging in feminine

behaviour as compared to women who indulge in masculine behaviour (Robinson- Wood, 2013 as cited in Gladding, 2018 p. 82). According to this definition masculinity is a set of beliefs rooted in socio-cultural ideologies pertaining to gender. Thus, we can infer the definition of masculinity is then significantly influenced by its cultural and social context; moreover, males as well as females could engage in masculinity. Defining masculinity thus, opens up prospects of change or modification, psychologically speaking. This inference follows the presumption that feelings, emotions and behaviour are more susceptible to change than genes or hormones (Levant & Pryor, 2020).

2.2. Measuring Masculinity

2.2.1. Traditional Masculinity Ideology (TMI)

The various correlations and findings pertaining to masculinity in relation to various factors are determined by how masculinity is defined and operationalized. Operationalization of masculinity, like several other psychological constructs, is done through scales. An important component which sets the context for operationalizing masculinity is the ideology it is based on. The masculinity scales were constructed to measure the dominant masculinity form which existed in the U.S. culture. Often termed hegemonic, sexist, traditional or patriarchal masculinity, it refers to “White, post-World War II, Christian, cisgender, heterosexual masculinity.” (Levant & Pryor, 2020). Herein, Traditional Masculinity Ideology (TMI) is the basis for the scales measuring masculinity psychologically. TMI refers to the various beliefs which perpetuate norms

of male masculinity (Levant, 2020). It can be admitted that the usage of the word ‘masculinity’ henceforth will be referring to TMI.

The cognizance of this ideology underlying the measurement of masculinity, and of its origin, is crucial to recognize the scope of the application as well as the limitation of the various findings with respect to masculinity which will be discussed hereon.

2.2.2. Scales

The foundational scale based on TMI was developed by David Brannon which is known as the Brannon Masculinity Scale (BMS) (Brannon and Juni, 1984 as cited in Levant & Pryor, 2020). BMS is especially important because later scales including the widely used Male Role Norms Scale (MRNS in 1984) were developed by modifying BMS (Thompson & Bennett, 2015). The BMS specified four norms:

1. *No Sissy Stuff*- Men should not be feminine. This component was operationalized with two subscales - avoiding femininity and concealing emotions.
2. *The Big Wheel*- Men should strive to be respected for successful achievement.
3. *The Sturdy Oak* - Men should never show weakness.
4. *Give ‘em Hell* - Men should seek adventure and risk and even accepting violence if necessary (Thompson & Bennett, 2015) (Levant & Pryor, 2020)

The BMS had statements such as “A man always deserves the respect of his wife and children”. These embodied the prescriptive as well as the descriptive proclamations of existing masculinity norms. The participants were expected to rate their personal endorsement of such beliefs (i.e. agreeing or disagreeing) (Thompson & Bennett, 2015).

Other widely used subsequent scales and the components they measure include:

1. Male Role Norms Scale (MRNS) - Edward Thompson Jr and Joseph Pleck in 1986:
 - Status Norms - Expectations to achieve success and others' respect
 - Toughness Norms - Expectations to become self-reliant and mentally and physically tough
 - Antifemininity norms - Expectations to avoid stereotypical feminine practices (Thompson and Pleck, 1986 as cited in Thompson & Bennett, 2015)
2. Male Role Norms Inventory (MRNI) - Ronald Levant et al. (developed in 1992, amended in 1988):
 - Avoidance of femininity
 - Restrictive emotionality
 - Achievement/status
 - Aggression
 - Self-reliance
 - Fear and hatred of homosexuals
 - Attitudes toward sex (Levant and Fischer, 1998 as cited Thompson & Bennett, 2015)
3. Conformity to Masculine Norms Inventory (CMNI) - James Mahalik et al. in 2003:
 - Winning
 - Emotional Control
 - Risk-Taking

- Violence
- Dominance
- Playboy
- Self-Reliance
- Primacy of Work
- Power over Women
- Disdain for Homosexuality
- Pursuit of Status (Levant, 2020)

It is important to note that while scales like the BMS, MRNI and the MRNS seek to understand the extent to which respondents endorse a particular belief regarding masculinity, CMNI breaks away from this by measuring how much they personally conform to the beliefs i.e. behavioral and affective conformity as opposed to mere cognitive conformity (Thompson & Bennett, 2015). An item of the MRNI-SF includes “men should be detached in emotionally charged situations.” while CMNI consists of items such as “taking dangerous risks helps me to prove myself.” (Levant, 2020). In a review of the masculinity measuring tools, one point of criticism was that no scale has been developed which adequately measures both endorsement as well as the personal conformity to the masculinity norms (Thompson & Bennett, 2015).

2.3. Theoretical Approaches

Theoretical approaches and paradigms pertaining to masculinity are not restricted to the measurement of masculinity, rather they seek to purport the possible implications of masculinity (as a set of beliefs), of gender roles at large or even different conceptualizations of masculinity. In the psychology of men and masculinities, Gender Role Strain Paradigm (GRSP) by Joseph

Pleck is considered to be the major theoretical paradigm (Levant & Pryor, 2020). Males who endorse Traditional Masculinity Ideology have been found to experience Gender Role Strain and its 3 components (Neilson et al., 2020). Here, we will discuss the GRSP and the Gender Role Conflict (GRC) theory as they are the most frequently mentioned ones in the research reviewed within this paper. Moreover, they stand to be theoretically most relevant to our research. Other theories of masculinity will be briefly discussed thereafter.

2.3.1. Gender Role Strain Paradigm (GRSP)

First proposed by Joseph Pleck in his landmark book *Myth of Masculinity*. The formulation of the GRSP consisted of 10 propositions which together posited "...how cultural standards of masculinity, as implemented in gender socialization, have potentially negative effects on individual males" (Pleck, 1995). He further discussed three ways in which the negative influence or "strain" manifests which form the core of the paradigm:

1. Gender Role Discrepancy - The consequences arising from the failure to meet the male role expectations. Low self-esteem and various other negative psychological consequences are experienced as a result of this disjuncture.
2. Gender Role Trauma - The trauma resulting from the socialization involved in meeting the male role expectations. This is referred to as the 'gender role trauma' which is often found to have long- term negative consequences (e.g. facing bullying for not being "man enough")
3. Gender Role Dysfunction - The negative-side effects resulting from the successful fulfilment of male role expectations. This component is explained as arising from the

male role expectations which by themselves are dysfunctional and cause harm to oneself and to others.

These 3 components form the basis of GRSP which seeks to explain the negative consequences of male role expectations, not only on themselves but ultimately on the individuals associated with them (Pleck, 1995)

2.3.2. Gender Role Conflict (GRC)

Gender Role Conflict is a concept introduced by James O'Neil which is closely related to the GRSP. GRC is defined as "a psychological state in which the socialized male gender role has negative consequences for the person and others" and occurs when "rigid, sexist, or limiting gender roles result in restriction, devaluation, or violation of self and/or others" (O'Neil, 2008, p. 362). It has been theorized to lead to restrictive emotionality; health care problems; obsession with achievement and success; restrictive sexual and affectionate behaviour; socialized control, power and competition issues; and homophobia (O'Neil, 2008).

2.3.3. Theories of male development and identity formation

Other theories within the domain of masculinity seek to explain male development and identity formation i.e. development of behaviour ascribing to the male gender norms as opposed to the repercussions of it, which is explained by the GRSP and GRC. The Psychoanalytic Object Relations Theory, developed by Nancy Chodorow and modified by William Pollack posits masculinity (a masculine identity) as arising from two different forces: core gender identity and core gender role identity. The core gender identity is theorized as the affirmation of masculine identity in reaction to the shame ("psychic trauma") a boy experiences due to the disconnection

from his mother. This disconnection results from the mother's conscious and unconscious dis-identifying behaviour from her son. As a result of this "shameful and premature separation" the boy (and men at large) now have a "continuing need to defend against urges toward affiliation and intimacy". The core gender role identity on the other hand is more socially influenced. It results from the internalization of unconscious schemas of "being a man" which is mediated by the family and the social and cultural context (Pollack, 1995, as cited in Phillips, 2006). The Self-in-Relation Theory by Scott Bergman theorizes that men form their masculine identities in relation to the various individuals in their lives and thus intimacy comes before identity in the process of development. A contradistinction within this theory is its perspective on the "disconnection" or separation of the son from his mother which is considered to be a violation and as turning away from growth in relations (as opposed to it being considered "necessary" like in the earlier aforementioned theories) (Bergman, 1995, as cited in Phillips, 2006).

The different theories have been classified as modern and postmodern. Herein the important distinction is that modern meanings of masculinity posit an innate maleness or femaleness which will be developed in biologically predetermined ways. The range of normality here is narrow of what constitutes being a "male". On the other hand, postmodern positions theorize that humans are born into a culture which defines them as male or female, both as a self-identity as well as in the eyes of others through the gender norms which pervade all spheres of cultural interactions (Phillips, 2006).

3. Relevance

The two important questions which need to be addressed while exploring the literature associated with mental health in men and masculinity are (a) why is there a need for dialogue on mental health of men (b) what is its relation to masculinity. The answer to both questions is found in the definition of a commonly used term ‘toxic masculinity’. Toxic masculinity is defined as “A set of attitudes and ways of behaving stereotypically associated with or expected of men, regarded as having a negative impact on men and on society as a whole.” (Oxford University Press (OUP), n.d.). This term closely resembles the earlier discussed Gender Dysfunction Strain which is a component of GRSP: “. successful fulfilment of male role expectations... have inherent negative side effects, either for males themselves or for others”. Thus, it is recorded that the role of masculinity is formidable with regard to its negative repercussions on men and others associated with them, therefore, society at large. Going back to the questions, the need for dialogue can only be understood with an understanding of how serious the mental health crisis is among men which will be addressed first. The relation of masculinity to male mental health will thereafter be explored. Both these factors are equally significant in providing a complete picture of the relationship of masculinity, mental health of men and its implications.

3.1. Male Suicide Statistics

In seeking to understand the state of mental health in males, an important parameter stands to be the Male Suicide. Male Suicide has been often been referred to as a ‘silent epidemic’, “epidemic because of its high incidence and substantial contribution to men’s mortality, and silent because of a lack of public awareness, a paucity of explanatory research...”

(Bilsker & White, 2011). The statistics pertaining to male suicide paint a grave picture. Suicide is the “single biggest killer” of men under the age of 45 in the UK (Schumacher, 2019). According to the American Foundation for Suicide Prevention, males are 3 times more likely to die by suicide in Australia, 3.5 times in the U.S. and according to the World Health Organization (WHO) , more than 4.5 times likely to die by suicide in Russia (Schumacher, 2019). According to the WHO, 40% countries show a suicide rate of 15 suicide deaths per 100,000 men and such a high rate is found only in 1.5% countries for women (Schumacher, 2019). As far as India is concerned, statistics show that India is the greatest contributor to the absolute number of suicide deaths (GBD Results Tool | GHDx, n.d.). Statistics from the Registrar General of India show that the suicide death ratio of men to women is 2:1 in India (Wayback Machine, n.d.).

Why are suicide rates important in the dialogue on male mental health? According to Ronald Levant, mental health concerns in men are aggravated by several factors such as barriers to help-seeking, lack of support, stigma, fewer resources which result in extreme measures such as suicides. Moreover, the available data on mental health concerns in men is believed to be significantly under-representing the actual incidence (owing to men not reporting the same) which makes suicide statistics an important parameter to estimate the prevalence of mental health concerns in men (Levant & Pryor, 2020). Most importantly, among sufferers of depression, men are four times as likely as women to take their lives (Brooks, 2001). All of these factors have led researchers to believe the prevalence of mental health disorders in men is much higher than previously estimated.

3.2. Male Mental Health and Violence

In order to understand the harm caused to others by mental health concerns in men and masculinity, the research done by Ronald Levant is especially significant. In his book *The Tough Standard: The Hard Truths About Masculinity and Violence*, Traditional Masculinity Ideology (TMI) has been highlighted to be associated with different forms of gun violence, intimate partner violence and sexual violence (Levant & Pryor, 2020). However, the role of masculinity is highly pervasive as it causes harm to the male mental health in various ways which will be discussed later. What is important to note is that in his landmark book *Male, Female: The Evolution of Human Sex Differences* David C. Geary highlights an important distinction in psychopathology in men and women. It has been stated that men and boys largely outnumber women in all forms of externalizing disorders and the ensuing violence (Geary, 2020, pp. 433). This distinction is especially important while discussing mental health concerns in men and their repercussions on others. The various ways in which masculinity plays a role in the mental health of men will be discussed in the following section.

An important conclusion can be drawn which is highlighted in an article by Michael Gurian who is a prominent figure in masculinity studies:

the most dangerous male is not one who is strong, aggressive, and successful; the most dangerous male is one who is depressed, unable to partner or raise children successfully, unable to earn a living, unable to care for his children. The most dangerous man is not one with power but one who feels powerless (Gurian, 2019).

4. Masculinity and Mental health

Mental Health has been defined by the American Psychological Association: “a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life.”(APA Dictionary of Psychology, n.d.).

The relationship between masculinity and men’s mental health is complex. In some cases, TMI or its specific components have been correlated with mental health disorders. In other instances, research indicates a relationship between masculinity and overall well-being, which in turn has adverse effects on the mental health. Thus, literature has been reviewed with an attempt to first shed light on the factors which influence well-being in men and thereby impose threats to their mental health before examining the relation between masculinity and various mental health disorders.

4.1. Masculinity and Well-being

The American Psychological Association (APA) has defined well-being as “a state of happiness and contentment, with low levels of distress, overall good physical and mental health and outlook, or good quality of life” (APA Dictionary of Psychology, n.d.). Within the scope of this research, several factors ranging from seemingly innocuous beliefs and attitudes to more explicitly unhealthy behavior which were influenced by the traditional masculinity ideology, were correlated with adverse effects on different components of well-being in men.

4.1.1. Physical Health

In a study conducted on male college students, 7 focus groups were formed to inspect the attitudes towards physical health among these students. The findings showed that the students were aware of the health concerns. Physical as well as emotional health concerns were correctly identified by the students. Despite such an acknowledgement and the accepted prevalence of alcoholism and substance abuse as the most important concerns men, it was found that the students took little action to address their needs, Socialization to be independent and to conceal vulnerability were found to be the significant barriers to seek any help to address these concerns (Davies et al., 2000). Yet another study conducted with 140 men aged 18-78 sought to examine their perception of normative health behaviours of men i.e. the beliefs they held regarding how healthy other men should be and to what extent they should partake in activities which ensure better health (e.g. dieting, exercising, using social support etc.). The results indicated that these perceptions of male normative health behaviors predicted the participants' own health (while perceptions of female normative health behaviours were found to have no relation). The findings indicated that traditional male role norms encourage men to put their physical health at risk (Mahalik, Burns and Syzdek, 2007). Furthermore, an important study indicated that the leading causes of death in men such as tobacco usage, alcohol usage, and poor diet were correlated with masculinity (Garfield et al., 2008b).

4.1.2. Stress

Stress has been proven to have monumental influence on health. Research has also found stress to be one of the greatest contributors to men's higher mortality rates (Williams, 2003 as cited in Levant & Pryor, 2020). Masculinity norms cause significant stress for men, with the

norms expecting men to be the breadwinners and initiators. Yet another factor for stress is the male role expectation to be always ready for sex. Likewise, norms demanding men to be the tough protectors while simultaneously expecting them to not show emotions or vulnerabilities are major sources of stress in men. Men are expected to not seek or receive help in the form of emotional support and healthy coping mechanisms which include crying, yoga and meditation are discouraged as feminine. Furthermore, men with alexithymia (which will be later discussed in the context of its relation with TMI) engage in unhealthy behaviours such as substance abuse and smoking (Levant & Pryor, 2020).

4.1.3. Self-Esteem and Self-Acceptance

A study was conducted by Vonda Olson Long with male professionals, male college students and male clients in 1989 which aimed to measure masculinity, femininity, education, occupation and locus of control in the participants. The aim of the study was to gauge which of these factors were the best predictors of self-esteem and self-acceptance in these groups. The results showed masculinity to be the best predictor of self-esteem in professionals and students and of self-acceptance in clients. These results are significant because they shed light on the significance of masculine gender norms on men which has been found to be greater than that of education and occupation even locus of control (Long, 1989).

.

4.1.4. Intimacy

In his book, Ronald Levant uses a story which appeared in a magazine to highlight how men are socialized with regard to intimacy which has been summarized as follows :

Daddy drove into the driveway... his three children were waiting to greet him. He first hugged and kissed one daughter and then another, while his 5-year-old son stood waiting.

"No Timmy, men don't do that." (Levant & Pryor, 2020).

Intimacy in men was hypothesized to be adversely affected by the traditional masculinity ideology which encouraged men to restrict their emotional experience (Brannon, 1976; Levant, 1992; O'Neil, 1981 as cited in Fischer and Good, 1997). A study conducted by Fischer and Good (1997) undertook the task to test this hypothesis with 208 men where TMI scales were used. Participants who reported higher levels of gender role conflict (GRC) were also found to have higher levels of fear of intimacy. Herein, emotional inexpressiveness and restrictive emotionality were found to be the major contributors to this fear of intimacy. The repercussions inferred from the study were that the inability to share one's thoughts and feelings, even with their romantic partner would leave men with a lack of access to personal connections of any form, even with a psychotherapist. This concern is highlighted with the fact that generally men's support systems primarily consist of only one romantic partner whereas women tend to have larger social networks (Fischer and Good, 1997). However, recent research has found that men indulge in diverse patterns of intimacy; whereas some men maintained the desire to be independent and rejected the need for social support, others actively engaged in relations to seek emotional support. This finding is significant in contradistinction to the previously held belief that men only seek relationships which were instrumental and were less interested in building emotional and supportive relations (McKenzie, Collings, Jenkin and River, 2018).

4.1.5. Shame

It is interesting to note that shame as an emotion exerts tremendous influence on men. This influence is supported by the fact that shame is experienced by men in instances of violation of the masculine gender norms they are expected to conform to (and thus incorporate in their self-identity). Thus, this relation proves to be significant from the point of relevance to this current study. Significant work has been done in understanding how shame manifests in men and its repercussions, by Fred Wright. Shame and shame-related emotions such as humiliation, embarrassment and guilt cause great discomfort within men as they are incongruent with the masculine identity and emotions they are not supposed to feel. According to Wright, in order to deal with this shame, men engage in excessive usage of counteractive defenses such as: “intellectualization, rationalization, reaction formation, doing and undoing, isolation, identification with the aggressor, reversal, overcompensation, grandiosity, devaluation, and idealization”(Wright, 1994). Counteractive defenses are especially unhealthy since they do not merely avoid impulses or conflicts, but rather seek to alter or transform them. Such defenses are commonly associated with psychopathologies of aggression, narcissism, obsession-compulsion, and paranoia (Blatt & Blass, 1992; Campbell, 1993; Lewis, 1976 as cited in Wright, 1994).

An important implication of shame is its manifestation in males in context to separation from an individual. Following the separation from a significant other (most often a woman for adults) the reaction is particularly intense and is frequently full of shame, humiliated fury, and despair. This reaction is understandable considering that men are afflicted by fear of abandonment more than females (Stevens & Gardner, 1994 as cited in Wright, 1994). Fear of abandonment is a fundamental element to the experience of shame. Hence, following such a separation the reaction is as intense as mentioned above and males engage in counteractive

defenses. The activation of these defenses, often result in destructive behaviours such as severe substance abuse, suicide, and abuse of women, including homicide.

4.1.6. Alexithymia

The term ‘alexithymia’ is derived from Greek and literally translates to having no words for emotions :a=lack, lexis=word, thymos=emotions. According to the website Psychiatric Times, alexithymia is used to describe the condition of “patients who seem not to understand the feelings they obviously experience, patients who seem to lack the words to describe these feelings to others.” (Muller, n.d.). In a review of the psychometric properties of the alexithymia scale (González-Arias et al, 2018), the authors detail all the pathologies associated with alexithymia as:

This concept has proved to be related to several psychological and pathological processes such as: interoceptive awareness (Herbert et al., 2011), traumatic memories (Nandrino et al., 2006), suicide risk (De Berardis et al., 2017), depression (Arancibia and Behar, 2015; Melin et al., 2017), eating disorders (Behar et al., 2014), somatoform and conversion disorders (Arancibia et al., 2016), chronic pain (Saariaho et al., 2017) and also psychosomatic illness (Kano and Fukudo, 2013; Porcelli et al., 2017), among others. Resulting in unsatisfactory interpersonal relationships and decreased social adjustment (Taylor and Bagby, 2012). Alexithymia has also been associated with different kinds of addictive disorders, such as pathological gambling (Lumley and Roby, 1995; Maniaci et al., 2017), Internet addiction (Dalbudak et al., 2013; Scimeca et al., 2014), maladaptive sexual behavior (Scimeca et al., 2013), and abnormal illness behavior (Scimeca et al., 2016) (González-Arias et al, 2018).

In a significant study conducted in 2018, the researchers sought to examine a direct relationship between depression, alexithymia and traditional masculinity ideology. The participants were asked to rate themselves on the Toronto Alexithymia Scale (TAS) which is the major scale used in measurement of alexithymia and their masculinity was measured using the Male Role Norms Scale. The results indicated a relationship between depression and TMI which was mediated by alexithymia (López Cruz and Presmanes-Roqueñí, 2018).

The most important concept under alexithymia is the ‘Normative Male Alexithymia’ (NMA) hypothesis proposed by Ronald Levant. The hypothesis is that males who are brought up adhering to the traditional masculine norms display some degree of alexithymia (Levant, 1992, as cited in Levant et al., 2009). Using 41 existing samples and deriving their effect size estimate, researchers found results which aligned with the hypothesis, which indicated higher occurrence of alexithymia are found among men than women (Levant et al., 2009).

4.2. Masculinity and Mental Illness

An important aspect of the study of masculinity and its relationship with mental illnesses is not just the correlation or causation which research has been influential in discovering, but the attitudes towards these disorders in males who experience them. The various mental disorders and their relationship with masculinity is discussed in this section.

4.2.1. Depression

A major study undertaken by López Cruz and Presmanes-Roqueñí in 2018 sought to examine a direct relationship between TMI and depression. This research resulted in the finding

that there was a relationship between TMI and depression which was mediated by alexithymia (López Cruz and Presmanes-Roqueñí, 2018).

Research indicates that men are four times as likely to commit suicide as women (Brooks, 2001). However a significant concern with male depression is its incongruence with the male identity i.e. men are not supposed to experience feelings of worthlessness or fatigue. Therefore, males undergo what is called ‘silent depression’ preventing the identification of their symptoms by others, and often, by themselves (Levant & Pryor, 2020). This leads men to suppress their depression. Any expression of depression then occurs in ways more ‘acceptable’ for men which include alcohol abuse and aggressive behaviour (Brooks, 2001).

4.2.2. Anxiety Disorders

1732 adolescent males aged 12-18 participated in a study which aimed to seek the impact of masculinity on literacy of anxiety health related disorders. It is important to note that this particular study measured how aligned the students were with hegemonic masculinity (and not TMI). The results show that students who were less aligned with hegemonic masculinity were found to have a greater correlation of anxiety-specific mental health literacy and of help-seeking behaviours. Such a correlation was not observed in students who were more aligned to the hegemonic masculinity. Moreover, students who were more willing to seek help from a family member or to research online about their mental health concerns were more likely to seek professional help as well (Clark et al, 2020).

4.2.3. Eating Disorders and Body Image Concerns

Among the very few studies which attempted to examine eating disorders in males, a noteworthy attempt was made by Shepherd and Rickard in 2012 in a study of 176 undergraduate men. Attitudes toward help-seeking, stigma and their Gender Role Conflict (GRC) were assessed along with their Drive for Muscularity (DM) which refers to the desire to have an ideal muscular body (Shepherd and Rickard, 2012). GRC and DM which are concepts highly correlated with TMI were found to have a negative correlation with help-seeking behaviours for body image concerns and disordered eating and exercises behaviours in men. Herein, the relationship between GRC and intentions to seek help was mediated by the self-stigma of seeking help and attitudes towards seeking help (Shepherd and Rickard, 2012).

4.2.4. Post-traumatic Stress Disorder (PTSD)

Among the various studies correlating masculinity with Post Traumatic Stress Disorder, the study by Caddick et al. stands out in its attempt to introduce newer perspectives. The researchers conducted a study on combat veterans who were diagnosed with PTSD. These veterans were a part of a surfing group. The researchers sought to understand how the veterans performed their masculinity based on their learnings from the military service. Thereafter through participant observations, interviews and then intervention, attempts were made to reorient their masculinity to deal with their disorder. Rather than considering PTSD a weakness and denying it, they were urged to consider it as a challenge which they needed to face and not run away from. These attempts were successful in helping the veterans. An important inference highlighted in this study is that rather than immediately perceiving masculinity as problematic masculinity can be reoriented to perform healthier masculinities (Clark et al. 2020).

4.2.5. Help-seeking

The most important factor in the relation between masculinity and mental disorders (or mental health) is the lesser likelihood of men to engage in help-seeking behaviors. Foremost, the literacy of mental health in males is lesser which is combined by the lesser ability to identify problems of anxiety and trauma as compared to women, which was indicated in a study conducted on 1249 students (Haavik et al., 2017). In a systematic review of the factors associated with lower help-seeking behaviours in men, Yousaf et al. examined 41 citations amounting to 21,787 participants aged 18-80 and the primary barriers to help-seeking were inferred: “disinclination to express emotions/concerns about health, embarrassment, anxiety and fear, and poor communication with health-care professionals” (Yousaf et al., 2013).

In yet another significant attempt, Anne Cleary conducted research on fifty-two males, aged between 18 and 30 years who attempted suicide. The research was conducted 7 years after their suicide attempts all of which had been classified as medically serious. The aim was to examine the factors and attitudes associated with help-seeking. Lack of awareness of psychiatric symptoms, reluctance to disclose distress and negative attitudes to seeking professional help were the factors associated with traditional male expectations. These factors were found to act as barriers towards help-seeking in males (Cleary, 2016).

A very distinct methodology was adopted by Rasmussen and colleagues in their attempt to investigate what could have been the barriers to seeking help for 10 young men aged 18-30 with no record of mental illnesses who died by suicide. 61 In-depth interviews were conducted with parents, siblings, friends, and ex-partners of these men. 6 suicide notes were analyzed using

interpretive phenomenological analysis. After extensive research, the study concluded with identifying 3 barriers to help-seeking. First was a sense of total defeat which would have been experienced by the males upon seeking help. Secondly, they were socialized with an expectation to harbour no room for weakness. Thirdly, there was an observable fear of having a mental disorder. Yet another considerable barrier could be the shame experienced upon falling short of one's standards as well as those of the significant male others in their lives (Rasmussen et al., 2017).

Thus, the negative attitudes towards seeking help in any form along with expectations to be invulnerable which were imposed by masculine gender role expectations were found to be at the root of the reluctance to seek help even in instances of mental distress.

4.2.6. Meta-Analysis

In what could be considered the most ambitious attempt ever undertaken for research in the fields of masculinity and male mental health, Wong et al. conducted a meta-analysis of 78 samples and 19, 453 participants. The results are important in providing direction for further research : “Conformity to masculine norms was modestly and unfavorably associated with mental health as well as moderately and unfavorably related to psychological help seeking.” (Wong et al., 2016). However, the results included some interesting aspects. *Self-reliance*, *power over women*, and *playboy* were factors which were consistently unfavourably related to mental-health whereas one factor which was not significantly related to any mental-health related outcome was *primacy of work*(Wong et al., 2016). The researchers provided a significant insight by concluding that it was not the concept of masculinity as a whole but how it was constructed which would be beneficial to examine, with special emphasis on its individual components.

4.3. Acquired Capability for Suicide (ACS)

An influential theory which seeks to explain the higher male suicide rate is the Acquired Capability for Suicide (ACS) component of the Interpersonal Theory of Suicide (ITS) proposed by Thomas Joiner (Joiner 2005, as cited in Van Orden et al., 2010). The theory comprises of 3 components: thwarted belongingness (social isolation), perceived burdensome (feeling of being a liability to others in your life) and acquired capability for suicide (fearlessness of death). According to the theory, the *desire for suicide* is created by the simultaneous occurrence of the first 2 factors, however, for a suicide attempt to result in death, the desire for suicide has to be combined with an acquired capability for suicide (Joiner 2005, as cited in Van Orden et al., 2010).

Several studies have isolated the last component of ACS to measure its occurrence in males and to thereby establish relationships with masculinity. These studies seek to explain the higher suicide rates with a higher correlation of ACS in males. Correlations have been found between ACS and the TMI factors of stoicism and sensation-seeking (Witte et al., 2012). However, research conducted in this direction has questionable validity for a number of reasons. Firstly, a systematic review conducted of all articles addressing ACS from January 2005 to July 2015 which consisted of 66 studies found that perceived burdensomeness proved to be strongest predictor of suicide ideation among all 3 components (Ma et al., 2016). This finding indicates that all studies isolating ACS as a singular component to explain suicide have questionable validity.

Secondly, male suicide rate is attempted to be explained by the perceived fearlessness and (rather unrelated) factors such as stoicism and sensation-seeking. Is it then implied that all individuals displaying higher levels of these two factors are suicidal? More importantly, is the

presence of these two factors adequate for a person to contemplate and attempt and die by suicide ? If not, then what purpose does such research seek to serve, is one important question that emerges. The explanation that male suicide rate can be explained merely through the fact that men use lethal weapons looks merely at the symptoms. The relevant question here is, why in fact, do men use more lethal means? Can it be attributed to the supposed fearlessness men acquire through their socialization which makes them apparently immune to the fear of death?

These questions are significant, especially since alternative explanations have been hinted at by Brooks and colleagues in their discussion of male depression wherein, they conclude that men are four times more likely to “take their own lives” (Brooks, 2001). On the other hand, it has also been indicated that men who experience Interpersonal Trauma have fewer resources, less support, more stigma and a massive amount of shame and therefore, will experience the more severe outcomes which leads up to suicides (Levant & Pryor, 2020). Thus, research undertaken in this regard needs to delve deeper into the causes as opposed to drawing conclusions from the symptoms which leave them vulnerable to criticism.

5. Towards Newer Schemas

The findings and data encountered during the course of this research, forced the author (who identifies as a male) to modify their schema of men as a group in unexpected ways. This section is an ode to those findings and perspectives which are seldom voiced, causing them to remain unknown and unacknowledged in popular discourse. Before we attempt to explore the data, it is therefore imperative to define what a schema is. According to the American Psychological Association (APA), schema is defined : “a collection of basic knowledge about a concept or entity that serves as a guide to perception, interpretation, imagination, or problem solving” (*APA Dictionary of Psychology*, n.d.-c). Within this context, the aforementioned *entity* is the group of men. Yet another associated concept which needs to be highlighted is stereotype:

a set of cognitive generalizations (e.g., beliefs, expectations) about the qualities and characteristics of the members of a group or social category. Stereotypes, like schemas, simplify and expedite perceptions and judgments, but they are often exaggerated, negative rather than positive, and resistant to revision even when perceivers encounter individuals with qualities that are not congruent with the stereotype (*APA Dictionary of Psychology*, n.d.-e).

An overwhelming volume of literature in all fields of social sciences revolve around the male perpetrators of violence. A lesser documented dimension is of male victims of violence and interpersonal trauma.

This section seeks to examine the research and findings associated with male victims of interpersonal trauma, the role of masculinity, findings associated with attitudinal differences and instances of systemic failure in addressing such violence and rehabilitating such victims.

5.1. Interpersonal Trauma

Interpersonal Trauma is explained by the website for Cognitive Behavioural Therapy for Personal Development as “Interpersonal traumas involve events in which we have been hurt by other people”(*Interpersonal Trauma: 5 Steps to Help Yourself*, 2020). Another definition for Interpersonal trauma highlighted it in terms of its categories; “*Interpersonal trauma* was defined as involving any of the following traumatic experiences: emotional abuse (EA), emotional neglect (EN), physical abuse (PA), physical neglect (PN), and/or sexual abuse (SA) in childhood and/or adulthood” (Mauritz et al., 2013). Within this section we cover the male victims of Interpersonal Trauma with regard to Intimate Partner Violence (IPV) and Sexual Abuse.

5.1.1. Female - Perpetrated Intimate Partner Violence (IPV)

The website of Centers for Disease Control and Prevention (CDC) of the U.S. government explains Intimate Partner Violence : “the term “intimate partner violence” describes physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse” (Intimate Partner Violence |Violence Prevention|Injury Center|CDC, n.d.). We discuss the findings associated with different forms of IPV wherein the victims were males and the perpetrators were females.

5.1.1.1. Physical Aggression

. According to a National Intimate Partner and Sexual Violence Survey by the CDC, One in 4 women and 1 in 9 men experienced Intimate Partner Violence in their lives where IPV/domestic violence was defined as: punching, hitting, shoving, choking and otherwise physically harming the partner (Smith et al, 2017).

The commonly held belief until the latter half of the 1990s was that females engaged in IPV only in retaliation to men inflicting violence first, in self-defense. However, Pearson (1997) reports that 90% of the women she studied assaulted their partner because they were furious or jealous, or frustrated and not because they tried to defend themselves. These motives are parallel to the motivations of male perpetrators (Pearson, 1997 as cited in Straus, 2008).

A study was conducted by Murray Straus in 2008 with heterosexual couples across 32 nations with 13, 601 university students. The study aimed to inspect the *symmetry* of domestic violence i.e. the differences in occurrences of violence inflicted by females and males in the last 12 months of their relationship. The study considered two forms of violence (assault) which were categorized as minor and severe. The results were formed combining results from both forms of violence. According to Straus (2008):

“minor” assault are: (1) pushed or shoved, (2) grabbed, (3) slapped, (4) threw something at partner and (5) twisted arm or hair. The items in the “severe” assault scale are: (1) punched or hit a partner, (2) kicked, (3) choked, (4) slammed against a wall, (5) beat up, (6) burned or scalded and (7) used a knife or gun on partner (Straus, 2008).

The results combining both forms of violence showed that the most frequent form of violence was bi-directional i.e. by both men and women. The second most frequent was female-only violence where the perpetrators were only the female partners. The least frequent form of violence was male- only (Straus, 2008).

Table depicting the rate incidence of any assault and the gender difference in perpetrators:

Table 2

Prevalence and bidirectionality of any physical violence

Nation	Assault rate (%)	Bidirectionality type ^a		
		Male-only %	Female-only %	Both Violent%
All (median)	31.2	9.9	21.4	68.6
Iran	77.1	4.0	1.3	94.6
Mexico	44.1	6.6	15.5	77.7
South Africa	39.5	7.6	10.2	82.0
Great Britain	37.5	4.2	19.2	76.5
Tanzania	37.4	6.9	1.7	91.3
Hong Kong**	37.0	7.7	36.9	55.2
Taiwan	36.1	6.7	25.4	67.8
China**	34.7	6.9	31.7	61.2
Lithuania**	33.9	5.6	23.5	70.7
Belgium**	33.4	11.2	19.8	68.8
India	32.3	8.3	16.6	75.0
South Korea	32.2	8.0	19.3	72.5
Russia	32.2	2.8	27.1	70.0
Romania	31.9	6.9	25.5	67.4
Netherlands*	31.7	4.6	24.2	71.0
United States	30.0	9.7	20.6	69.6

(Straus, 2008)

A meta-analytic review of domestic violence cases reported between 1967 to 1990 which explored over 300 titles of cases found that in heterosexual partners, females were more likely to use physical aggression than men (Archer, 2000).

A recent study conducted by Bates and colleagues sought to explore the attitudinal differences where participants were presented with two versions of the each instances of violence and the only change: the genders of the victim and perpetrator were reversed. They were then asked to identify which of them qualified as violence and where they would be more likely to intervene. Results showed that “IPV less likely to be identified toward male victims and considered more acceptable compared to when the victim was female” (Bates et al., 2018). Moreover, the participants responded that they were more likely to intervene themselves and report an instance when the victim was female and they expected greater outcome expectancy

(resolution of such violent behaviour) in the same cases as opposed to when the victims were males. In the second part of this study, stereotype priming – gender congruent and gender incongruent was examined as a variable. To illustrate, in gender congruent stereotyping, participants were presented with statements which aligned with stereotypes i.e. “men engage in more physical domestic violence in men”. In gender incongruent stereotyping, the statements were like “men have also found to be victims of violence by their partners”. It was found that this added variable did not have any effect or change the attitudes of participants in any way (Bates et al., 2018).

Such cases of violence were not recorded earlier due to lack of resources for men. This changed in the U.S. in 2000 when the Domestic Abuse Helpline for Men was set up (Levant & Pryor, 2020). 54 percent of the callers reported being involved in a relationship where a serious injury could result if the partner found out that they were calling a hotline (Levant & Pryor, 2020). Other forms of aggression besides Physical Aggression in IPV were discovered which have been mentioned below.

5.1.1.2. Psychological Aggression

These acts of aggression have been defined as being comprised of: “ "expressive aggression" (name calling, insulting, humiliating partner)” and “coercive control” (Behaviours intended to monitor, control or threaten an intimate partner)” (Levant & Pryor, 2020). 77% of the callers on the Domestic Abuse Helpline for Men reported threats by female partners to have them falsely arrested and 74% reported emotional abuse (gaslighting and humiliation) (Levant & Pryor, 2020).

5.1.1.3. Legal and Administrative Aggression (LA aggression)

Such acts of aggression have been defined as “Using legal systems and related resources to harm them [male partners] and exert control.” (Levant & Pryor, 2020). Instances of such aggression included a woman making threats or taking steps to prevent their partner from seeing their children. A study on male victims of IPV found that 49% participants experienced threats by their partners to take sole custody of their child, or keep their children away from them (Hines et al., as cited in Levant & Pryor, 2020). A serious method used to inflict LA aggression on males was through threats of falsely accusing the victim (caller) of abuse or some other crime. LA aggression has been correlated with occurrences of Depression and PTSD (Berger et al., 2016 as reported in Levant & Pryor, 2020). In the Indian context, the Supreme Court directed the government to amend the domestic violence and dowry law (Section 498a) taking cognizance of the large number of false and malicious cases reported (TNN, 2010).

5.1.2. Sexual Violence

The National Intimate Partner and Sexual Violence Survey by the CDC found that while 1 in 4 women will experience sexual violence in their lifetime so will 1 in 6 men (Smith et al, 2017) when sexual violence consisted: Unwanted sexual contact, Non-contact Unwanted sexual contact, sexual coercion and rape (Smith et al, 2017). The gender of the perpetrator was found to be of significance. With female perpetrators, males were not able to identify the rape as violence given that as a man they were “supposed to enjoy it”. On the other hand, victims of sexual violence by male victims experienced tremendous distress caused by a confusion regarding their sexual orientation (Levant & Pryor, 2020).

5.1.3. Observations on Male Victims

The belief that men cannot be abused is so strong that, in occurrences of both IPV and sexual violence, male victims have often gone through their whole lives never identifying as having experienced abuse or coercion. Moreover, those who did identify, experienced tremendous shame because they felt they were supposed to prevent it and that they were “responsible” for it (Levant & Pryor, 2020). A review conducted by Mauritz (2013) of 33 studies found that people who were diagnosed with severe mental illnesses had higher likelihood of having been exposed to interpersonal trauma and having trauma related disorders than the general population (Mauritz, 2013). According to Ronald Levant, men who experience Interpersonal Trauma have fewer resources, less support, more stigma and a massive amount of shame and therefore, will experience the more severe outcomes which leads up to suicides (Levant & Pryor, 2020) .

In the Indian context, no law exists to protect men from domestic violence (Desai, 2017) (Sexual Harassment of Men, n.d.). Ironically, the laws protecting women from domestic violence have been misused to inflict domestic violence on men (Gole, 2019). The Supreme Court directed the Indian government to amend the domestic violence and dowry law Section 498a taking cognizance of the large number of false and malicious cases against men (TNN, 2010). Furthermore, there exist no laws in India to protect men against sexual harassment and rape , even the Vishakha Guidelines for Sexual Harassment at workplace find no mention of protection of men (Khan, 2017) (Sexual Harassment of Men, n.d.).

6. Positive Psychology/Positive Masculinity (PPPM)

A new field emerged within psychology in the 1980s in an attempt to change the way the discipline looked at humans; more specifically the direction that research within psychology undertook. This was the field of Positive Psychology which aimed to focus more on the human virtues and how life could be made more meaningful considering the view that psychology had for long focused on the deficiencies and pathologies in humans. Former President of the APA, Martin Seligman is considered to be the father of Positive Psychology (Positive Psychology, n.d.).

Researchers adopting this approach were of the opinion that minimal attention had been directed to the study and promotion of “positive emotion, character strengths, and human virtues” (Hogan, 2005, as cited in Kiselica & Englar-Carlson, 2010). Thereafter, attempts were made to incorporate the approach in the fields of masculinity and men’s mental health in the last few years, given the dearth of articles published from this standpoint. A recent study conducted to analyze the articles published in the *Psychology of Men and Masculinities* journal by the APA in the years 2000 to 2018, found that of the 590 articles reviewed only 15% of them reflected a positive focus (Cole et al., 2021). The positive psychology approach has been adopted in masculinity studies in recent years which is referred to as the *Positive Psychology/Positive Masculinity* (PPPM) model. The model is based on two fundamental assumptions which underlie the entire PPPM approach which seeks to explore the beneficial and healthy aspects of traditional masculinity:

First, positive psychology emphasizes the study of strengths and virtue over disease, weakness, and damage. Second, positive psychology is focused on building in people

what is right rather than fixing what is wrong (Aspinwall & Staudinger, 2003; Seligman & Csikszentmihalyi, 2000 as cited in Kiselica & Englar-Carlson, 2010).

Research in this field has been promoted by several studies of which one significant study was conducted by Hammer and Good: conformity to traditional masculine values of risk-taking, dominance, primacy of work, and pursuit of status, was correlated with higher levels of personal courage, autonomy, endurance, and lower levels of these factors were found in association with conformity to norms of winning, emotional control, self-reliance, and pursuit of status lower levels (Hammer & Good, 2010). Such research has been helpful in identifying and isolating the most beneficial aspect of masculinity.

In congruence with the PPPM framework, Kiselica, Englar-Carlson and their colleagues proposed the masculine strengths which would improve our understanding of and enhance the clinical practice with boys and men. According to Kiselica and Englar-Carlson (2010) the male strengths based on the positive aspects of masculinity:

1. *Male relational styles* – Males tend to develop intimacy through action-oriented activities. These shared activities, which are often instrumental in nature are a major source of enjoyment and bonding for men e.g. Sports, working on a project, etc.
2. *Male ways of caring* – Psychologically healthy families raise men to caring and protective with their loved ones and friends. Males are also found to engage in high levels of action empathy - taking action based on how an individual sees thing from someone else's point of view.
3. *Generative fathering* – Men who are good fathers engage in generative fathering. As fathers, they readily and consistently work to address the developmental needs of their children and to foster their child's emotional, educational, intellectual, and social growth.

4. *Male self-reliance*- This refers to the socialization men undergo to utilize their own resources to confront life's challenges which equips them with self-reliance. Such healthy independence helps in a healthy identity and also helps in relating this self-reliance in relation to others to address their needs and serve them.
5. *The worker/provider tradition of men*- The norm to engage in work and earn and provide not only helps men to gain a sense of satisfaction in achieving their culturally prescribed role but work provides a sense of meaning and fulfillment, all of which play a significant role in male identity and self-esteem.
6. *Male courage, daring, and risk-taking*- Males display tremendous courage and forms of daring while undertaking worthwhile risks. These include "facing peril to protect others, completing dangerous but necessary jobs, or pushing themselves to their limits during athletic competitions" (Kiselica & Englar-Carlson, 2010). Healthy attributes include being able to draw a distinction between sensible and foolhardy (or reckless) risks and learning to avoid the latter.
7. *The group orientation of boys and men*- Banding together for achievement of a common purpose comes under behaviours that men are oriented towards; research shows that men spend more time in coordinated group activity as compared to men who engage more in dyadic interaction (Benenson, Apostoleris, & Parnass, 1997 as cited in Kiselica & Englar-Carlson, 2010). Men value groups as they find comfort in them and act as important sources of identity and community.
8. *The humanitarian service of fraternal organizations*- For centuries men have formed service- oriented organizations such as the 100 Black Men of America and Shriners. Such organizations engage in humanitarian work which instills a sense of social interest

and belonging in men and the attitudes to work for a common greater good and make the world a better place.

9. *Men's use of humor*- Humour is used as a method to attain intimacy. Males use humour to create happy experiences, to form friendships and to develop them and it is an important method to express their affection and care for others. Humour is also used by men as an effective strategy to diffuse tension and in conflict-management, while research also indicates that men use humour as “a healing and coping tool in times of stress and illness” (Brooks & Goldstein, 2001; Chapple & Ziebland, 2004; Wolin & Wolin, 1993 as cited in Kiselica & Englar-Carlson, 2010).
10. *Male heroism* – Many or all of the aforementioned strengths have been used by men throughout ages to exemplify the positive aspects of traditional masculinity. These strengths have been embodied by men to have “heroic” lives who: “use many or all of the previously mentioned qualities to demonstrate exceptional nobility in the way they lead their lives, overcoming great obstacles and making great contributions to others through extraordinary efforts.” (Kiselica & Englar-Carlson, 2010). Abraham Lincoln, Martin Luther King, Cesar Chavez, and Harvey Milk, have been used as examples of monumental historical figures. Likewise, devoted, hard-working fathers are considered to be everyday heroes.

These are the male strengths proposed by the Kiselica & Englar-Carlson (2010) which has been further elaborated with its application in therapy.

An interesting case study has been presented in the article of a client called Clifford who approached a new therapist adopting the PPPM framework after being disheartened by his experience with his former therapist. The difference in their approaches is highlighted. The

former therapist accused Clifford of being a “typical male” who was incapable of expressing his emotions to his family members and was afraid of intimacy which resulted in Clifford harboring frustration, anger and resentment towards the therapist who used a cold clinical approach and the client was left feeling he had not been understood by the therapist and had rather been misunderstood. The second therapist firstly acknowledged, validated and appreciated the efforts taken by Clifford as a husband and as a father after probing to understand the intentions and attitudes which lay at the root of his actions and behaviour. The further therapy sessions continued with this acknowledgement while seeking to help the client understand how his actions affected those around him (Kiselica & Englar-Carlson, 2010).

Essentially, the PPPM framework is an attempt to shift the focus in understanding males by seeking to emphasize their strengths (virtues) as opposed to their unhealthy or maladaptive behaviours. More accurately, it comes across as an attempt to probe further to the intentions and which lie at the root of their behaviour (including, and especially the maladaptive behaviour). There is an unstated assumption that males (and humans at large) are by nature, inherently noble. This observation is further supported by the fact that positive psychology has been found to echo the principles of humanistic psychology, where Abraham Maslow used the term ‘positive psychology’ as early as in the 1950s (Positive Psychology, n.d.).

The major contribution of the *Positive Psychology/Positive Masculinity* or PPPM *framework* has been in identifying and isolating the traits erstwhile considered to be a part of TMI or ‘masculinity’ which are in fact, healthy. Thus, an important inference is that the term masculinity with all its implications, in its entirety cannot be used to draw conclusions (with pathologies) without due acknowledgement of its varied effects i.e. healthy behaviour which as highlighted by the PPPM research. And these effects need to be incorporated and utilized for

further research seeking to examine male mental health. Therefore, it can be inferred that the PPPM framework helps in furthering our understanding of males and masculinity and to use this enhanced understanding to modify our clinical practice with men and boys by focusing on the root causes and not on the symptoms. Simply put, PPPM seeks to raise healthy men as opposed to ‘correcting’ unhealthy men.

7. Primary Research

The literature reviewed in the course of the research for the paper consists majorly, if not entirely, of studies from the European and American countries and specifically the U.S. which begs the question of validity especially considering that masculinity as a concept is rooted in its socio- cultural context. Therefore, an attempt was undertaken to gain a glimpse into the implications of the research in the Indian context through primary research, Primary research conducted in the due course of this research paper is divided into 4 parts based on their distinct investigations. Research has been undertaken with an attempt to gauge the validity of components constituting masculinity and to inspect correlation among various factors within this specific domain. Finally, an attempt has been made to gain an attitudinal representation of the respondents with regard to different aspects pertaining to men and their mental health. The research also involved construction and thus, a proposed introduction of a new component: *Emotionally Active*. The last section (Section 4) consists of visual representation of the significant responses, which is not included in the final discussion given their self-explanatory nature. Further elements will be discussed in the subsequent subsections.

7.1. Sample

The sampling method used in this study was convenient sampling. The sample comprised of cisgender males residing in Mumbai, India. The sample size is 65. The age range is 17-36, with maximum participants belonging to the 20-21 age range. All participants of the survey are literate, educated individuals either natives of Mumbai, currently or formerly living in Mumbai.

7.2. Methodology

The research consisted of a questionnaire with 24 questions (excluding questions for name and age). The questionnaire was formulated on Google Forms and circulated through WhatsApp to the participants. The questionnaire consisted of rating scales (1-10), rating on agreement (strongly disagree- strongly agree), rankings and multiple-choice questions. Another point to be noted is that a point of criticism regarding masculinity scales has been addressed in this questionnaire by asking respondents to answer based on both their beliefs as well as their practice. In order to control the social desirability factor as a confounding variable in responses, the option of anonymity was presented to the participants (not mentioning their name in the form). After the collation and tabulation of responses, they were operated upon for statistical analysis. R-studio is the software used for statistical analysis and Microsoft Office along with Google Forms were used for visual representation of data.

7.3. Tools

The primary tools used in statistical analysis are chi-squared test of independence and Spearman's rank correlation. According to the official website of Kent University, the Chi-squared test of Independence is explained thus: "The Chi-Square Test of Independence determines whether there is an association between categorical variables (i.e., whether the variables are independent or related). It is a nonparametric test." (LibGuides: SPSS Tutorials: Chi-Square Test of Independence, n.d.). The most important result of the chi-squared test is its p-value or the level of significance, for which the accepted standard in psychology is $p < 0.05$. However, an association results from various factors among which extraneous or confounding variables are common. In an attempt to rule out (or at least to minimize) the possibility of a

spurious association, the pair of variables with which were found to be associated according to the chi-squared test were further operated using the Spearman's Rank Correlation which is defined : "The Spearman's Rank Correlation Coefficient is the non-parametric statistical measure used to study the strength of association between the two ranked variables." (What Is Spearman's Rank Correlation Coefficient? Definition and Meaning, 2016). Only after the significance (p-value) for Spearman's Rank Correlation was also found to be acceptable, was any relationship considered to be acceptable. Furthermore, the Spearman's Rank Correlation coefficient (ρ) was used to measure the direction and the strength of any relation thus found. Thus, all posited correlations in this paper have undergone the Chi-squared test of independence as well as the Spearman's rank correlation.

7.4. Analysis

As mentioned earlier, the primary research analysis has been divided into 4 parts according to the different relations they seek to examine.

7.4.1. Section 1

The relationship between self-reported masculinity and masculinity according to BMS was examined. The respondents were asked to rate themselves on how masculine a person they considered themselves to be, on a scale of 1-10 (where 1 corresponded to not being masculine at all). It was presumed the respondents would use an individual and personal definition of masculinity for their rating. This response was termed as the *Self-Reported Masculinity*. Thereafter, the respondents were presented with the four factors of the earlier discussed Brannon Masculinity Scale(BMS): *No Sissy Stuff*- Men should not be feminine, *The Big Wheel*- Men

should strive to be respected for successful achievement, *The Sturdy Oak* - Men should never show weakness and *Give ‘em Hell* - Men should seek adventure and risk and even accepting violence if necessary (Brannon and Juni, 1984 as cited in Levant & Pryor, 2020). They were asked to rate their agreement on each of these factors. Chi-squared test was used to examine the relationship between the ratings on the self-reported masculinity and the ratings on the Brannon Masculinity Scale (with each of its components):

Table 1. Self– Reported Masculinity and BMS

X variable	Y variable	X-squared	df	p-value (Chi-squared)	Inference	p-value (Spearman’s Rank)	Inference
Self-Reported Masculinity	No Sissy Stuff	39.138	32	0.18	Independent	-	
Self-Reported Masculinity	The Big Wheel	22.932	32	0.8804	Independent	-	
Self-Reported Masculinity	Sturdy Oak	26.614	32	0.7358	Independent	-	
Self-Reported Masculinity	Give ‘em Hell	48.634	32	0.03005	Dependent	0.5625	Independent

In the Chi-squared test, the significance value for all components except *Give ‘em Hell* indicated the variables to be independent. The Spearman’s rank correlation was conducted to test the validity of the dependence indicated by the chi-squared test, with respect to *Self-reported masculinity* and *Give ‘em Hell*. The test proved these variables to be independent as well.

7.4.2. Section 2

The relation between self-reported masculinity and mental health and the relationship between self-reported masculinity and help-seeking behaviour was examined. The respondents were presented with the definition of mental-health by the American Psychological Association: “a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life.”(APA Dictionary of Psychology, n.d.). Based on the definition, the respondents were asked to rate their perceived current mental health on a scale of 1-10 (where 1 corresponded to the poorest mental health). They were then asked: “In the event that I experience symptoms of a mental illness (depression, anxiety or any other), I would reach out to someone and/or seek professional help”. This was termed as the behaviour of *help-seeking* which was rated on a scale of 1-10 (where 1 corresponded to not seeking help at all). Chi-squared test was conducted to examine the relation of self-reported masculinity(x) with mental health (y) as well as with help-seeking behaviour (y):

Table 2. Self- Reported Masculinity with Mental-Health and help-seeking

X variable	Y variable	X-squared	df	p-value (Chi-squared)	Inference
Self- Reported Masculinity	Mental Health	51.639	64	0.8669	Independent
Self- Reported Masculinity	Help-Seeking	85.417	72	0.1335	Independent

The results indicated both sets of relationships to be independent.

7.4.3. Section 3: *Emotionally Active*

This section is of special significance as it involved the construction and thus, the introduction of a new psychological construct termed as the *Emotionally Active* factor.

According to the proposed definition, the measure of how emotionally active a person refers to: “the proclivity and ability of an individual to introspect and identify one’s own emotions and those of others and to address their own emotional needs in relationships”. The *Emotionally Active* measure comprises of four different components:

1. Introspection: The proclivity of an individual to examine their emotions.
2. Emotional Awareness: The extent to which an individual demonstrates an awareness of their emotions at all times.
3. Emotionally Perceptive: The extent to which an individual demonstrates the ability to successfully identify the emotions of others.
4. Emotionally Assertive: The extent to which an individual addresses their emotions and emotional needs in their relationships.

The literature reviewed in the course of this research has indicated unawareness restriction, repression, denial and suppression of emotions and emotional needs as the major factor in poorer mental health in men. Therefore, the *Emotionally Active* factor has been proposed with an attempt to shed light on the reported emotional detachment males experience with themselves and others. Specifically, higher emotionally active scores could be examined to understand if they correlate with healthy behaviours and more importantly, lower emotionally active scores could be inspected for a negative correlation with unhealthy and toxic attitudes and behaviour.

An important factor is the extent to which an individual, aware of their own as well as the other's emotions, would address their personal emotional needs (since literature and the response in primary research show that male gender norms expect, idealize and eulogize men placing other's emotional needs first at the cost of their own). Thus, an important point to be noted is the absence of mention of empathy within this factor. This detail is significant as it highlights the true purpose of this construct; how much an individual asserts their *own* emotions as opposed to those of others (given the factors mentioned above).

7.4.3.1. Mental Health

The *Emotionally Active* factor was used to examine the relation of each of its four components with the ratings on mental-health.

Table 3. Emotionally Active Factor and Mental Health

X-variable	Y-variable	Chi-Squared(p)	Inference	Spearman's Rank (p)	Inference	Spearman's Correlation Co-efficient	Relation
Mental Health	Introspection	0.5065	Independent	-	-	-	-
Mental Health	Awareness	0.03382	Dependent	0.0294	Dependent	0.2703558	<i>Positive Weak</i>
Mental Health	Perceptive	0.03118	Dependent	0.005923	Dependent	0.3378023	<i>Positive Weak</i>
Mental Health	Assertive	0.01094	Dependent	0.08014	Independent	-	-

While the other 2 factors were indicated to be independent with mental-health ratings, *Emotional Awareness* and *Emotionally Perceptive* factors were found to have a relation in both chi-squared and Spearman's test. Both these factors indicated a weak positive correlation with (better) mental-health ratings.

7.4.3.2. Help-Seeking

The aforementioned *Emotionally Active* factor was examined for a relation with the how likely respondents were to seek mental-health related help, which is termed as the rating of *help-seeking*. Help-seeking was considered to be the x-variable and its relation with each of the components of the emotionally active factor was inspected:

Table 4. Emotionally Active and Help-Seeking

X variable	Y variable	Chi Square (p)	Inference	Spearman's Rank (p)	Inference	Spearman's Correlation Co-efficient	Relation
Help-Seeking	Introspection	0.3212	Independent	-	-	-	-
Help-Seeking	Awareness	0.4548	Independent	-	-	-	-
Help-Seeking	Perceptive	0.02416	Dependent	0.5131	Independent	-	-
Help-Seeking	Assertive	0.004633	Dependent	0.01064	Dependent	0.3148177	<i>Positive Weak</i>

While all other factors were indicated to be independent of the *help-seeking* behaviour, the *Emotionally Assertive* factor was proved to have a relation in both the tests. The *Emotionally Assertive Factor* and help-seeking behaviours were found to have a weak positive correlation.

7.4.4. Section 4 – Visual Representation of Significant responses

1.

As a man, I feel I have let myself down if I have to reach out to someone about my emotions when I feel low:

65 responses

2.

Even if I open up to someone, I find it difficult to identify and express my emotions clearly in words:

65 responses

3.

In my relationships and interactions with people from other genders, as a man I feel I should place their emotional needs before mine:

65 responses

4.

Society disregards the emotional needs of men while portraying them as 'tough' and 'providers' and 'protectors'

65 responses

5.

What is your course of action when you are feeling low or overwhelmed (with sadness, fear, anxiety etc.) - rank in order of what you usually: two options should not be given the same number)

6.

Do you wish you were better at identifying your emotions and more comfortable with talking about them?

65 responses

7.

From your personal experience and observations, your view on the practice of raising men to be 'masculine' (MCQ) is :

65 responses

8.

Do you think there is adequate dialogue and discussion on men's mental health and their challenges?

65 responses

7.5. Results & Inference

The 3 sections examined different relations and the results i.e. the significant findings are summarized in this section.

In Section 1, each of the 4 factors of the Brannon Masculinity Scale were examined for their relationship with the Self-Reported Masculinity. None of the 4 factors were found to have a relation i.e. all four pairs were independent of each other.

In Section 2, Self-Reported Masculinity ratings were examined for their relation first with ratings of mental health, and secondly with help-seeking behavior. Both these relations were indicated to be independent.

In Section 3, the Emotionally Active factor was examined where each of its 4 components were tested for independence with mental health ratings. A positive weak correlation was found between Mental Health ratings and factors of *Emotional Awareness* and *Emotionally Perceptive*. Thereafter, the same four factors were examined for their relation with help-seeking behaviours which found that the *Emotionally Assertive* factor had a weak positive correlation with help-seeking behaviours.

So, what can be inferred from these results? It would be more appropriate to answer the question: what do these results suggest? The results from Section 1 indicate no relation between self-reported masculinity and the measures of masculinity in the BMS. The inference is that the Brannon Masculinity Scale, considered to be the foundational scale of TMI, in its original version has no correlation with how individuals define their masculinity. In other words, the factors used by the respondents in their personal definition of masculinity have no relation with the factors used in the BMS. This indicates a strong disjuncture in the definition and conceptualization of masculinity itself. David Brannon constructed this scale in 1984 which has

undergone modification thereon but subsequent scales were extensions or modifications of its original version and it has thus had an undeniable influence in the conceptualization of masculinity and subsequently on all findings associated with it. More importantly, the TMI as a concept is rooted in the culture of the U.S. therefore, how applicable or valid are its implications elsewhere? The results from this primary tool analysis are significant because they point (strongly) to the need for a different conceptualization. Or at the very least, for the acknowledgement that the times have changed and so has the zeitgeist. Masculinity has ceased to be associated with several of these previously assumed notions which are now termed, rather as features of “hyper-masculinity”. So, the first factor is the generational difference. The second is the cultural difference. Are the factors considered to be components of masculinity the same in India? If men are not taught those things by the culture, how valid is it to apply the results of these. The takeaway is that masculinity, as psychologically defined, needs to be dissected and modified and examined, if it continues to address the male gender norms or merely takes behaviours and attitudes which are commonly considered to be unhealthy and maladaptive by themselves and correlates them to various disorders and pathologies. If the latter is true, is there a need for the concept of masculinity to exist as a middleman in the study of maladaptive behaviour and pathologies? The results raise several such pertinent questions which need to be addressed in further research.

The results from Section 2 could have two possible inferences. Firstly, the concept of masculinity could perhaps have no possible correlation with mental health as well as with help-seeking behaviours and extraneous variables are at play. However, that seems like too vague a conclusion which has minimal proof to back it up. The second and more reliable inference is that the defining components of masculinity in each of these respondents' individual definition

excludes the factors associated with (or influencing) mental-health and help-seeking behaviours. In that case, efforts need to be undertaken to investigate the same and conclude, if masculinity as it is defined by respondents of a particular place and year, has implications on factors excluding mental health and help seeking behaviours.

The results from section 3 have two parts. Firstly, the correlation of factors of *Emotional Awareness* and *Emotionally Perceptive* indicate a positive albeit weak correlation with Mental health ratings. Perhaps the correlation is not strong enough to establish or conclude firmly if these relationships are in fact correlated, however they certainly indicate a relationship which has tremendous scope to be explored, especially since these relations are logically plausible. The second result indicates *Emotionally Assertive* individuals are more likely to seek help which although, is again a weak and positive correlation. The validity of the finding needs to be ascertained by further diversifying and substantiating the factor of being *Emotionally Assertive* considering that individuals who do address their emotions in everyday interactions should be more likely to seek help in cases of mental distress too.

7.6. Limitations

The limitations exist in the sample as well as in the analysis. To begin with, the sample size of 65 individuals in any context is not adequately representative to draw strong and reliable inferences from, neither of a region, or of a culture, let alone of an entire gender. Another factor is the age of the respondents (concentrated in 19-21 years) which ties up with yet another limitation which could be considered a confounding variable. The millennial/Gen Z individuals are more exposed to the dialogue surrounding mental health which indicates the possibility of them giving a “correct” answer and avoiding “toxic” answers. Yet another limitation is the

respondents belonging to a metropolitan city which imply the attitudinal or behavioural tendencies cannot be considered as representative of the State or the country at large given its unique culture of modernity which metropolitan cities assume. Further still, the conclusions could have been the stark opposite had this questionnaire been administered in certain rural parts of India. Lastly, most of the respondents belonged to an economically *middle class* or *upper middle-class* social strata and are literate and educated, which could have played an important role in them being literate or ‘woke’ about mental health and the associated issues.

Admittedly, the analysis is of a rudimentary level and cannot be used to draw any strong conclusions by itself (without further examination). Partial and multiple correlation along with partial and multiple regression can be explored with the existing variables. However, the relations explored within the scope of this research can be developed to draw inferences in further research. Specifically, the respondents can be asked to list the factors they consider as a part of their masculinity to understand the recurring factors and how they are different from the factors assumed in existing scales. Mental-Health and Help-seeking behaviors can be gauged through various other methods which are less obvious and overt in their objective for a more reliable response. Lastly, each of the components in the *Emotionally Active* factor can be diversified and developed into scales comprising several valid and reliable items. Research is recommended in this last field with a presumed foresight of the implications and impact that such research could result in, which is hopefully expected to be of tremendous potential and scope in the fields and research concerned with men’s mental health and masculinity.

8. Conclusion

The course of the research undertaken for this paper provided several insights and resulted in certain unexpected findings. A few important observations and suggestions have been noted here.

Firstly, the knowledge of context of the origins of Traditional Masculinity Ideology (TMI) is a crucial prerequisite for any research undertaken in this field. The TMI is an ideology drawn from the culture of the United States of America, as discussed earlier, and it has its origins in a culture which existed decades ago. Therefore, any research conducted in the fields of masculinity using TMI as its measure needs to scrutinize what is the utility, applicability, relevance and most importantly the implication of using a construct laden with limitations such as the TMI.

Secondly, in the eternal debate of nature versus nurture, psychologists are expected to swear to never pick a side and form an immortal pact with the presumption of *nature and nurture*. However, it is interesting to note that literature in the fields of masculinity and mental health find negligible mention of biology and the differences in genetic and hormonal composition. One explanation for this exclusion has been that these are not amenable to change like attitudes and behaviours (Levant and Pryor, 2020). However, merely because these are amenable to change can the role of biological factors be denied or disregarded or even undermined? And yet another question is, what if these attitudes and behaviours have their roots in biology? This perspective has also been highlighted by Steven Pinker in his book *The Blank Slate*, wherein he argues against the widely applied assumption that gender differences are socially constructed (Pinker, 2002). Yet another argument that he puts forth is against the “simplistic” notion that repressing emotions is bad and venting emotions is good. This point

directs us to further explore the strengths of masculine traits which could in fact be promoted (not just in males but across all genders), an attempt undertaken by the Positive Psychology/Positive Masculinity (PPPM) model.

The PPPM model is an essential perspective which needs to be explored for the tremendous scope it offers. More importantly, its application in therapy needs to be considered with its due significance and further developed in order to improve the experience men have with therapy and to thus move one step closer in addressing the reluctance displayed by men to seek help and their likelihood to drop out of therapy.

Finally, considering that among the multitude of men who embody TMI only a fraction experiences the reported repercussions, attempts need to be made to explore alternative causes. Which further supports the points promoting healthy masculine traits is more important. Thus, an appropriate conclusion would be in the words of Frederick Douglas:

“It is easier to build strong children than to repair broken men.”

References:

APA Dictionary of Psychology. (n.d.). American Psychological Association.

<https://dictionary.apa.org/mental-health>

APA Dictionary of Psychology. (n.d.-b). American Psychological Association.

<https://dictionary.apa.org/well-being>

APA Dictionary of Psychology. (n.d.-c). American Psychological Association.

<https://dictionary.apa.org/schema>

APA Dictionary of Psychology. (n.d.-e). American Psychological Association.

<https://dictionary.apa.org/stereotype>

Archer, J. (2000). Sex Differences in Aggression between Heterosexual Partners: A Meta-Analytic Review. *Psychological Bulletin*, 126(5), 651–80.

<https://doi.org/10.1037//0033-2909.126.5.651>

Bates, E. A., Kaye, L. K., Pennington, C. R., & Hamlin, I. (2018). What about the Male Victims? Exploring the Impact of Gender Stereotyping on Implicit Attitudes and Behavioural Intentions Associated with Intimate Partner Violence. *Sex Roles*, 81, 1–15.

<https://doi.org/10.1007/s11199-018-0949-x>

Bilsker, D., & White, J. (2011). The silent epidemic of male suicide. *British Columbia Medical Journal*, 53(10), 529–534. <https://bcmj.org/articles/silent-epidemic-male-suicide>

Bohan, J. S. (1997). Teaching on the Edge: The Psychology of Sexual Orientation.

Teaching of Psychology, 24(1), 27–32. <https://doi.org/10.1177/009862839702400107>

Brooks, G. R. (2001). Masculinity and Men's Mental Health. *Journal of American College Health*, 49(6), 285–297. <https://doi.org/10.1080/07448480109596315>

- Caddick, N., Smith, B., & Phoenix, C. (2015). Male combat veterans' narratives of PTSD, masculinity, and health. *Sociology of Health & Illness*, 37(1), 97–111.
<https://doi.org/10.1111/1467-9566.12183>
- Clark, L. H., Hudson, J. L., Rapee, R. M., & Grasby, K. L. (2020). Investigating the impact of masculinity on the relationship between anxiety specific mental health literacy and mental health help-seeking in adolescent males. *Journal of Anxiety Disorders*, 76, Article 102292. <https://doi.org/10.1016/j.janxdis.2020.102292>
- Cleary, A. (2016). Help-seeking patterns and attitudes to treatment amongst men who attempted suicide. *Journal of Mental Health*, 26(3), 220–224.
<https://doi.org/10.3109/09638237.2016.1149800>
- Cole, B. P., Moffitt-Carney, K., Patterson, T. P., & Willard, R. (2021). Psychology of Men and Masculinities' focus on positive aspects of men's functioning: A content analysis and call to action. *Psychology of Men & Masculinities*, 22(1), 39–47.
<https://doi.org/10.1037/men0000264>
- Davies, J., McCrae, B. P., Frank, J., Dochnahl, A., Pickering, T., Harrison, B., Zakrzewski, M., & Wilson, K. (2000). Identifying male college students' perceived health needs, barriers to seeking help, and recommendations to help men adopt healthier lifestyles. *Journal of American College Health*, 48(6), 259–267.
<https://doi.org/10.1080/07448480009596267>
- Desai, D. (2017). When husbands are victims of domestic violence - Times of India ►.
Retrieved 2 February 2021, from <https://timesofindia.indiatimes.com/life-style/relationships/love-sex/when-husbands-are-victims-of-domestic->

violence/articleshow/26031858.cms#:~:text=%E2%80%9CDomestic%20violence%20a
gainst%20men%20in,offences%2C%20by%20his%20estranged%20wife.

Fischer, A. R., & Good, G. E. (1997). Men and psychotherapy: An investigation of alexithymia, intimacy, and masculine gender roles. *Psychotherapy: Theory, Research, Practice, Training*, 34(2), 160–170. <https://doi.org/10.1037/h0087646>

Garfield, C. F., Isacco, A., & Rogers, T. E. (2008b). A Review of Men's Health and Masculinity. *American Journal of Lifestyle Medicine*, 2(6), 474–487. <https://doi.org/10.1177/1559827608323213>

GBD Results Tool | GHDx. (n.d.). Global Health Data Exchange. <http://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2017-permalink/4eda0172a1cdc5d92b2be4b4950cf9a8>

Geary, D. C. (2020). Male, Female: The Evolution of Human Sex Differences (3rd ed., pp. 433-439). American Psychological Association.

Gladding, S. T. (2018). Counseling: A comprehensive profession. In *Counseling: A comprehensive profession* (8th ed., pp. 82-84). New York: Pearson Education.

Gole, E. (2019, November 19). *International Men's Day: 'I'm a Man Who Faced Domestic Abuse.'* TheQuint. <https://www.thequint.com/news/india/stories-male-victims-domestic-violence-india#read-more>

González-Arias, M., Martínez-Molina, A., Galdames, S., & Urzúa, A. (2018). Psychometric properties of the 20-item Toronto Alexithymia Scale in the Chilean population. *Frontiers in Psychology*, 9, Article 963. <https://doi.org/10.3389/fpsyg.2018.00963>

- Gurian, M. (2019, January 24). Masculinity Is Not Our Enemy. Psychology Today.
<https://www.psychologytoday.com/us/blog/the-minds-boys-and-girls/201901/masculinity-is-not-our-enemy>
- Haavik, L., Joa, I., Hatloy, K., Stain, H. J., & Langeveld, J. (2017). Help seeking for mental health problems in an adolescent population: the effect of gender. *Journal of Mental Health*, 28(5), 467–474. <https://doi.org/10.1080/09638237.2017.1340630>
- Hammer, J. H., & Good, G. E. (2010). Positive psychology: An empirical examination of beneficial aspects of endorsement of masculine norms. *Psychology of Men & Masculinity*, 11(4), 303–318. <https://doi.org/10.1037/a0019056>
- Interpersonal Trauma: 5 Steps to help yourself. (2020, December 2). CBT Psychology.
<https://cbtpsychology.com/interpersonal-trauma/>
- Intimate Partner Violence |Violence Prevention|Injury Center|CDC. (n.d.). Centers for Disease Control and Prevention.
<https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html>
- Khan, Z. (2017, May 2). *Adam, what do you mean you were teased?* The Hindu.
<https://www.thehindu.com/thread/reflections/men-too-may-be-sexually-harassed/article18351375.ece>
- Kiselica, M. S., & Englar-Carlson, M. (2010). Identifying, affirming, and building upon male strengths: The positive psychology/positive masculinity model of psychotherapy with boys and men. *Psychotherapy: Theory, Research, Practice, Training*, 47(3), 276–287. <https://doi.org/10.1037/a0021159>

- Legalservicesindia.com. n.d. Sexual Harassment of Men. [online] Available at:
 <<http://www.legalservicesindia.com/article/2039/Sexual-Harassment-of-Men.html>>
 [Accessed 8 January 2021].
- Levant, R. (2020). What Is Masculinity and How Do Psychologists Measure It?. Retrieved
 1 February 2021, from [https://www.psychologytoday.com/us/blog/men-
 crossroads/202004/what-is-masculinity-and-how-do-psychologists-measure-it](https://www.psychologytoday.com/us/blog/men-crossroads/202004/what-is-masculinity-and-how-do-psychologists-measure-it)
- Levant, R. F., & Pryor, S. (2020). The tough standard. The hard truths about masculinity
 and violence. Oxford University Press.
- Levant, R. F., Hall, R. J., Williams, C. M., & Hasan, N. T. (2009). Gender differences in
 alexithymia. *Psychology of Men & Masculinity*, 10(3), 190–203.
<https://doi.org/10.1037/a0015652>
- Lexico. (n.d.). Toxic masculinity. In Lexico.com dictionary. Retrieved February 8, 2021,
 from https://www.lexico.com/definition/toxic_masculinity
- LibGuides: SPSS Tutorials: Chi-Square Test of Independence. (n.d.). Kent State
 University.
<https://libguides.library.kent.edu/spss/chisquare#:~:text=The%20Chi%2DSquare%20Test%20of%20Independence%20determines%20whether%20there%20is,Chi%2DSquare%20Test%20of%20Association.>
- Long, V. O. (1989). Relation of masculinity to self-esteem and self-acceptance in male
 professionals, college students, and clients. *Journal of Counseling Psychology*, 36(1),
 84–87. <https://doi.org/10.1037/0022-0167.36.1.84>

- López-Ruiz, M. B., & Presmanes-Roqueñi, L. (2018). Depression in men and its relation to the traditional male ideology and alexithymia. *Psychology Research*, 1(1), 95–110.
<https://doi.org/10.33000/mlspr.v1i1.113>
- Ma, J., Batterham, P. J., Calear, A. L., & Han, J. (2016). A systematic review of the predictions of the Interpersonal–Psychological Theory of Suicidal Behavior. *Clinical Psychology Review*, 46, 34–45. <https://doi.org/10.1016/j.cpr.2016.04.008>
- Mahalik, J. R., Burns, S. M., & Syzdek, M. (2007). Masculinity and perceived normative health behaviors as predictors of men's health behaviors. *Social Science & Medicine*, 64(11), 2201–2209. <https://doi.org/10.1016/j.socscimed.2007.02.035>
- Mauritz, M. W., Goossens, P. J. J., Draijer, N., & van Achterberg, T. (2013). Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *European Journal of Psychotraumatology*, 4(1), 19985.
<https://doi.org/10.3402/ejpt.v4i0.19985>
- 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>
- Muller, R. J. (n.d.). When a Patient Has No Story To Tell: Alexithymia. *Psychiatric Times*.
<https://www.psychiatrictimes.com/view/when-patient-has-no-story-tell-alexithymia>
- Neilson, E. C., Singh, R. S., Harper, K. L., & Teng, E. J. (2020). Traditional masculinity ideology, posttraumatic stress disorder (PTSD) symptom severity, and treatment in service members and veterans: A systematic review. *Psychology of Men & Masculinities*, 21(4), 578–592. <https://doi.org/10.1037/men0000257>

- O'Neil, J. M. (2008). Summarizing 25 Years of Research on Men's Gender Role Conflict Using the Gender Role Conflict Scale. *The Counseling Psychologist*, 36(3), 358–445. <https://doi.org/10.1177/0011000008317057>
- O'Neil, J. M. (2008). Summarizing 25 years of research on men's gender role conflict using the Gender Role Conflict Scale: New research paradigms and clinical implications. *The Counseling Psychologist*, 36(3), 358–445. <https://doi.org/10.1177/0011000008317057>
- Phillips, D. A. (2006). MASCULINITY, MALE DEVELOPMENT, GENDER, AND IDENTITY: MODERN AND POSTMODERN MEANINGS. *Issues in Mental Health Nursing*, 27(4), 403–423. <https://doi.org/10.1080/01612840600569666>
- Pinker, S. (2002). *The Blank slate*. London: Penguin Books.
- Pleck, J. H. (1995). The gender role strain paradigm: An update. In R. F. Levant & W. S. Pollack (Eds.), *A new psychology of men* (p. 11–32). Basic Books/Hachette Book Group.
- Psychology Today. n.d. Positive Psychology. [online] Available at: <https://www.psychologytoday.com/intl/basics/positive-psychology> [Accessed 1 February 2021].
- Rasmussen, M. L., Hjelmeland, H., & Dieserud, G. (2017). Barriers toward help-seeking among young men prior to suicide. *Death Studies*, 42(2), 96–103. <https://doi.org/10.1080/07481187.2017.1328468>
- Schumacher, H. (2019, March 18). Why more men than women die by suicide. BBC Future. <https://www.bbc.com/future/article/20190313-why-more-men-kill-themselves-than-women>

Search results for. (n.d.). American Foundation for Suicide Prevention.

<https://afsp.org/search-results/?query=about+suicide+suicide+statistics+&source=https://afsp.org/about-suicide/suicide-statistics/>

Shepherd, C. B., & Rickard, K. M. (2012). Drive for muscularity and help-seeking: The mediational role of gender role conflict, self-stigma, and attitudes. *Psychology of Men & Masculinity*, 13(4), 379–392. <https://doi.org/10.1037/a0025923>

Smith, S. G., Chen, J., Basile, K. C., Gilbert, L. K., Merrick, M. T., Patel, N., Walling, M., & Jain, A. (2017). The National Intimate Partner and sexual violence survey (NISVS): 2010–2012 state report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Straus, M. A. (2008). Dominance and symmetry in partner violence by male and female university students in 32 nations. *Children And Youth Services Review*, 30(3), 252–275. <https://doi.org/10.1016/j.childyouth.2007.10.004>

Thompson, E. H., & Bennett, K. M. (2015). Measurement of masculinity ideologies: A (critical) review. *Psychology of Men & Masculinity*, 16(2), 115–133. <https://doi.org/10.1037/a0038609>

TNN. (2010, August 16). *Amend dowry law to stop its misuse, SC tells govt*. The Times of India. <https://timesofindia.indiatimes.com/india/Amend-dowry-law-to-stop-its-misuse-SC-tells-govt/articleshow/6321987.cms?referral=PM>

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E. (2010). The interpersonal theory of suicide. *Psychological Review*, 117(2), 575–600. <https://doi.org/10.1037/a0018697>

- VandenBos, G. R. (2015). APA Dictionary of Psychology® (2nd ed.). American Psychological Association.
- Web.archive.org. n.d. Wayback Machine. [online] Available at:
 <<https://web.archive.org/web/20140513155939/http://ncrb.nic.in/CD-ADSI-2012/suicides-11.pdf>> [Accessed 1 January 2021]
- What is Spearman's Rank Correlation Coefficient? definition and meaning. (2016, July 9). Business Jargons. <https://businessjargons.com/spearmans-rank-correlation-coefficient.html>
- Witte, T. K., Gordon, K. H., Smith, P. N., & Van Orden, K. A. (2012). Stoicism and sensation seeking: Male vulnerabilities for the acquired capability for suicide. *Journal of Research in Personality*, 46(4), 384–392. <https://doi.org/10.1016/j.jrp.2012.03.004>
- Wong, Y. J., Ho, M.-H. R., Wang, S.-Y., & Miller, I. S. K. (2017). Meta-analyses of the relationship between conformity to masculine norms and mental health-related outcomes. *Journal of Counseling Psychology*, 64(1), 80–93.
<https://doi.org/10.1037/cou0000176>
- Wright, F. (1994) Men, Shame, and Group Psychotherapy. *Group*, 18(4), 212–224.
<https://doi.org/10.1007/BF01458098>
- Yousaf, O., Grunfeld, E. A., & Hunter, M. S. (2013). A systematic review of the factors associated with delays in medical and psychological help-seeking among men. *Health Psychology Review*, 9(2), 264–276. <https://doi.org/10.1080/17437199.2013.840954>