ARMENIA

UNDERSTANDING HOW MEN SEEK PSYCHO-SOCIAL SUPPORT

Research for Action
and Advocacy

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CASA MĂRIOAREI
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Armenian Progressive Youth

Sexual Assault Crisis Center

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REDEFINING MASCULINITY.

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Contents

Acknowledgements **5**

List of Abbreviations **6**

List of Figures **7**

Executive Summary **8**

Chapter 1. Introduction **10**

1.1 Background and Rationale 11

1.2 Country Contexts 12

1.2.1. Armenia 12

1.2.2. Belarus 13

1.2.3. Georgia 14

1.2.4. Moldova 14

1.3 Purpose 15

1.3.1 Purpose of the Study 15

1.3.2 Research Objectives 16

Chapter 2. Theoretical Background **17**

2.1 Intersectional Feminist Approaches to Masculinity and Health 18

2.2 Masculinity Theory and the Evolution of Hegemonic Masculinity 19

2.3 Men's Mental Health and Global Help-Seeking Patterns 20

2.4 Violence, Trauma, and Post-Conflict Masculinities 22

2.5 Synthesis: Conceptualizing Men's Help-Seeking in the Four-Country Context 23

Chapter 3. Research Design and Methodological Approach **24**

3.1 Study Design and Method of Data Collection 25

3.2 Sampling 25

3.3 Survey Instrument 26

3.4 Data Collection and Processing 26

3.5 Ethical Considerations 27
3.6 Study Limitations 28

Chapter 4. Descriptive Results and Overall Highlights 30
4.1 Demographic Profile of Participants 31
4.2 Armenia 33
4.3 Belarus 37
4.4 Georgia 41
4.5 Moldova 44
4.6 Key Takeaways and Next Analytical Steps 48

Chapter 5. Concluding synthesis 49
5.1 Overview: Masculinity, Mental Health, and Help-Seeking in Post-Soviet Contexts 50
5.2 Masculinity as Moral Responsibility: The Family-Nation Nexus 51
5.3 Economic Precarity and the Provider Imperative 51
5.4 Selective Progressivism: Redefining Male Roles without Gender Parity 53
5.5 Generational Dynamics and Masculinity in Flux 54
5.6 Awareness, Uncertainty, and the Feminization of Help-Seeking 54
5.7 Emotional Distress and Silent Endurance 56
5.8 The Private Nature of Support and the Fear of Exposure 57
5.9 Violence, Militarized Masculinity, and Emotional Cost 58
5.10 Peer Solidarity and Privatized Compassion 58
5.11 From Endurance to Ethical Care 60

Chapter 6. Recommendations: Research for Advocacy and Policy 61
6.1 General Strategic Recommendations 62
6.2 Country-Specific Recommendations 66
6.2.1 Armenia: Reducing Normative Uncertainty and Integrating Post-Conflict Care 66
6.2.2 Belarus: Guaranteeing Safety and Trust under Conditions of Surveillance 66

6.2.3 Georgia: Bridging Acceptance and Action in a Stoic Context 67
6.2.4 Moldova: Countering Feminization among Younger Men and Preventing Silent Endurance 68
6.3 Concluding Note: From Findings to Action 68

References 69

Appendixes 74

Annex 1. Demographic Profile of Respondents (by Country) 74
Annex 2. Core Cross-Country Patterns and Paradoxes 75
Annex 3. Analytical Additions 76
Annex 4. Recommendation Matrix 77
Annex 5. Full questionnaire 88

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List of Abbreviations

Abbreviation	Full Form / Description
AGBU	Armenian General Benevolent Union
AIFS	Australian Institute of Family Studies
APA	American Psychological Association
BMC	BioMed Central (publisher of peer-reviewed medical journals, e.g., *BMC Health Services Research*)
CAWI	Computer-Assisted Web Interviewing
CIS	Commonwealth of Independent States
CoE	Council of Europe
CRRC	Caucasus Research Resource Center – Armenia Foundation
EBRD	European Bank for Reconstruction and Development
EU	European Union
EUCOMS	European Community Mental Health Services Network
HRDO	Human Rights Defender's Office (Republic of Armenia)
IF	Intersectional Feminist (approach/theory)
IMAGES	International Men and Gender Equality Survey (Equimundo)
LiTS	Life in Transition Survey (EBRD)
NGO	Non-Governmental Organization
OHCHR	Office of the United Nations High Commissioner for Human Rights
OECD	Organisation for Economic Co-operation and Development
PHQ-4	Patient Health Questionnaire-4 (brief mental health screening tool)
PTSD	Post-Traumatic Stress Disorder
RED-C	RED C Research (Modern Masculinity Monitor study)
REDEFINE	Regional initiative led by MÄN Sweden promoting healthier masculinities and gender equality in Armenia, Belarus, Georgia, and Moldova
Sida	Swedish International Development Cooperation Agency
TCI Global	Transparency and Compliance Initiative Global (policy research organization)
UNDP	United Nations Development Programme
WHO	World Health Organization
WHO Europe	World Health Organization Regional Office for Europe

List of Figures

Figure 1. Country of Residence of Respondents (%) N= 591 31

Figure 2. Age Distribution of Respondents (%) N = 591 31

Figure 3. Educational Attainment of Respondents (%) N= 591 32

Figure 4. Male roles according to respondents (%) N = 466 34

Figure 5. Experienced anxiety and depressive symptoms (%) N = 165 35

Figure 6. Experienced forms of violence (%) N = 234 37

Figure 7. Male roles according to respondents (%) N = 341 38

Figure 8. Experienced anxiety and depressive symptoms (%) N = 122 39

Figure 9. Experienced forms of violence (%) N = 250 40

Figure 10. Male roles according to respondents (%) N = 496 41

Figure 11. Experienced anxiety and depressive symptoms (%) N = 177 43

Figure 12. Experienced forms of violence (%) N = 259 44

Figure 13. Male roles according to respondents (%) N = 376 45

Figure 14. Experienced anxiety and depressive symptoms (%) N = 127 46

Figure 15. Experienced forms of violence (%) N = 167 47

Figure 16. Moralized Masculinity as a Shared Regional Framework 50

Figure 17. The Provider Imperative under Economic Precarity 52

Figure 18. Selective Progressivism in Masculinity Norms 53

Figure 19. From Awareness to Action: Where Help-Seeking Breaks Down 55

Figure 20. The Violence–Distress–Silence Nexus 56

Figure 21. Current Relational Support Practices 59

Figure 22. Peer Networks as Gatekeepers and Potential Gateways 60

Executive Summary

This report presents findings from a cross-country study examining men's attitudes, emotional well-being, masculinity norms, and help-seeking behaviors in Armenia, Belarus, Georgia, and Moldova. The study draws on data from 591 adult men (18+) collected through a Computer-Assisted Web Interview (CAWI) survey administered between November and December 2025. The research aims to better understand how social norms, structural conditions, and contextual factors shape men's engagement with psycho-social support systems in the region.

To the best of the authors' knowledge, this study represents the first systematic, cross-country empirical analysis of men's mental health, masculinity norms, and help-seeking behaviors in these post-Soviet countries, conducted explicitly from men's own perspectives. Despite growing attention to gender equality and mental health, men's experiences of distress, vulnerability, and care-seeking have remained largely under-researched and insufficiently documented in these contexts.

Across all four countries, masculinity remains strongly shaped by provider-protector ideals, with financial provision, family safety, and responsibility consistently ranked as core male roles. At the same time, emotional openness and help-seeking continue to be constrained by norms of self-reliance and stigma. While many respondents endorse certain egalitarian principles in abstract, such as rejecting violence, supporting consent before sexual activity, and equal responsibility between men and women on reproductive decisions, other egalitarian principles were less agreed with, such as affirming equal respect regardless of sexual orientation and shared responsibility for caregiving and domestic tasks. Egalitarian attitudes do not consistently translate into behavior, particularly in relation to seeking professional mental health support.

Psychological distress is widespread across the target population, with substantial shares of respondents reporting symptoms of anxiety, worry, anhedonia, or depressive mood within the two weeks preceding the survey. Despite this burden, actual help-seeking remains low in all countries. Informal sources of support, especially partners, friends, and family members, are overwhelmingly preferred, while trust in professional services remains limited. Barriers to professional help-seeking are remarkably consistent across contexts. Respondents most often cite a desire to keep problems private, beliefs that men should handle difficulties on their own, limited information about available services, and concerns about affordability. Even in settings where service availability is perceived as relatively high, utilization remains low, highlighting a persistent gap between awareness, attitudes, and behavior.

The fieldwork itself also revealed important methodological and contextual challenges. Political developments, post-conflict environments, post-electoral tensions, and low institutional trust reduced engagement with online surveys, while social desirability bias and self-censorship may have affected responses on sensitive topics. These limitations underscore the need for cautious interpretation of results, particularly regarding stigmatized experiences.

Overall, the study demonstrates that improving men's mental health in the region requires more than expanding services and awareness. Distress is deeply embedded in moral expectations of endurance, self-control, and responsibility, and, in turn, economic insecurity, exposure to violence, and institutional mistrust is present.

The report therefore calls for a shift from individual-focused approaches toward gender-responsive, trauma-informed, and trust-based strategies that reframe help-seeking as a legitimate form of responsibility. The recommendations emphasize coordinated action across policy, advocacy, and

practice, combining structural reforms, normative change, and service redesign. Ultimately, these findings and recommendations offer a practical roadmap for moving from moral endurance toward sustainable, inclusive systems of care for men across the region.

Reading Guidance

This report is structured to guide the reader from the broad conceptual and contextual foundations toward the empirical findings and their applied implications for advocacy and policy. Each chapter builds progressively upon the previous one, linking theoretical insights, data analysis, and strategic recommendations.

- **Chapter 1. Introduction** - Presents the study's overall rationale, context, and purpose. It outlines the social and institutional factors shaping men's mental health and help-seeking behaviors across Armenia, Belarus, Georgia, and Moldova, and clarifies the research objectives and scope.
- **Chapter 2. Theoretical Background** - Reviews the main theoretical and empirical literature informing the study. It introduces key analytical frameworks, including intersectional feminist theory, masculinity studies, and global research on men's mental health and help-seeking patterns.
- **Chapter 3. Research Design and Methodological Approach** - Details the study's research design, sampling strategy, ethical principles, and data collection methods, explaining how cross-country comparability and participant safety were ensured.
- **Chapter 4. Descriptive Results and Country Highlights** - Presents the main descriptive findings for each country. It outlines men's attitudes, behaviors, and experiences across thematic domains such as masculinity norms, emotional well-being, and help-seeking behavior.
- **Chapter 5. Concluding Synthesis** - Integrates the empirical results into a comparative and theoretical analysis. It identifies core country patterns, paradoxes, and typologies of masculinity, linking the findings to broader debates on gender, care, and social transformation.
- **Chapter 6. Recommendations: Research for Advocacy and Policy** - Translates analytical insights into actionable recommendations for advocacy, program design, and policy reform. It offers practical strategies for fostering healthier, more equitable masculinities and improving men's access to psycho-social support.

Chapter 1.

Introduction

This chapter introduces the broader context and rationale, purpose, and objectives of the study, outlining the social, cultural, and institutional factors shaping men's mental health and help-seeking behaviors. It situates the issue within regional and global debates on gender and health, providing the conceptual foundation for the theoretical and empirical analyses that follow.

1.1 Background and Rationale

Across Europe and its neighboring regions, men's mental health and help-seeking behaviors have emerged as increasingly salient public health and social policy concerns. Despite advances in gender equality policy and development frameworks, particularly those promoting women's rights, gender mainstreaming, and non-discrimination in health, labor, and education, men remain significantly less likely than women to seek professional psychological help, a pattern attributed in part to sociocultural constructions of masculinity that emphasize emotional control and self-reliance (Gough & Novikova, 2020). This underutilization is accompanied by heightened risks of suicide and untreated psychological distress, with evidence showing that men are much more likely than women to die by suicide and often delay or avoid help-seeking due to stigma and traditional gender norms (Gough & Novikova, 2020; Eggenberger et al., 2024). These challenges are particularly pronounced in post-Soviet contexts, where entrenched gender norms, limited emotional socialization, and structural barriers intersect with political, economic, and institutional legacies to compound risks for men's mental health (Gough & Novikova, 2020).

Within this broader regional landscape, Armenia, Belarus, Georgia, and Moldova share common historical trajectories while also exhibiting distinct sociopolitical realities. Traditional expectations of masculinity, emphasizing emotional restraint, self-reliance, and breadwinning, continue to shape men's identities and behaviors, often discouraging vulnerability and help-seeking (Gough & Novikova, 2020). Research indicates that conformity to traditional masculine norms inhibits recognition of psychological distress and reduces engagement with mental health services (Staiger et al., 2020). At the same time, access to psycho-social support services remains uneven, stigmatized, or poorly understood, especially in environments characterized by political repression, conflict-related trauma, or weak welfare systems (Gough & Novikova, 2020).

The REDEFINE project, led by MÄN Sweden, addresses these challenges by promoting healthier, more equitable masculinities as a pathway toward gender equality and improved well-being. The present study, implemented by CRRC-Armenia, constitutes the quantitative research component of the REDEFINE initiative. It systematically examines men's attitudes, norms, experiences, and behaviors related to masculinity, emotional well-being, and help-seeking across the four participating countries. By generating comparable empirical evidence, the study aims to inform advocacy, programming, and policy dialogue at both regional and national levels.

Adopting a cross-country comparative perspective allows the study to identify shared regional patterns while remaining attentive to country-specific dynamics. The research design balances methodological rigor with contextual sensitivity, particularly given the political and ethical constraints affecting data collection in some settings. In doing so, the study seeks to produce evidence that is analytically robust, policy-relevant, and accessible to practitioners working on gender-transformative approaches and men's mental health.

1.2 Country Contexts

Across Armenia, Belarus, Georgia, and Moldova, men's help-seeking behaviors are shaped by the intersection of gendered expectations, structural barriers, and historical legacies. Norms of stoicism and self-reliance, inherited from militarized and patriarchal traditions, continue to discourage expressions of vulnerability and reliance on psycho-social support. At the same time, public stigma, institutional distrust, and uneven service provision reinforce avoidance of formal mental-health care.

These dynamics reflect broader global patterns linking masculinity with low help-seeking, yet are intensified in post-Soviet settings by geopolitical instability, economic insecurity, and the enduring influence of Soviet-era psychiatric models. These models were historically characterized by centralized institutional care, paternalistic and medically dominated treatment approaches, limited patient autonomy and rights, and weak development of community-based and preventive psychosocial services, legacies that continue to shape mental health systems in many post-Soviet countries and constrain the availability and acceptability of non-institutional mental health care (Jenkins et al., 2007; Petrea, 2012). While younger generations show gradual shifts toward openness and awareness, systemic and cultural obstacles remain significant.

The following sub-sections provide concise country-specific context relevant to men's mental health and help-seeking, highlighting key structural features, dominant norms, and recent developments that shape the study findings. These profiles are not intended as comprehensive mental health system reviews, but rather as contextual grounding for the empirical analysis that follows.

1.2.1. Armenia

Armenia faces considerable mental health burdens, with estimates suggesting that between 10% and 38% of the population experiences mental health challenges depending on measurement criteria (Rushforth & Jensen, 2021). However, utilization of mental health services remains low. The system is constrained by limited funding, few professionals, and uneven geographic distribution of services. Those experiencing mild or moderate distress often go untreated due to stigma, unawareness, or limited access to support services.

The psycho-social and mental-health support ecosystem in Armenia remains strongly shaped by its Soviet legacy of institutionalization, medicalized treatment approaches, and hierarchical professional cultures. While the government has initiated reforms toward community-based and human-rights-oriented care, psychiatric hospitals still dominate service provision (TCI Global, 2025). Outpatient care is mainly provided through regional psychiatric dispensaries, and non-clinical psychosocial services, such as counseling, early intervention, or peer support, are underdeveloped (Ballard Brief, 2021). The legal framework is defined by the Law on Mental Health Services and Servicing (No. ZR-80, 2004), which regulates outpatient and inpatient treatment, patients' rights, and procedures for involuntary hospitalization (CIS Legislation, 2004). Ongoing collaboration with the Council of Europe aims to align Armenia's mental-health system with international human-rights standards, particularly regarding informed consent and deinstitutionalization (Council of Europe, 2025).

Stigma is a central barrier. Public narratives often frame mental illness as shameful or dangerous, and media portrayals reinforce misconceptions (AGBU, 2021). Men face particular pressure to appear strong, unemotional, and self-reliant. Seeking therapy may be perceived as dishonorable

or indicative of severe pathology. These masculine expectations intersect with structural barriers, limited access to community care and weak social-support infrastructure, to reduce help-seeking among men. These norms are slowly evolving, particularly among younger Armenians (Bayramyan, 2025). The recent 2020 Nagorno-Karabakh war and ongoing post-war tensions with Azerbaijan have further shaped masculine ideals and mental health dynamics in Armenian society. Studies examining populations exposed to the 44-day conflict[1] report higher rates of PTSD, anxiety, and depressive symptoms among directly affected groups, indicating a strong association between direct war exposure and adverse psychological outcomes (Movsisyan et al., 2022). Such experiences intersect with social expectations of endurance and fortitude, potentially reinforcing masculine norms that valorize self-sacrifice and silence, even as the emotional toll increases, suggesting an immediate need for mental health resources.

Influences from diaspora communities, social media, and global mental-health movements have encouraged more open discussion of mental health, reframing help-seeking as self-care rather than weakness (Bayramyan, 2025). Nonetheless, the tension between traditional expectations and emerging norms continues to affect men's willingness to seek support.

1.2.2. Belarus

Belarus's mental-health environment is shaped by a strong legacy of Soviet institutional psychiatry, combined with contemporary political authoritarianism. Large psychoneurological boarding institutions remain prevalent, with limited oversight and outdated practices (Belarusian Human Rights House, 2015). Community-based services are scarce, and psychotherapy is not widely accessible. Stigma is pervasive; mental illness is often associated with instability, danger, or moral weakness.

According to the World Health Organization (2022) Mental Health Atlas, Belarus retains a highly institutionalized mental-health system with limited availability of outpatient psychosocial services and unequal distribution of personnel. The country has mental-health legislation in place but implementation is weak and data on rights protections are incomplete (WHO, 2022).

Studies reveal that individuals who use psychiatric services are heavily stigmatized, and even mental health professionals experience status stigma within Belarusian society (Belarusian Human Rights House, 2015). Men in Belarus face social expectations of emotional restraint, reinforced by political conditions that discourage public vulnerability and trust in state structures, creating a climate characterized by fear and self-censorship (Belarusian repression; political repression normalised since 2020) that can extend into avoidance of professional psychological help (Barometer of Repression, 2024; OHCHR, 2025). The 2020–2021 political crisis has exacerbated psychological distress while reducing trust in state-run healthcare services (UNDP, 2025). The result is a mental-health context in which formal support systems are both inaccessible and distrusted.

In this environment, concerns about confidentiality and potential surveillance are widely perceived as practical risks rather than abstract fears. Individuals may hesitate to seek professional support if they believe personal information could be accessed by authorities or expose them to negative consequences. As a result, trust in mental-health services is closely tied to perceptions of confidentiality, independence, and neutrality. For many men, the decision to seek help therefore may depend not only on stigma or gender norms but also on whether services are perceived as safe and non-political.

1. Those who lost a loved one, had a loved one get injured, and had a loved one participate in the 2020 Artsakh War had higher mean scores on depression, anxiety, and PTSD relative to those who did not (Movsisyan et al., 2022).

1.2.3. Georgia

Georgia has undergone major mental-health reforms since the 2000s, shifting gradually from institutional to community-oriented care (Chkonia et al., 2016). However, structural and cultural barriers persist. Public stigma remains high: national surveys reveal widespread fear, desire for social distance, and misconceptions linking mental illness to danger (Chkonia et al., 2016). Georgian men, in particular, face pressures to embody strength and emotional stoicism, discouraging admission of distress.

The National Mental Health Strategy (2015–2020) and subsequent policy initiatives have prioritized deinstitutionalization and expansion of community centers (World Bank, 2023). The legal framework for mental health care is anchored in the Law on Psychiatric Care (2007, amended 2015) and supplemented by Ministerial Orders on patient rights and consent (LegalClarity, 2025). Nevertheless, funding constraints and uneven regional implementation limit coverage. Informal support through family and religious networks remains central, often delaying professional help-seeking (BMC Health Services Research, 2018).

Although modern community mental-health centers have been established, services remain unevenly distributed and public funding limited (Zavradashvili & Matiashvili 2024). Many Georgians, especially in conflict-affected and economically insecure regions, rely on informal support networks or non-clinical coping strategies, delaying or foregoing formal help-seeking (Saxon et al., 2017; Chikovani et al., 2015). Research among conflict-affected populations shows that despite elevated prevalence of depression, anxiety, and PTSD symptoms, less than half of those in need access professional mental-health services (Chikovani et al., 2015). These realities underscore how structural barriers (geographic access, under-resourced community services) and cultural norms (stigma, reliance on informal coping) intersect, resulting in widespread unmet need, particularly among men who may face additional pressure toward emotional restraint and self-reliance.

1.2.4. Moldova

Moldova's mental-health system remains heavily institutionalized, with high numbers of psychiatric hospital beds and long-term residential facilities (de Vetten-Mc Mahon et al., 2019). Community mental-health centers have been introduced but remain limited in scale and capacity. Funding is exceptionally low compared to European averages, and psycho-social services such as counseling and rehabilitation are sparse.

The legal framework is defined by the Law on Mental Health (Moldova has a relatively new mental health law (Law Regarding the Rendering of Psychiatric Care, number 1402-XII, of 16 December 1997), which regulates community care, primary care, and involuntary treatment (Zinkler, Boderscova & Chihai, 2009). Reform efforts supported by the World Health Organization and EU projects aim to integrate mental-health services into primary care and expand community-based rehabilitation (Cambridge University Press, 2022). However, implementation remains slow, and institutional culture persists (Chihai, 2023).

Stigma around mental illness is deeply entrenched. Public perceptions frequently associate mental illness with danger, chronic disability, or shame, influencing families to hide symptoms or avoid psychiatric services. Men in Moldova face strong expectations to endure hardship silently, and economic pressures, coupled with migration, intensify stress while reducing opportunities for emotional support. High male suicide rates (WHO, 2022) and the prevalence of alcohol misuse among working-age men point to unaddressed psycho-social distress. Recent youth-

focused campaigns by the Ministry of Health and WHO Europe indicate modest shifts toward destigmatization, yet men remain underrepresented in service use. Moldova records some of the region's highest suicide rates, reflecting substantial unmet mental-health needs (de Vetten-Mc Mahon et al., 2019). Recent public awareness campaigns aimed at youth have begun shifting norms, but these efforts remain limited in reach.

1.3 Purpose

This report is intended as a multi-purpose analytical resource to support decision-making, learning, and strategic development within the REDEFINE initiative and among its partners. Hence, this report is outlined to inform program design and adaptation, strengthen advocacy and public communication efforts, and guide policy dialogue at both national and regional levels. In this sense, the report serves not only as a documentation of research findings, but as a tool for translating evidence into gender-transformative action.

1.3.1 Purpose of the Study

Within this broader intent, the primary purpose of this study is to generate new empirical knowledge on how men conceptualize masculinity, perceive psycho-social support, and navigate help-seeking in contexts where mental health stigma persists and services remain unevenly accessible. The study is designed to support MÄN Sweden and its national partners in developing evidence-based, context-sensitive interventions that:

- challenge harmful and restrictive masculinity norms;
- normalize emotional expression, vulnerability, and help-seeking among men;
- strengthen gender equality and gender-transformative efforts; and
- expand formal and informal pathways for men's psycho-social support.

Beyond descriptive insight, the study aims to inform advocacy strategies, public communication campaigns, and policy recommendations aligned with REDEFINE's broader mission. By providing a quantitative foundation for regional comparison, the research contributes to identifying leverage points for norm change and programmatic action across diverse sociopolitical environments.

In this sense, the study functions both as a diagnostic instrument, mapping attitudes, barriers, and behaviors, and as a strategic roadmap for interventions seeking to transform harmful masculinity norms and improve men's mental health outcomes.

Crucially, this study approaches men's mental health not as an individual or attitudinal issue, but as a socially and structurally embedded phenomenon shaped by gender norms, economic conditions, institutional trust, and political and geographic context. It seeks to move beyond explanations that attribute men's limited help-seeking to lack of awareness or personal resistance, examining how masculinity is produced and negotiated within specific social and institutional environments. By foregrounding the interaction between norms and structures, the study identifies why existing services and messaging often fail to engage men, even where awareness is high. In doing so, it provides a general analytical basis for designing interventions that are not only gender-sensitive but also contextually realistic.

1.3.2 Research Objectives

The research objectives are designed to explore how masculinity norms, social expectations, and structural factors shape men's attitudes toward psycho-social support and their willingness to seek help. Specifically, the study aims to:

1. Assess men's awareness of available psycho-social support services in Armenia, Belarus, Georgia, and Moldova.
2. Examine attitudes toward psychological and emotional help-seeking, including perceptions of therapy, counseling, and informal support networks.
3. Identify key barriers and enablers shaping help-seeking behavior, including social norms, stigma, emotional literacy, economic constraints, and access-related factors.
4. Analyze cross-country similarities and differences in masculinity norms, mental health experiences, and support-seeking patterns.
5. Provide empirical evidence to inform gender-transformative advocacy, policy development, and program design aimed at promoting healthier masculinities and gender equality.

These objectives guide not only the data collection and analysis, but also the structure of the final analytical report and the recommendations generated through the study.

Chapter 2.

Theoretical Background

In this study, understanding men's psycho-social help-seeking in Armenia, Belarus, Georgia, and Moldova requires engagement with several interrelated bodies of scholarship: intersectional feminist theory, critical masculinity studies, public health literature on men's (mental) health, and research on help-seeking behavior in socio-culturally conservative or post-Soviet settings. This chapter reviews the theoretical and empirical foundations as they relate to Armenia, Belarus, Georgia, and Moldova. The aim is to situate the present study within established academic debates while highlighting substantial gaps in regional knowledge. The literature suggests that patriarchal norms and structural barriers jointly shape the mental health trajectories of men across different societies, yet these dynamics remain understudied in the four countries of focus. By tracing global, regional, and country-specific evidence, this chapter establishes the conceptual groundwork for the survey on men's psycho-social support seeking.

2.1 Intersectional Feminist Approaches to Masculinity and Health

The starting point for this study is an intersectional feminist (IF) lens, which posits that gender cannot be understood in isolation from other social categories such as class, ethnicity, sexuality, ability, age, religion, or geopolitical location (Crenshaw, 1989). Crenshaw's (1989) formulation of intersectionality demonstrates that individuals experience overlapping layers of privilege and marginalization. Applied to masculinity, this means that not all men benefit equally from patriarchal systems; rather, men's health and social experiences are shaped by the specific intersections of their identities and structural conditions (Griffith, 2012).

Within masculinity studies, the intersectional turn challenges earlier universalist accounts of "men" by emphasizing diversity among men and the dynamic character of masculinity (Connell & Messerschmidt, 2005). Brown and Ismail (2019) further argue that feminist theory and masculinity studies are mutually enriching precisely because both interrogate power relations, structural inequality, and social justice. An intersectional feminist approach highlights that many men simultaneously experience gendered privilege while, at the same time, being constrained by norms that demand toughness, stoicism, and self-reliance. These norms may restrict emotional expression and undermine mental health, particularly in contexts where traditional gender expectations remain strong (Mokhwelepa & Sumbane, 2025).

The IF lens is especially relevant in post-Soviet contexts. Men in these societies navigate identities shaped by militarized cultures, economic precarity, ethno-national tensions, and legacies of authoritarianism (Eichler, 2011). These layered structural conditions create environments wherein certain expressions of masculinity, often aligned with toughness, discipline, endurance, and emotional suppression, are rewarded, while vulnerability or help-seeking can be perceived as weakness. Intersectionality thus provides a nuanced framework for understanding why help-seeking behaviors differ not only between men and women but also among different groups of men within the same society (Bowleg, 2012; Griffith et al., 2013).

Moreover, the IF approach helps illuminate how men's mental health needs and access to care are deeply shaped by the broader historical and structural legacies of post-Soviet societies. As Eichler (2011) demonstrates, militarized ideals of toughness, discipline, and endurance, rooted in conscription practices and state-sanctioned masculinities, continue to influence men's sense of self and acceptable emotional expression. Similarly, Fraser (2019) traces how Soviet and postwar institutions reinforced a model of "military masculinity" that privileged stoicism and emotional suppression, leaving lasting imprints on contemporary norms of help-seeking and vulnerability. These historical trajectories intersect with social inequalities across the region: from deep rooted norms and limited health services, to post-war societies and political repression. Together, these dynamics illustrate why an intersectional feminist approach is essential for understanding how diverse structural, cultural, and historical forces shape men's help-seeking behaviors and mental health across post-Soviet contexts.

2.2 Masculinity Theory and the Evolution of Hegemonic Masculinity

Masculinity scholarship provides additional analytical depth for understanding men's mental health behaviors. Connell's (1995) concept of hegemonic masculinity posits that societies uphold a dominant ideal of manhood, characterized by authority, heterosexuality, control over emotions, and physical and economic strength. This hegemonic ideal is not necessarily embodied by all men; however, it shapes expectations, social pressures, and hierarchies among men. Connell and Messerschmidt (2005) later revised the model to emphasize the plurality and historical fluidity of masculinities, noting that multiple forms of masculinity coexist and are constantly redefined.

Building on this, recent psychological frameworks have examined how specific components of traditional masculinity, such as emotional stoicism, self-reliance, competitiveness, and avoidance of vulnerability, can restrict men's emotional expression and relational intimacy (American Psychological Association, 2018). These traits, while culturally valorized, may also contribute to patterns of aggression, relational distance, and resistance to help-seeking. Kupers (2005) conceptualizes this as "toxic masculinity," referring not to masculinity itself, but to the socially destructive aspects of hegemonic norms that promote dominance, homophobia, and the suppression of empathy. This perspective complements sociological theories by highlighting the psychological and behavioral mechanisms through which masculine norms become detrimental to men's own well-being and to those around them.

From a Foucauldian perspective, these hegemonic ideals can be understood as effects of power relations that are diffuse, relational, and productive rather than merely repressive (Foucault, 1977, 1978). Power operates through institutions, discourse, and everyday practices to produce and regulate bodies, behaviors, and identities, establishing what is perceived as "normal" masculinity. Thus, hegemonic masculinity functions as a disciplinary mechanism, a social script that both constrains and enables men's identities, shaping how they perform self-control, authority, and emotional restraint within different contexts.

Hegemonic masculinity has been widely used to explain why men often avoid seeking psycho-social support. The normative emphasis on self-reliance and emotional restraint conflicts with the vulnerability required to acknowledge psychological difficulties or request help. As Mahalik et al. (2003) argue, conformity to masculine norms such as stoicism and risk-taking is strongly associated with lower help-seeking intentions. Courtenay (2000) further theorizes that men may engage in unhealthy behaviors, including substance use, denial, or aggression, as symbolic enactments of masculinity, reinforcing the very conditions that harm their health. At the same time, scholars caution against overgeneralized interpretations of hegemonic masculinity. Brown and Ismail (2019) warn that the concept can obscure differences among men and overlook how patriarchal systems interact with heteronormativity, nationalism, racism, or class inequality.

Empirical studies demonstrate that the collapse of Soviet-era social protections and the ensuing economic precarity deeply destabilized traditional working-class masculinities, leading many men to renegotiate their sense of self under neoliberal and uncertain conditions (Vanke, 2017; Randall, 2020). At the same time, the persistence of state-sanctioned militarized masculinity, rooted in past conscription and conflict, continues to shape dominant gender ideals, discouraging vulnerability or help-seeking (Eichler, 2012; Borenstein, 2021).

Complementing hegemonic masculinity, the "Man Box" framework used in international research operationalizes harmful masculine norms as a set of rigid expectations regarding emotional restriction, aggression, heterosexual dominance, and the suppression of weakness (Equimundo, 2022; Andrews & Reed, 2024). Studies consistently show that men who strongly endorse "Man Box"[2] beliefs are less likely to seek help, more likely to engage in violence, and more likely to experience emotional isolation.

Evidence from Equimundo's IMAGES surveys shows that adherence to hegemonic norms strongly predicts higher depressive symptoms, self-reported loneliness, and avoidance of formal support. RED-C's *Modern Masculinity Monitor* (2025) finds that even in Western Europe, a more gender-progressive region, men substantially underrate peers' acceptance of emotional vulnerability, which strengthens avoidance of therapy or counseling. These findings mirror dynamics observed in Boys Will Be (Andrews & Reed, 2024), where adolescent boys report wanting to express emotions but fear negative peer judgment, illustrating the persistence of hegemonic norms globally and across age groups.

2.3 Men's Mental Health and Global Help-Seeking Patterns

Globally, men underutilize mental health services despite facing significant mental health challenges. The World Health Organization reports that men are substantially less likely than women to seek formal psychological support, even though men account for approximately 75% of suicide deaths in many countries (WHO, 2022). This gender gap has been linked consistently to socialized masculine norms that equate vulnerability with weakness and promote emotional suppression (Gough & Novikova 2020). International survey data indicate that many men believe a "real man" should not seek help for emotional problems, reinforcing stigma and delaying treatment (Equimundo, 2022; Cleary, 2012).

Self-reliance remains one of the most consistently documented barriers to men's help-seeking. Many men interpret psychological distress as a personal failing that should be resolved independently rather than through professional support (Addis & Mahalik, 2003). This tendency is reinforced by norms of emotional restriction, which limit men's ability to recognize and articulate internal experiences and reduce comfort with talk-based or therapeutic settings (Seidler et al., 2016). Stigma, both internalized and community-based, further compounds these barriers. Men often fear being judged, ridiculed, or perceived as weak for expressing vulnerability or seeking professional help (Seidler et al., 2018; Pirkis et al., 2017). These patterns underscore how masculine socialization and gendered expectations intersect with cultural stigma to sustain avoidance of mental-health services across diverse contexts.

Structural barriers exacerbate these attitudinal factors. In many societies, mental health services are underfunded, inaccessible, or prohibitively expensive, with rural areas disproportionately underserved (OECD, 2021). Men's help-seeking is also influenced by workplace expectations, economic pressures, and limited health literacy (Seidler et al., 2016). These conditions create a complex interplay of cultural, psychological, and structural factors that hinder early intervention.

2. The "Man Box" refers to a conceptual framework developed by Equimundo and Unilever to describe a socially constructed set of beliefs defining what it means to "be a real man". These beliefs emphasize dominance, emotional suppression, self-reliance, heterosexuality, and control, reinforcing restrictive and often harmful expectations of masculinity (Heilman, Barker & Harrison, 2017).

At the same time, research demonstrates that men are more willing to seek help when services are culturally adapted, confidential, and non-judgmental. Peer support, anonymous helplines, and community-based approaches have proven effective in lowering barriers (Cooper et al., 2024). Culturally sensitive, community-based interventions that are responsive to local contexts and emphasize accessibility and empathy further enhance men's willingness to seek support (Ajayi & Thompson, 2025). Younger generations, influenced by global media and mental health advocacy, show greater openness to discussing emotional issues, signaling potential shifts in norms (Bayramyan, 2025). These developments underscore that masculine norms are not static but responsive to social change.

RED-C (2025) finds that men aged 18–35 increasingly report mental health struggles but seldom seek help early, citing fear of judgment and weak emotional skills. IMAGES data across 15 countries similarly show that endorsement of masculine norms is a major predictor of depression, alcohol misuse, and gender-based violence (Equimundo, 2022). These findings emphasize the universality of stigma and highlight generational shifts in attitudes, with younger men expressing more openness but still constrained by perceived expectations[3].

Contemporary masculinity studies emphasize the potential for accountability and emancipatory norm change, arguing that research should not only describe harmful gender norms but actively contribute to transforming them (Gardiner, 2002; Brown & Ismail, 2019). This approach links theory to praxis by addressing how institutions, cultural systems, and interpersonal relations reproduce inequality and by amplifying alternative masculinities grounded in care, empathy, and emotional expression. Scholars stress that masculinity itself is not inherently harmful but becomes problematic when expressed through rigid, restrictive norms, patterns that can be reshaped through more flexible, health-promoting practices (Levant & Richmond, 2008). In post-Soviet societies, where men navigate tensions between inherited toughness and emerging openness, norm change is particularly relevant to understanding shifting identities. Behavioral research shows that many men misperceive peers' attitudes, believing others endorse stoicism and toughness more strongly than they actually do, a form of pluralistic ignorance that reinforces silence and deters help-seeking (Prentice & Miller, 1993; Bursztyn et al., 2023; Matavelli, 2024). Correcting these misperceptions has been proven to alter behavior, as men who realize peers value emotional openness become more likely to seek support (Bursztyn et al., 2020; RED-C, 2025; Andrews & Reed, 2024). Evidence from gender-transformative interventions, such as IMAGES-inspired MenCare programs and the Ten to Men study, confirms that reflection, peer dialogue, and positive role modeling can reduce endorsement of harmful norms and increase help-seeking (Equimundo, 2022; AIFS, 2023). Together, this body of work demonstrates that masculinity norms are socially constructed and thus changeable, making accountability and collective norm transformation a realistic pathway toward improved men's mental health and gender equality.

3. This is in line with the fieldwork results, where a large number of respondents were considered young: 40.4% were aged 18-29 and 35.9% were aged 30-44.

2.4 Violence, Trauma, and Post-Conflict Masculinities

Exposure to violence, conflict, and political repression profoundly shapes masculine identities and men's mental health needs across post-Soviet societies. Research demonstrates that armed conflict and political instability not only generate trauma but also reinforce gendered expectations of stoicism, endurance, and emotional restraint (Quest, 2022; Touquet & Schulz, 2025; Malonda et al., 2023). In contexts such as Ukraine and the Western Balkans, men's experiences of war, displacement, and social disruption have been linked to heightened risks of depression, post-traumatic stress, substance misuse, and emotional withdrawal (Bogdanov et al., 2025; Miller & Rasmussen, 2024). Qualitative findings indicate that men often adopt coping mechanisms, such as alcohol use or isolation, that align with socially sanctioned ideals of masculine endurance while deepening psychological distress (Bogdanov et al., 2024).

Across Armenia, Georgia, and Belarus, these dynamics are compounded by militarized forms of masculinity and institutional distrust. Decades of compulsory military service, political violence, and state repression have normalized emotional suppression as a marker of strength (Equimundo, 2025). At the same time, social misperceptions sustain these norms: men frequently overestimate their peers' endorsement of toughness and violence, a pattern known as pluralistic ignorance, which further discourages vulnerability and help-seeking (Bursztyn et al., 2020). Correcting these misperceptions has been shown to reduce tolerance of violence and increase willingness to access support.

The post-Soviet mental health landscape reinforces these gendered barriers. The legacy of Soviet psychiatry, marked by institutionalization, punitive practices, and biomedical reductionism continues to shape public attitudes and service structures (Petrea, 2013; Mundt et al., 2012). Community-based and psychosocial models remain limited, while psychiatric hospitals dominate care systems (Shek et al., 2011). Deep-seated stigma and fear of coercion have left many men reluctant to engage with formal services, associating mental illness with weakness or social deviance (Makhashvili & van Voren, 2013).

These historical, structural, and cultural factors interact with masculine norms emphasizing self-reliance and emotional control, producing a complex environment where help-seeking is both socially discouraged and institutionally constrained. Economic instability, labor migration, and militarization further complicate men's identities, reinforcing ideals of toughness that conflict with expressions of vulnerability. Together, these interlocking forces create a pattern of "silenced distress", where trauma and mental strain are internalized rather than addressed through professional or communal support systems.

2.5 Synthesis: Conceptualizing Men's Help-Seeking in the Four-Country Context

Taken together, the literature reveals that men's engagement with mental health in the region cannot be understood through gender alone but through the interplay of social structure, cultural norms, and historical context. Addressing these multilayered barriers requires not only expanding access to services but also transforming the social meanings of masculinity and care within post-Soviet societies.

Building on this conceptual synthesis, the present study attempts to translate these theoretical insights into an empirical research design that provides a broad understanding of how men from Armenia, Belarus, Georgia, and Moldova themselves articulate masculinity, distress, and help-seeking within their lived contexts.

The following chapter therefore details the methodological framework developed to operationalize these concepts, outlining how theoretical assumptions about masculinity, care, and institutional trust informed the study design, sampling strategy, survey instrument, and ethical safeguards.

Chapter 3.

Research Design and Methodological Approach

This chapter outlines the research design, data collection procedures, and ethical framework underpinning the study. Given the sensitivity of the research focus, men's mental health, masculinity norms, help-seeking behaviors, and experiences of violence, particular attention was paid to methodological choices that balance analytical rigor with ethical responsibility and participant safety. By detailing the study design, sampling strategy, survey instrument, and ethical safeguards, this chapter provides the necessary foundation for understanding the empirical results presented in the subsequent chapters.

3.1 Study Design and Method of Data Collection

The study employs a cross-sectional, multi-country quantitative research design based on Computer-Assisted Web Interviewing (CAWI). The CAWI approach was selected for its capacity to ensure respondent anonymity, and accommodate heightened ethical and security considerations, particularly in politically restrictive environments such as Belarus. In addition, CAWI was the most preferred data-collection mode to allow consistent implementation in all four countries, allowing for methodological coherence, while avoiding the challenges associated with mixed modes of data collection, divergent instruments, sampling logics, and resulting limitations in compatibility.

3.2 Sampling

The sampling approach was nonprobability sampling, implemented through a time-bound CAWI survey conducted over a 30-day fieldwork period. No minimum sample size was defined in advance; data collection proceeded within the established timeframe and concluded when the fieldwork period expired. Within this approach, a combination of purposive & convenience sampling strategies was adopted. While this approach limits statistical representativeness, it ensures ethical feasibility, respondent safety, and ensures exploratory insight into population-level realities and tendencies across the four countries for this sensitive topic. Additionally a fixed fieldwork window allowed for controlled exposure, risk mitigation, and methodological consistency across countries, while enabling sufficient outreach through digital networks without prolonged recruitment that could increase participant fatigue, security risks, or ethical concerns.

The study focused on adult men aged 18 and older residing in or originating from Armenia, Belarus, Georgia, and Moldova. Given the informative nature of the research, the approach aimed to understand living contexts and main tendencies rather than to produce nationally representative data.

Recruitment relied on digital recruitment channels such as:

- Targeted Social Media advertisements mainly through Facebook, Instagram, Telegram, and Linkedin;
- Online community groups and discussion forums (including Facebook and Telegram channels);
- Partner organizations' networks, groups of collaborating experts, and other mailing lists;
- Snowballing through peer-to-peer sharing.

Recruitment was also conducted continuously throughout the entire fieldwork period and was accompanied by daily monitoring of response volumes, sample composition, and country-level participation. The research team closely tracked incoming data across all four countries to assess progress, identify imbalances or underrepresented groups, and detect emerging recruitment gaps in real time. This allowed the real time adaptation of recruitment strategies. The results indicate associations within the target population and should not be interpreted as representative of the general population.

3.3 Survey Instrument

A standardized questionnaire was developed by CRRC-Armenia and following review and approval by MÄN Sweden and the reference group in English, later translated and adapted into Armenian, Georgian, Romanian, and Russian, informed by a theoretical framework on masculinities, mental health, and help-seeking, as well as by prior regional research. The instrument underwent expert review to ensure conceptual validity, cultural appropriateness, and ethical sensitivity (see Annex 5).

The questionnaire covers the following thematic domains:

- demographic and socioeconomic characteristics;
- masculinity norms, attitudes, and perceived social expectations;
- emotional well-being (including items conceptually aligned with brief screening tools such as PHQ-4);[4]
- awareness and perceptions of psycho-social support services;
- comfort with emotional expression and vulnerability;
- help-seeking behaviors, intentions, and preferred support channels;
- perceived barriers and enablers, including stigma, affordability, access, and social expectations;
- sensitive experiences, such as exposure to violence, bullying, or stigma.

Question ordering and wording were carefully designed to minimize respondent fatigue and social desirability bias, particularly for sensitive topics.

3.4 Data Collection and Processing

Data for this study were collected using an online questionnaire programmed in SurveyCTO. The platform was also used to support data monitoring and fieldwork management, enabling continuous quality control, effective oversight, and secure storage of all collected data. The survey was conducted in the relevant local languages with cultural adaptations to enhance clarity, relevance, and respondent comprehension among adult men (18+) residing in and originating from Armenia, Belarus, Georgia, and Moldova, including diaspora and exiled populations. The primary data collection took place from *November 10 to December 10, 2025*.

In total, *591 complete interviews* have been collected. The table below presents the distribution of responses by country.

4. The Patient Health Questionnaire-4 (PHQ-4) is a brief, validated screening tool used to assess symptoms of anxiety and depression. It consists of four items measuring the frequency of core anxiety and depressive symptoms over the previous two weeks. The PHQ-4 is widely used in population-based surveys and cross-cultural research to provide an overall indication of psychological distress; it is not intended to serve as a clinical diagnosis.

Distribution of responses by country

Country	Number of responses
Armenia	165
Georgia	177
Moldova	127
Belarus	122
Total	**591**

After data cleaning the *average completion time of the survey was 13.7 minutes* (maximum: 67.8 minutes, minimum: 2.0 minutes, standard deviation: 9.6 minutes, n = 561 (excluded extreme duration outliers).

Following data collection, the dataset was cleaned and processed to prepare it for analysis. Data cleaning and processing were conducted using R statistical software and followed standardized quality-control procedures, including:

- consolidation of all language versions into a single harmonized dataset;
- de-randomization of randomized question blocks;
- assignment of a single country identifier through cross-checking multiple country-related variables;
- division of the consolidated dataset into country-specific sub-datasets;
- removal of straight-lining and other low-quality responses;
- logical and statistical consistency checks;
- recoding and harmonization of categorical variables across countries;
- translation and standardization of open-ended responses;
- preservation of the raw dataset and export of finalized data for analysis.

3.5 Ethical Considerations

The study adheres fully to CRRC-Armenia's ethical research standards and internationally recognized principles for research involving human participants. Ethical considerations are particularly salient due to the sensitivity of topics related to mental health, gender norms, violence, and trauma, as well as the political contexts in which the research was conducted.

1. Informed Consent and Voluntary Participation

All participants received clear information about the study's purpose, voluntary nature, confidentiality measures, and potential risks prior to participation. Informed consent was obtained digitally. Respondents were free to skip any question or discontinue participation at any point without consequence.

2. Beneficence and Harm Minimization

Survey items were designed to reduce the risk of distress or re-traumatization. Where sensitive topics were addressed, respondents were provided with information on locally available psycho-social support resources. The research team remained committed to a "do no harm" principle throughout the study lifecycle.

3. Anonymity, Privacy, and Data Security

No personally identifying information, including IP addresses, GPS data, or device identifiers, was collected. All data were encrypted, stored on the secure server of CRRC-Armenia, and accessible only to authorized research staff. Enhanced anonymity and data protection measures were implemented for Belarus to mitigate potential risks to participants.

4. Justice and Fair Participation

Recruitment strategies sought to minimize exclusion, though the online-only design inherently favors individuals with internet access and digital literacy. Participation did not involve individuals under coercion or within controlled institutional settings.

5. Country-Specific Ethical Adaptations

- **Belarus:** Reinforced anonymity protocols and heightened risk mitigation measures in an authoritarian context.
- **Georgia:** Ongoing monitoring of political developments and adaptive recruitment practices.
- **Armenia:** Sensitivity to conflict-related trauma and post-war psychosocial stressors.
- **Moldova:** Exclusion of Transnistria due to security and access constraints.

6. Data Retention and Protection

All data were anonymized at the point of collection and will be retained until project completion, once the report has been finalized and approved by the commissioning body and the review board.

3.6 Study Limitations

The findings of this study should be interpreted in light of several methodological and contextual limitations. These are presented below as (1) general limitations applicable to the overall study design and (2) country-specific limitations reflecting contextual constraints in each research setting.

General and Cross-Cutting Limitations

- **Non-probability and non-representative sampling:** The study relies on a non-probability convenience sample recruited through online channels. As a result, findings cannot be generalized to the national male populations of Armenia, Belarus, Georgia, or Moldova. The results are indicative rather than representative and should be interpreted as reflecting patterns within the surveyed population.

- **Online recruitment bias:** The CAWI methodology inherently favors individuals with internet access, relatively higher digital literacy, and greater engagement with online platforms. This may have led to the underrepresentation of some groups (e.g., older men, men living in rural or remote areas, individuals with lower socioeconomic status, and those less connected to digital networks).
- **Self-report and social desirability bias:** Data are based on self-reported attitudes and behaviors, which may be influenced by social desirability, especially for sensitive topics such as emotional vulnerability, mental health struggles, experiences of violence, or help-seeking. Despite anonymity safeguards, some respondents may have underreported stigmatized experiences or overreported socially acceptable attitudes.
- **Measurement constraints:** While the questionnaire draws on validated conceptual frameworks and includes items aligned with established screening tools, it does not constitute a clinical assessment. Indicators of emotional distress and well-being should therefore be interpreted as indicative rather than diagnostic.
- **Bias Toward More Open and Engaged Participants:** Participation in an online survey focused on emotions, masculinity, and help-seeking likely attracted men who are already relatively open and reflective. Men who are more strongly attached to traditional masculine norms, more resistant to discussing vulnerability, or less comfortable with emotional self-disclosure are most likely underrepresented.

Taken together, the methodological choices described in this chapter reflect a deliberate emphasis on ethical feasibility, participant safety, and analytical depth in complex socio-political contexts. While the reliance on online, non-probability sampling limits generalizability, it enables access to men who are often difficult to reach on topics of vulnerability, emotional well-being, and violence, particularly in environments marked by institutional distrust or political risk.

The following chapter builds on this methodological foundation by presenting the empirical findings of the study, beginning with an overview of respondent's characteristics and moving toward detailed country-level analyses of attitudes, behaviors, and lived experiences related to mental health and masculinity.

Chapter 4.

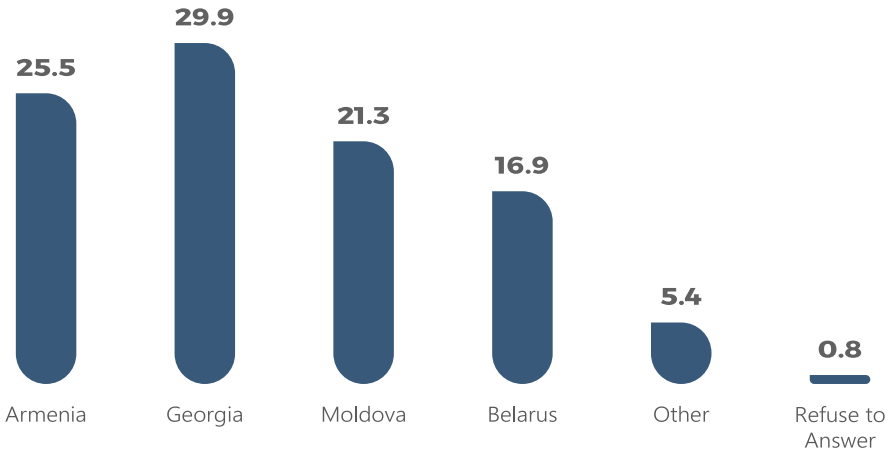
Descriptive Results and Overall Highlights

This chapter presents a descriptive overview of the survey findings across Armenia, Belarus, Georgia, and Moldova. It begins with a profile of the sample, followed by cross-cutting highlights and the identification of four core thematic areas that structure the remainder of the report. These themes reflect the primary analytical priorities of the project and provide a coherent framework for interpreting the experiences, attitudes, and behaviors of the study's respondents, related to masculinity, health, and help seeking behaviour. It should be noted that the results described in this chapter indicate associations within the target population *only* and should *not* be interpreted as representative of the general population.

4.1 Demographic Profile of Participants

Most respondents reside in one of the four study countries (Armenia, Belarus, Georgia, or Moldova) and in most cases their country of residence corresponds to their country of origin (see Figure 1), indicating low overall levels of cross-border residence. Nevertheless, a notable minority, particularly in Armenia (14 respondents) and Belarus (22 respondents), reported living outside their country of origin. This reflects regional patterns of labor, diaspora, and political migration and is taken into account when interpreting findings related to socioeconomic conditions and help-seeking behavior (for the full demographic table, please see Annex 1).

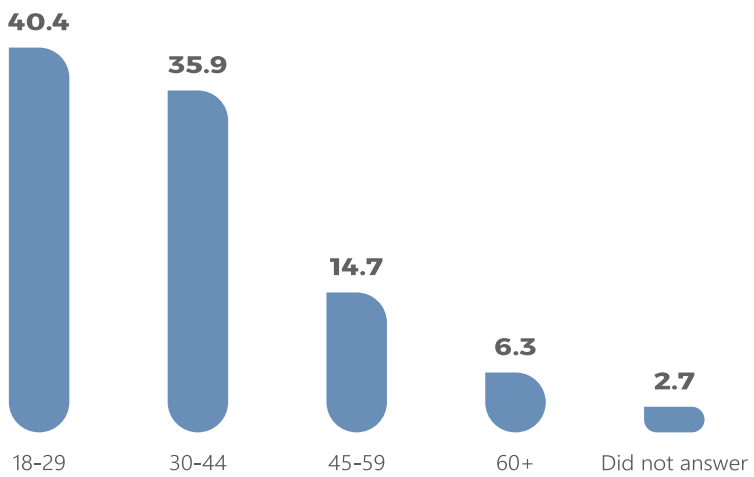
Figure 1. Country of Residence of Respondents (%) N= 591



Age

The target population includes adult men aged 18 and older, with representation across multiple age cohorts (see Figure 2). Younger and middle-aged men constitute the largest share of respondents, while older age groups are comparatively less represented, an expected outcome given the online recruitment strategy.

Figure 2. Age Distribution of Respondents (%) N = 591



Type of Settlement

Respondents predominantly reside in urban areas, including capital cities and other towns. Rural residents are present but underrepresented, reflecting disparities in internet access and digital engagement.

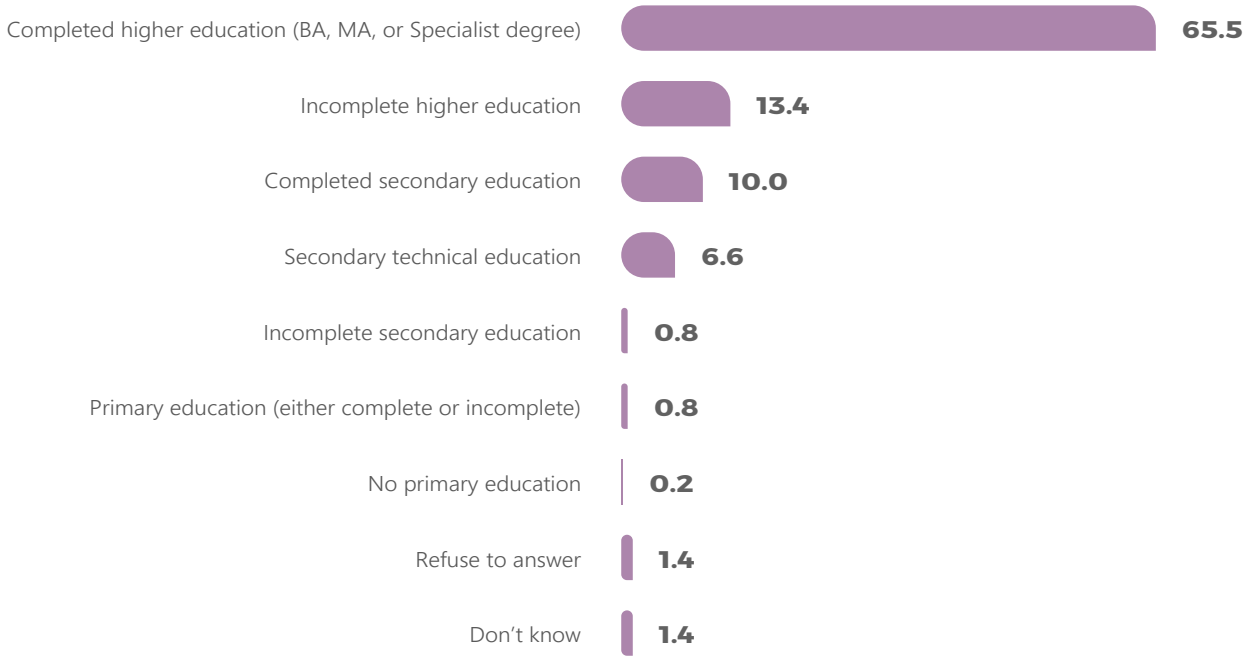
Financial situation and Employment Status

Most respondents reported being employed, though notable shares were students, unemployed, or otherwise economically inactive, reflecting variation in national labor market conditions. In terms of financial situation, just over half of respondents (57.2%) described their household finances as very good or comfortable, while a substantial share reported financial strain: 31.6% indicated they were "just getting by" and 7.4% reported struggling. Financial insecurity therefore affects a sizable portion of the respondents and represents an important contextual factor shaping stress and help-seeking behavior.

Educational Attainment

The target population is characterized by relatively high levels of educational attainment, with a substantial proportion of respondents reporting tertiary or post-secondary education (see Figure 3). This pattern is consistent across all four countries and reflects the online nature. of the survey. Higher education levels are associated with greater awareness of psycho-social support services, but do not necessarily translate into higher levels of help-seeking in practice.

Figure 3. Educational Attainment of Respondents (%) N= 591



Marital Status

Marital status among respondents is diverse. Just over one third are single (38.4%), while a similar share is married or partnered and have children (34.7%). A further 19.3% are married or partnered without children. Smaller proportions are divorced or separated (4.4% combined), and very few respondents are widowed (1.2%). Relationship status is relevant for understanding men's informal support networks, particularly the potential role of partners in emotional support.

4.2 Armenia

Country Profile

Armenian respondent's attitudes reveal a masculinity that is morally anchored and relationally responsible, yet emotionally constrained and uncertain about help-seeking. Key tendencies include:

- Dominant provider-protector identity[5], tempered by moral rather than authoritarian traits;
- Moderate egalitarianism in decision-making but enduring traditionalism in caregiving;
- High psychological distress paired with discomfort expressing vulnerability.
- Strong reliance on close personal relationships for support, minimal engagement with professional services;
- Widespread uncertainty about norms and service availability, very high prevalence of "don't know" levels.

Sample Characteristics

From the total sample of 591 respondents across four countries, 165 were from Armenia (27.9%). To some extent all age groups are represented, though to a lesser extent the age group of 60+. Most were aged 30-44 (51.5%), 27.3% were aged 18-29, 16.4% were aged 45-59, and the smallest age group were 60+ (4.2%). The largest group live in urban areas, of which the most in the capital Yerevan (71%). The educational attainment among Armenian respondents is high, with 81.2% completed higher education. Regarding financial situations, almost half of the respondents classified their financial situation as comfortable (49.7%), while 25.5% is just getting by, 14.5% has a very good financial situation, and 7.9% is struggling. Finally, 44.2% reported to be married and have children, 27.3% are single, 19.4% are married/partnered without having children.

Awareness and Perceptions of Help-Seeking

When asked for whom it is more acceptable to seek help for emotional or mental health problems, one-third (34.5%) of Armenian respondents said it is *more acceptable for women*, while only 4.2% said *more for men*. Equal acceptance for both genders (15.8%) was matched by

5. Dominant provider–protector identity, presented as morally grounded and responsible rather than overtly authoritarian. Yet, this framing often masks an implicit justification for hierarchical power. The discourse of protection, while expressed as care, can reproduce authority and control over dependents, particularly women, by positioning men as moral guardians rather than equal partners. This "benevolent" logic of protection may appear ethical or "heroic" on the surface, but in practice, it often legitimizes dominance and constrains reciprocity in relationships.

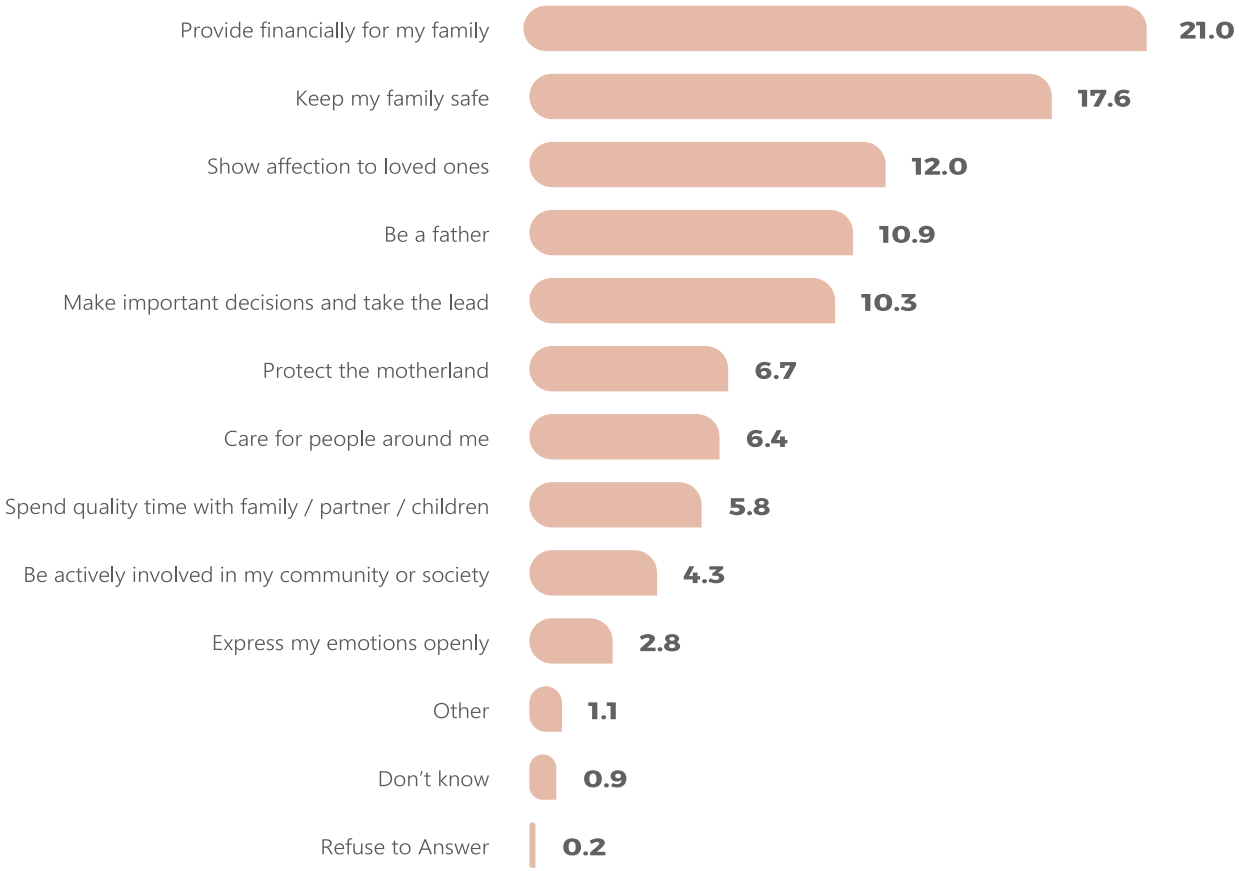
an identical share (15.8%) saying *for none*. Most strikingly, nearly one in three (29.7%) responded "don't know", the highest uncertainty rate across all four countries. This pattern suggests an "uncertainty crisis": norms around mental-health help-seeking are not clearly articulated, either socially accepted or stigmatized. Instead, Armenian respondents appear unsure what constitutes appropriate behavior in this domain.

Similarly, only 52.1% said emotional or psychological support services are available in their community, the lowest of the four countries, while 37.6% *didn't know*. These twin gaps in perceived acceptability and service awareness in their respective communities point to both informational and structural invisibility: help-seeking remains largely outside the public mental-health discourse.

Masculinity Norms and Gender Expectations

Masculinity amongst Armenian respondents remains strongly anchored in the "provider-protector" model. As shown in Figure 4 Financial provision (21%) and keeping the family safe (17.6%) dominate men's self-definitions, followed by fatherhood (10.9%) and affection (12%), while emotional expressiveness (2.8%) ranks among the least endorsed male roles.

Figure 4. Male roles according to respondents (%) N = 466[6]



Comparing personal and societal expectations of what men should do, reveals a key "motherland gap". Only 6.7% view *protecting the motherland* as personally important to do as a man, while

6. Note: This is a multiple-choice question, with N calculated based on the number of "yes" responses.

22.1% believe society expects this of men, illustrating persistent militarized masculinity linked to Armenia's conflict legacy.

Regarding desirable masculine traits, responsibility (25.8%) overwhelmingly leads, followed by rational thinking (13.9%), honesty (11.6%), and leadership (11.6%). Traits tied to dominance (1.1%) or emotional control (7.1%) are marginal, suggesting an ethical, dutiful masculinity centered on reliability rather than authority or power. Empathy (3.9%) and independence (5.2%) receive limited emphasis.

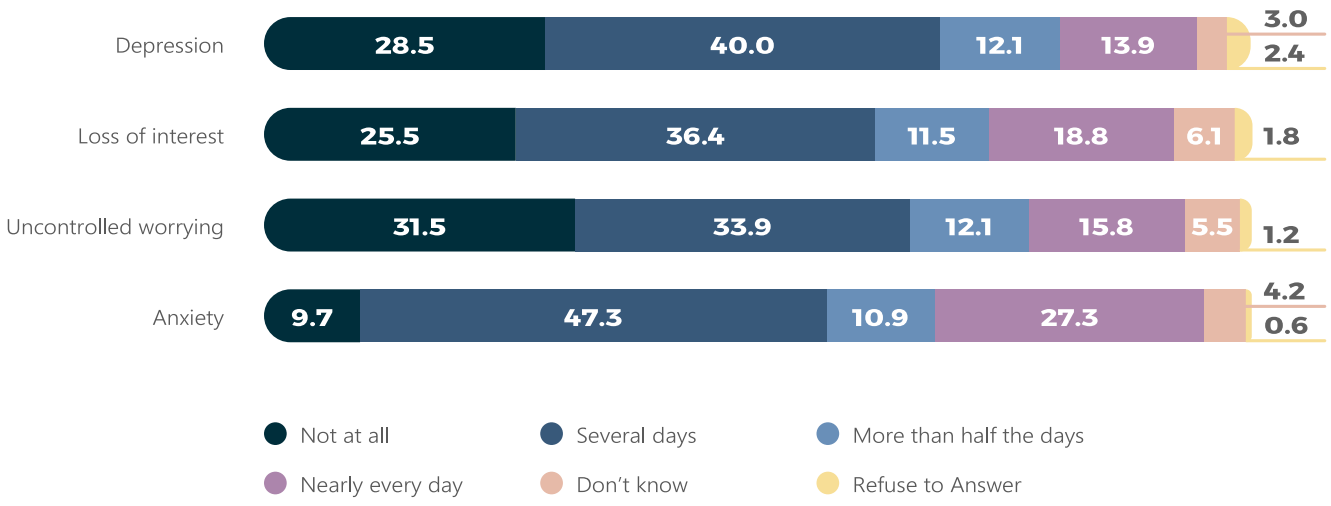
In household norms, traditional caregiving roles persist, 54.5% say caregiving is mainly women's responsibility, but 43.6% support equal sharing. Meanwhile, decision-making shows more egalitarianism: 82.4% favor joint reproductive-health decisions, and 59.4% support shared financial decision-making. At the same time, one third of the respondents (31.5%) believe that men should be responsible for financial decisions, which is in line with the earlier, popular chosen male role providing financially for the family. These patterns show cognitive equality without full practical redistribution, men endorse equality in principle but not always in everyday care work.

Normative Attitudes and Emotional Well-Being

Rigid self-reliance, stoicism, is losing ground: 64.8% disagreed that men should always solve problems alone, though 32.1% still agreed. Violence is overwhelmingly rejected (94.5%) and consent in sexual activity is widely endorsed (87.9% agree that men should always ask for consent). Moreover, 74.5% agree that a man should be monogamous. However, ambivalence persists toward male intimacy and sexual diversity: while 72.7% disagree that caring for other men is "weak", 17% selected "don't know". Support for equal respect regardless of sexual orientation is divided (55.8% agree; 40.7% disagree), signaling a society in moral transition, rather progressive on violence and consent but hesitant about same-sex care and equality.

Emotional openness remains constrained. Half (50.9%) feel uncomfortable discussing emotions, only 25.5% feel comfortable, and 21.8% are neutral. Yet emotional distress is widespread: 85.5% experienced anxiety several days or more in the past two weeks, of which 27.3% nearly every day. Around 61.8% struggled with worrying, 66.7% reported loss of interest, and 66% felt depressed or hopeless for several days or more (see Figure 5).

Figure 5. Experienced anxiety and depressive symptoms (%) N = 165



This creates a core contradiction: high distress coexists with low emotional comfort. Armenian respondents often experience substantial psychological strain but internalize rather than articulate it, mirroring cultural norms of endurance and composure.

Help-Seeking Behavior and Barriers

Despite this emotional burden, 54.5% sought *no support* (personal or professional) for emotional or mental-health challenges in the past year. About 26.7% sought support more than once, 14.5% once.

Help-seeking preferences show that Armenian respondents strongly prefer relational and private sources of support. The most popular option of comfort to talk to when experiencing personal or emotional challenges was wife/partner, by 33.7% of respondents, followed by friends (32%), other family members (13.6%), and psychologists/mental health professionals (11.6%). Meanwhile, the least comfortable support systems to talk to, according to respondents from Armenia, are community organizations (33.6%), followed by online platforms and religious leaders (both chosen by 18% of respondents), and other family members (10.6%). It is worth noting that only 6.4% of respondents mention they would not feel comfortable talking to psychologists and other mental health professionals.

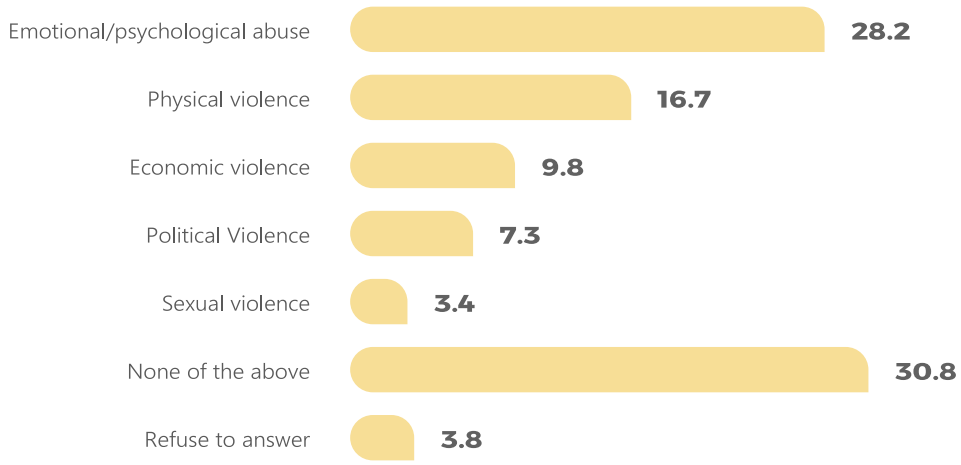
Help-seeking in practice, in line with the preferences mentioned above, is highly relational and private. Support is most often sought from friends (26.4%) and wives or partners (22.5%), with family (17%) secondary. Only 13.7% had seen a psychologist and 6% a doctor. Reliance on community organizations (1.6%) or religious leaders (2.7%) is negligible.

When asked what prevents professional help-seeking, the top reasons were: wanting to keep challenges private (24.1%), believing problems should be handled alone (21.9%), high costs (14.6%), and not knowing where to go (12.4%). The coexistence of explicit rejection of self-reliance norms (in principle) and continued behavioral avoidance (in practice) reveals deep attitude-behavior dissonance.

Violence Exposure and Peer Support

In total, more than half of respondents (65.4%) reported experience of violence. Emotional or psychological violence was reported by 28.2%, physical violence by 16.7%, economic violence by 9.8%, political violence by 7.3%, and sexual violence by 3.4% (see Figure 6). This may reflect genuinely lower violence exposure or potentially greater reluctance to disclose sensitive experiences. When asked how they would respond to a friend seeking support, 80.6% said they would listen and help themselves, while 10.3% would refer the friend to formal services.

Figure 6. Experienced forms of violence (%) N = 234[7]



4.3 Belarus

Country Profile

Belarusian respondent's attitudes reveal a masculinity that is ethically grounded and socially progressive, yet constrained by political fear and institutional mistrust. While male respondents strongly value responsibility and equality, emotional openness remains limited by historical and political legacies. Help-seeking is more common than elsewhere, but often shaped by concerns over safety, privacy, and state surveillance. Key tendencies include:

- Ethically oriented masculinity emphasizing responsibility, honesty, and care rather than dominance;
- High endorsement of gender equality and shared decision-making in family life;
- Strong rejection of self-reliance norms, yet emotional restraint persists;
- High psychological distress coexisting with active but cautious help-seeking;
- Political repression and surveillance fears as unique structural barriers to trust in formal services.

Sample Characteristics

The Belarus subsample includes 122[8] respondents (20.6% of the total). Most participants were 30-44 years old (49.2%) or 18–29 (33.6%), with smaller shares in older age groups. The respondents are overwhelmingly urban and educated: 50% live in the capital Minsk, 47.5% in other cities, and just 2.5% in villages, the lowest rural share among the four countries. Over 76.2% possess completed higher education, and most are employed or self-employed (81.2%). Half describe themselves as

7. Note: This is a multiple-choice question, with N calculated based on the number of "yes" responses.
8. Due to security concerns and differential internet accessibility, a portion of Belarusian respondents (22 out of 122) reported to reside outside Belarus. While the responses provide valuable insights into Belarusian men's perspectives, the sample may partially reflect experiences of Belarusians in emigration. Additionally, concerns about personal safety may have influenced how some respondents reported their views.

financially "comfortable", a third as "getting by", and a minority as "struggling". These demographics suggest an urban, educated group whose attitudes likely reflect progressive, digitally connected, middle-class segments rather than the general population.

Awareness and Perceptions of Help-Seeking

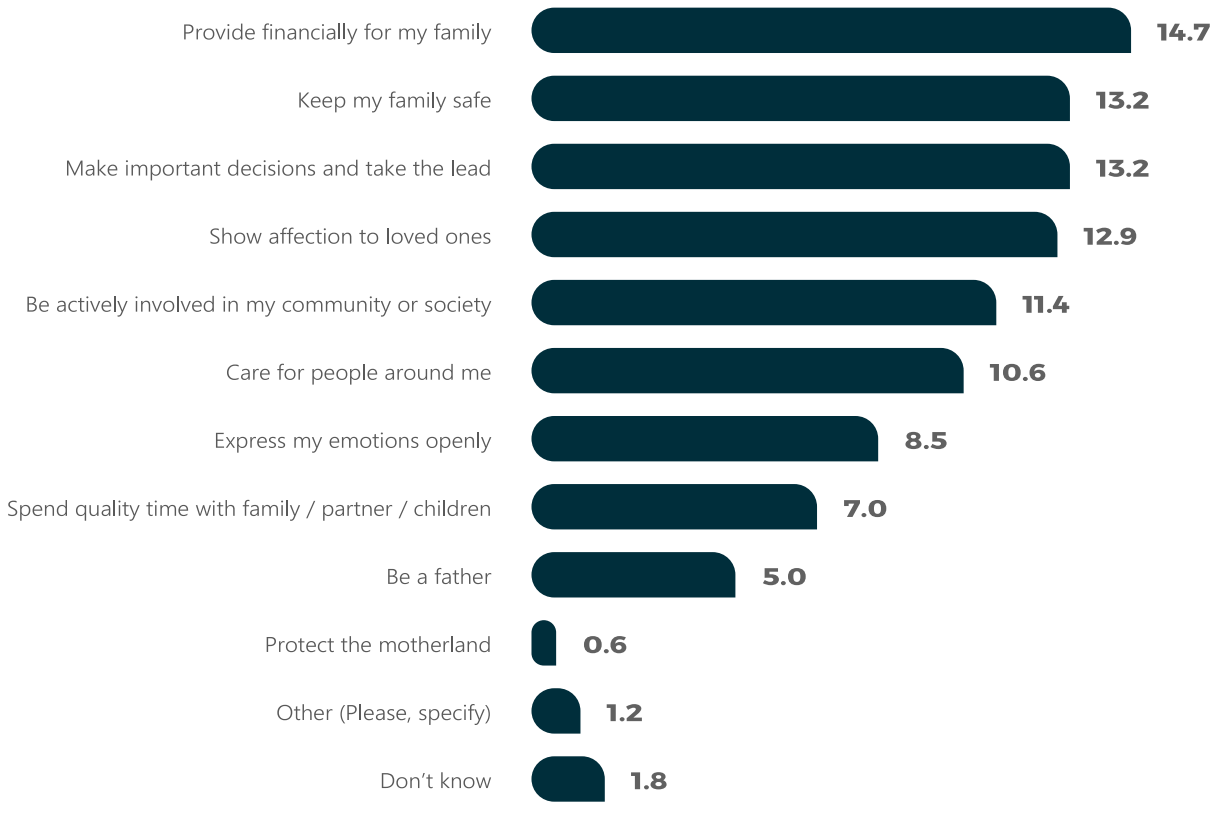
Belarusian respondents demonstrate clearer normative definitions of help-seeking than their Armenian counterparts. A majority (53.3%) said seeking help is more acceptable for women, 21.3% said equally for both, and 13.1% for none. Only 10.7% selected "don't know". While this clarity marks social consensus, it remains gender-biased, reinforcing help-seeking as feminized behavior.

Awareness of mental health services is comparatively high: 73% report that formal support exists in their community, though 21.3% still answered "don't know". The challenge, therefore, lies less in informational ambiguity and more in cultural gendering of mental health behaviors.

Masculinity Norms and Gender Expectations

Belarusian respondents define masculinity primarily through financial provision (14.7%), leadership and decision-making (13.2%), and protecting family (13.2%), forming a "provider-leader-protector" triad. Yet, significant attention to affection (12.9%), community involvement (11.4%), and caring for others (10.6%) suggests a broader, relational masculinity that integrates responsibility with empathy (see Figure 7).

Figure 7. Male roles according to respondents (%) N = 341[9]



9. Note: This is a multiple-choice question, with N calculated based on the number of "yes" responses.

A dissonance emerges between personal and societal expectations of what men should do: only 0.6% personally identify protecting the motherland as central, but 19% believe society expects this. This gap is the largest amongst the respondents in this study, reflecting rejection of state-driven nationalism amid compulsory military service and authoritarian symbolism.

Trait valuations emphasize responsibility (19%), honesty (15.6%), and rational thinking (15.3%), with moderate support for emotional control (10.5%) and empathy (9.1%). Dominance (0.6%) is almost entirely dismissed, confirming that masculinity among Belarusian respondents, while still role-bound, values ethics and self-discipline over power.

Belarusian respondents display the most egalitarian domestic attitudes among all study countries. 78.7% support equal sharing of caregiving and household tasks, compared to 17.2% who assign them "mostly to women". Reproductive health (84.4%) and financial decision-making (76.2%) are also viewed as joint responsibilities.

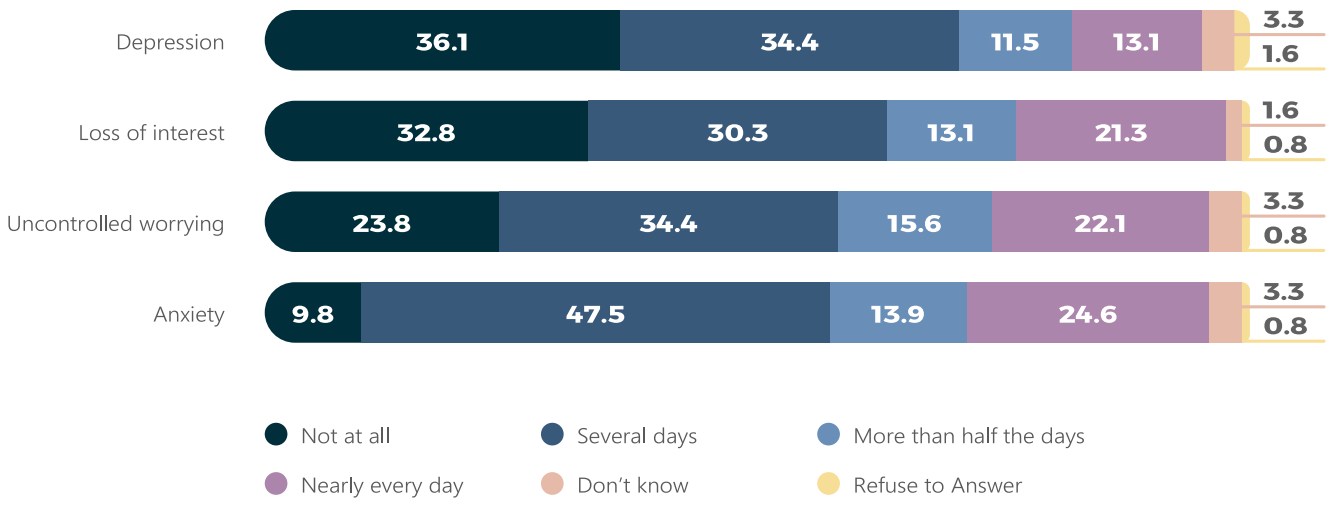
This combination, egalitarian domestic values coexisting with enduring breadwinner expectations, suggests an evolving masculinity that embraces equality in principle but retains instrumental responsibility as part of male identity.

Normative Attitudes and Emotional Well-Being

Belarusian respondents demonstrate some of the most progressive normative profiles overall[10]. 77% reject the notion that men should solve their problems alone, a strong stoicism rejection of rigid self-reliance. 96.7% reject violence in relationships, and 85.3% endorse consent before sexual activity. Additionally, 51.7% *agree* that men should be monogamous, while 29.5% *disagree* and 17.2% *don't know*. On gender and sexuality, 90.2% agree that all men deserve equal respect regardless of sexual orientation, and 91% reject the idea that male affection signals weakness. This profile portrays a rather relative progressive masculinity.

Emotional discomfort remains common: 50% feel uneasy discussing emotions, and 31.1% feel comfortable. Yet, as seen in Figure 8, psychological distress is the highest across countries. 86% experience anxiety several days or more (24.6% nearly every day). 72.1% struggle with worry, 64.7% report loss of interest or pleasure, and 59% feel depressed at least several days.

Figure 8. Experienced anxiety and depressive symptoms (%) N = 122



10. The relative progressive responses from Belarusian respondents may be explained by the demographic nature, where most respondents were young men from urban locations, including Belarusians who fled Belarus due to political pressure and/or violence.

Help-Seeking Behavior and Barriers

Despite high distress, Belarusian respondents show a high help-seeking rate: 68% sought some form of support in the past year, and only 27.9% did not. Among help-seekers, support sources align with preferences: most popular in both cases are friends (30.2%) and partners (21.6%) dominate, while psychologists (12.6%) and mental health professionals (5.5%) are consulted more than in other countries.

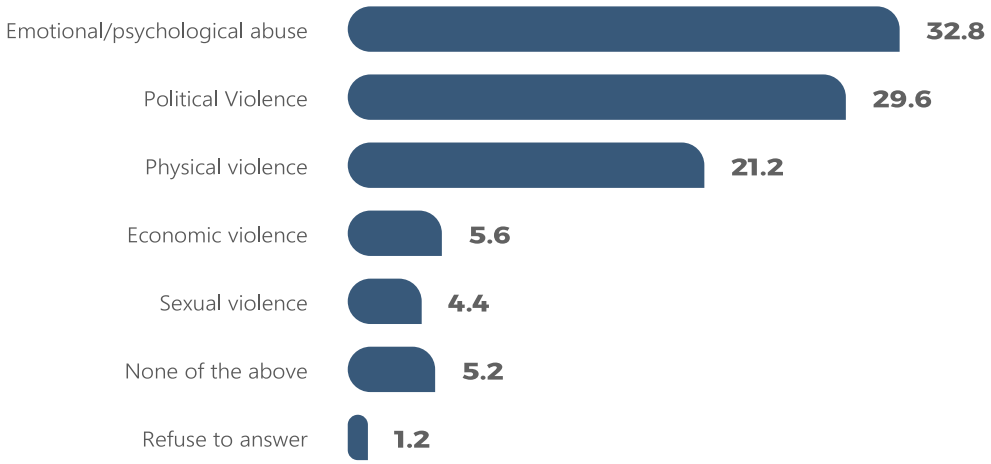
To the question of who they feel least comfortable talking to when facing personal or emotional issues, Belarusian respondents least favoured religious leaders (29.3%), community organizations (22.9%), and online platforms (19%).

Key barriers of why not to seek support include high service costs (25.9%), desire to keep problems private (20.8%), belief in handling issues independently (14.7%), and fear of government surveillance (6.6%), a uniquely Belarusian constraint reflecting authoritarian control. This pattern illustrates that structural barriers and political fear can persist even when gendered stigma weakens.

Violence Exposure and Peer Support

As shown in Figure 9 violence exposure is strikingly high: 93.6% report at least one form. Psychological abuse (32.8%), political violence (29.6%), and physical violence (21.2%) dominate. Economic violence was experienced by 5.6% of respondents and sexual violence by 4.4%.

Figure 9. Experienced forms of violence (%) N = 250[11]



At the same time, peer solidarity remains strong: 79.5% would listen and help a friend directly, while only 13.9% would refer him to formal services, showing trust in personal networks but limited institutional confidence.

11. Note: This is a multiple-choice question, with N calculated based on the number of "yes" responses.

4.4 Georgia

Country Profile

Georgian respondent's attitudes reflect a masculinity grounded in family responsibility, rational control, and moral composure, combining traditional expectations with elements of equality. While help-seeking is viewed as acceptable, self-reliance and privacy remain dominant behavioral norms. Emotional distress is present but managed quietly, reinforcing cultural ideals of endurance and dignity. Key tendencies include:

- Strong sense of duty and protection within the family, anchored in post-conflict identity;
- Cognitive acceptance of equality but persistent gender asymmetry in caregiving roles;
- Continued valorization of stoicism and self-reliance as masculine virtues;
- Limited emotional openness despite moderate distress levels;
- High willingness to support peers, yet low personal help-seeking from professionals.

Sample characteristics

The Georgian subsample includes 177 respondents (29.9%), the largest country subsample. The age distribution is relatively balanced, with 24.3% aged 18-29, 34.5% aged 30-44, 23.7% aged 45-59, and 13% aged 60+. Most respondents live in urban areas, primarily in the capital city Tbilisi (63.8%), while 28.2% live in other cities, 7.9% in villages. Educational attainment is high, with 74% reporting completed higher education. Employment levels are substantial, with 75.7% employed or self-employed. Financial situations vary: 42.9% describe their situation as comfortable, while 41.8% report just getting by. Over half of respondents (51.4%) are married or partnered and have children, while 30.5% are single.

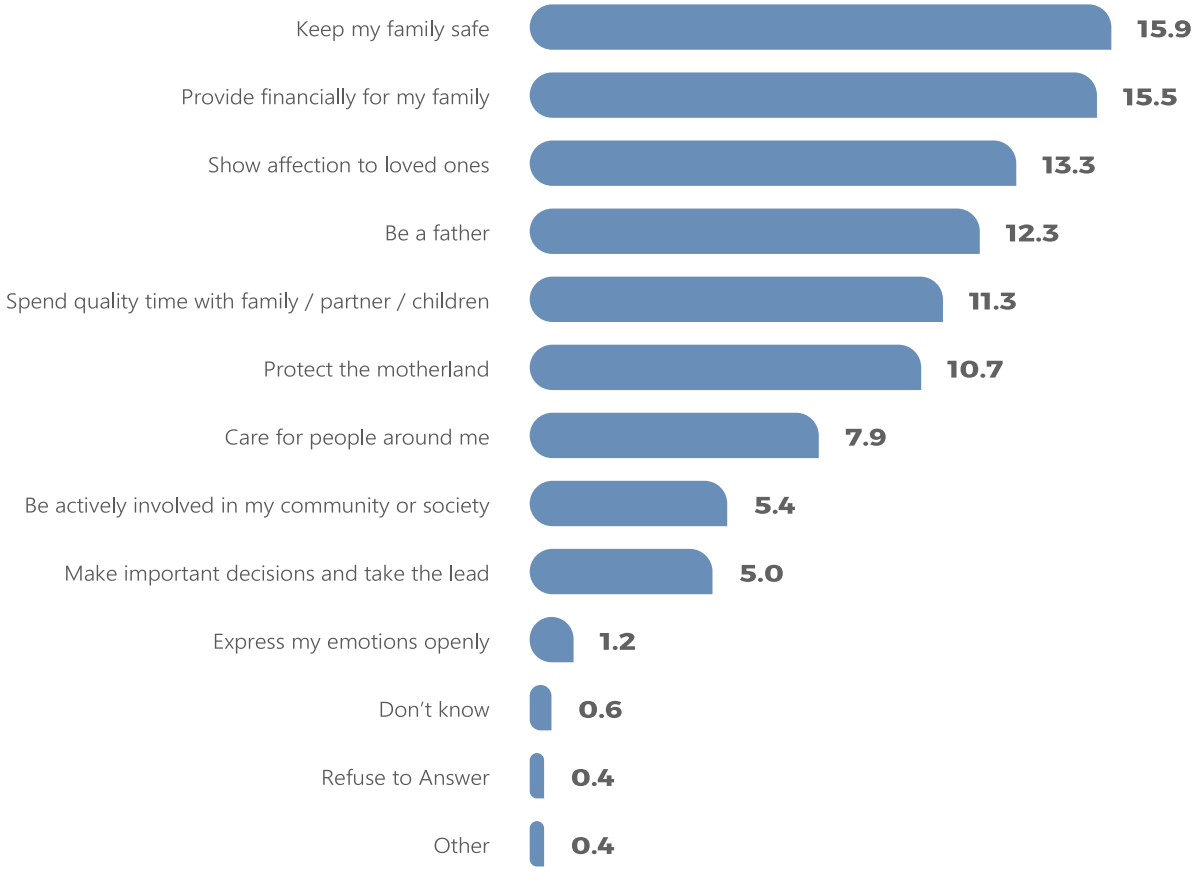
Awareness and perceptions of help-seeking

Georgian respondents show high egalitarian perceptions of help-seeking. Nearly half of respondents (49.2%) reported that seeking help is equally acceptable for men and women, while 24.3% stated it is "more acceptable for women" and 6.2% for men. Uncertainty is relatively low, with 9.6% selecting "don't know". Regarding service availability, 66.7% reported that psycho-social support services exist in their community, while 17.5% were uncertain.

Masculinity norms and Gender Roles

Personal masculine roles most often included keeping the family safe (15.9%) and providing financially (15.5%), alongside relational roles such as showing affection (13.3%) and being a father (12.3%). Protecting the motherland was personally important to 10.7%, while 16% perceived it as a societal expectation (see Figure 10). This suggests a greater personal resonance in Georgia, likely reflecting recent conflict (2008 Russia-Georgia war, the ongoing Abkhazia/South Ossetia tensions) and compulsory military service.

Figure 10. Male roles according to respondents (%) N = 496[12]



Responsibility was the most valued masculine trait (23.2%), followed by honesty and integrity (15%), while dominance was rarely endorsed (0.4%). In the household sphere, 54.2% supported equal sharing of caregiving, while 39.5% believed it should fall mostly on women. Support for equality was stronger in decision-making, with 81.9% endorsing shared responsibility for reproductive health and 75.7% for financial decisions.

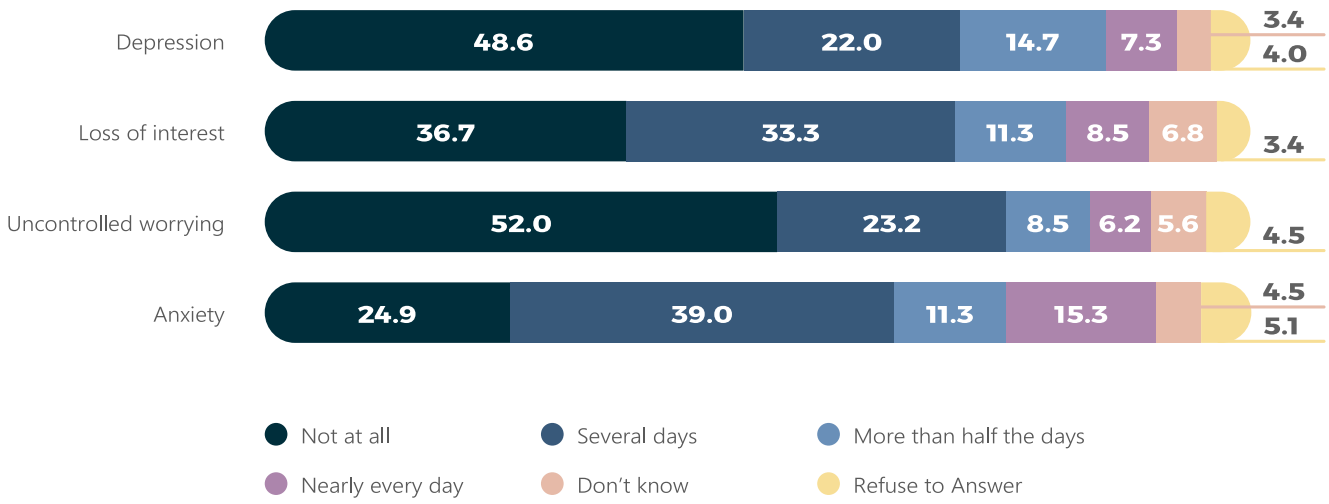
Normative attitudes and Emotional well-being

Georgian respondents show comparatively strong endorsement of self-reliance: 46.3% *agreed* that "men should solve their own problems without seeking help", while 49.7% *disagreed*. Attitudes toward violence are restrictive, with 90.4% agreeing that "men should never use physical violence in relationships". Support for consent in sexual activity norms is high (77.4%). Attitudes toward sexual orientation show moderate division, with 62.7% *agreeing* that all men deserve equal respect regardless of sexual orientation, while 25.4% *disagreed*. Views on male showing affection are more accepting, as 75.2% rejected the idea that men who show affection toward other men are weak.

Comfort with emotional expression is limited: 46.9% reported feeling uncomfortable talking about emotions, while 15.3% felt comfortable. Reported psychological distress is lower (see Figure 11). About one quarter (24.9%) reported no recent anxiety, while 65.6% experienced anxiety at least several days. Nearly half reported no recent depressive symptoms (48.6%) and not being able to stop worrying (52%).

12. Note: This is a multiple-choice question, with N calculated based on the number of "yes" responses.

Figure 11. Experienced anxiety and depressive symptoms (%) N = 177



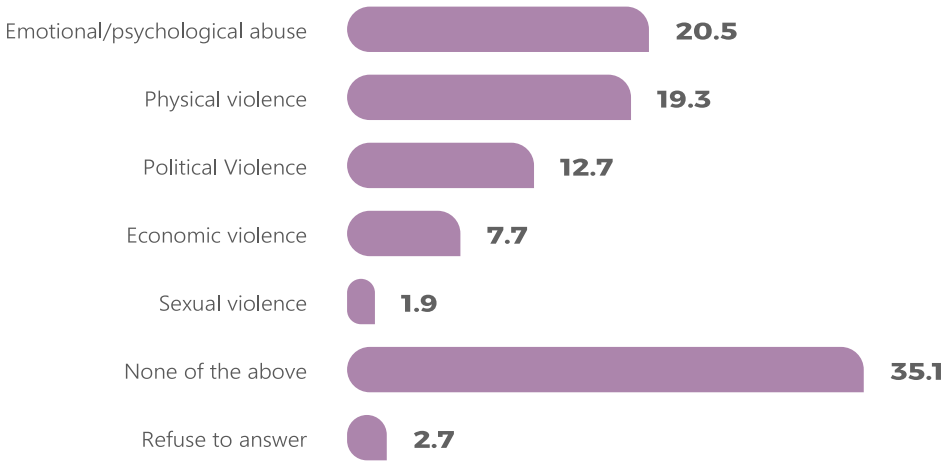
Help-seeking Behavior and Barriers

When facing emotional challenges, respondents most often preferred informal support from friends (37.4%) and wives/partners (31.6%). Comfort with psychologists was low (5.7%). Alternatively, the least preferred sources for support when facing personal or emotional issues are community organizations (29.6%), online platforms (22.6%), and religious leaders (13.3%). Meanwhile, only 15.3% reported seeking any support in the past 12 months, while 79.1% did not seek help at all. Among those who did seek support, friends (27%) and family (20.6%) were the most common sources. The least popular options were community organizations (0%) and religious leaders 1.6%). The most frequently cited barriers to professional help included wanting to keep challenges private (21.9%), believing problems should be handled alone (21.5%), and lack of information (9.7%).

Violence exposure and peer support

A bit over two third of respondents (62.1%) reported experience of violence. As shown in Figure 4.12 emotional or psychological violence was reported by 20.5%, physical violence by 19.3%, political violence by 12.7%, economic violence by 7.7%, and sexual violence by 1.9%. This may reflect genuinely lower violence exposure or potentially greater reluctance to disclose sensitive experiences. When asked how they would respond to a friend seeking support, 61.6% said they would listen and help them, while 18.1% would refer the friend to formal services (See Figure 12).

Figure 12. Experienced forms of violence (%) N = 259[13]



4.5 Moldova

Country Profile

Moldovan respondent's attitudes portray a masculinity that remains traditional and duty-bound, centered on family provision, protection, and moral reliability. While men increasingly endorse equality in decision-making, caregiving and emotional expression remain feminized. Awareness of support services is high, yet professional help-seeking remains low, with men relying mainly on close personal networks. Key tendencies include:

- Traditional provider-protector masculinity with moral overtones of responsibility;
- Support for equality in principle, but caregiving and emotional labor remain gendered;
- Strong reliance on partners, family, and friends for emotional support;
- Limited comfort with professional services, hindered by privacy and cost concerns;
- Moderate psychological distress internalized through silent endurance rather than open help-seeking.

Sample Characteristics

From the total sample, 127 respondents were assigned to Moldova (21.5%). The age distribution is strongly concentrated among younger men, with most respondents aged 18–29 (86.6%), while older age groups are less represented. Most respondents live in urban areas, with 65.4% residing in the capital city, 17.3% in other cities or towns, and 16.5% in villages. Educational attainment is high, with 74% reporting completed higher education and an additional share reporting incomplete higher or secondary technical education. Employment patterns are mixed: 34.6% are employed and 8.7% are self-employed, while a large proportion of respondents identify as students (44.1%). Financial situations are generally stable, with 59.8% describing their situation as comfortable and 26% reporting just getting by. In terms of marital status, most respondents are single (65.4%).

13. Note: This is a multiple-choice question, with N calculated based on the number of "yes" responses.

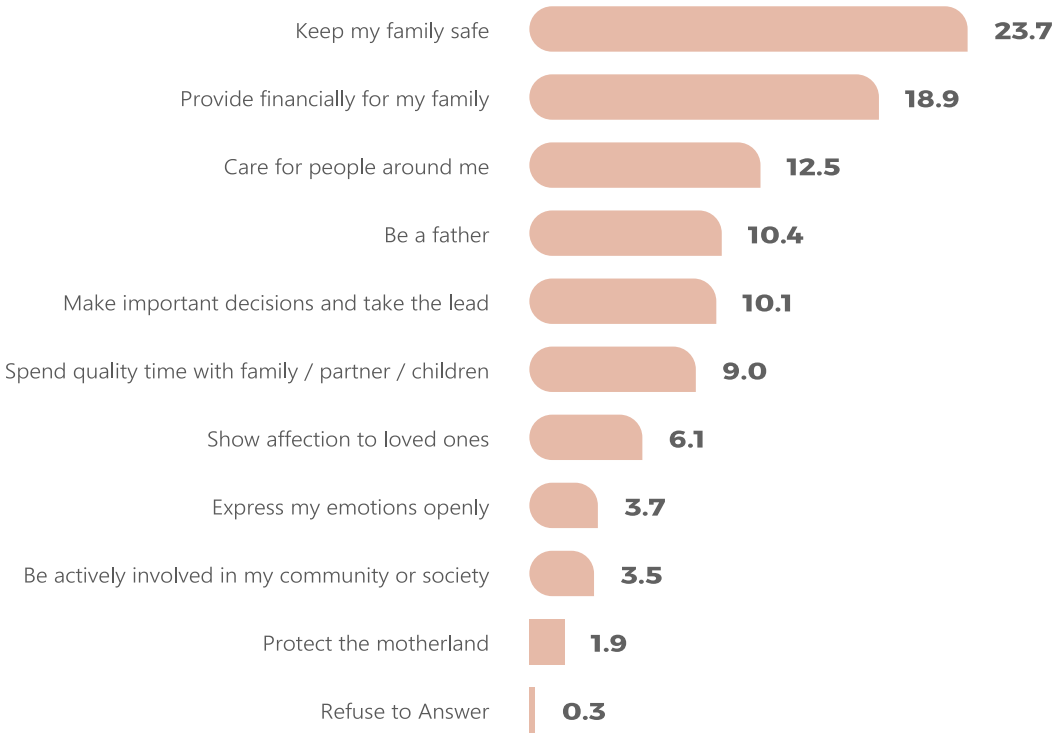
Awareness: Clear Feminization, High Service Visibility

Moldovan respondents show strong feminization of help-seeking norms, compared to the other countries. A majority of respondents (58.3%) reported that seeking help is more acceptable for women, while 22.8% viewed it as equally acceptable for both genders and only 0.8% as "more acceptable for men". Uncertainty is relatively low, with 15% selecting "don't know". At the same time, perceived service availability is high: 73.2% reported that psycho-social support services exist in their community, while 14.2% were uncertain.

Masculinity Norms and Gender Roles

Among Moldovan respondents, personal masculine roles are most strongly associated with keeping the family safe (23.7%) and providing financially for the family (18.9%). Relational and caregiving roles are also present but secondary, including caring for people around them (12.5%), being a father (10.4%), and taking the lead in decision-making (10.1%). By contrast, expressing emotions openly (3.7%) and protecting the motherland (1.9%) were among the least frequently selected personal priorities. In terms of perceived societal expectations, financial provision (24.5%) and family protection (17.9%) remain central, while protecting the motherland (14.1%) and leadership roles (13.9%) are viewed as substantially more expected by society than personally prioritized (see Figure 13).

Figure 13. Male roles according to respondents (%) N = 376[14]



14. Note: This is a multiple-choice question, with N calculated based on the number of "yes" responses.

Masculinity norms amongst Moldovan respondents center on traditional roles, with financial provision, family safety, and leadership forming the core masculine priorities. "Responsibility" is the most strongly endorsed masculine trait, selected by over 17.4% of respondents, while "Dominance" receives minimal support (below 5%) and "Remains" marginal (under 20%).

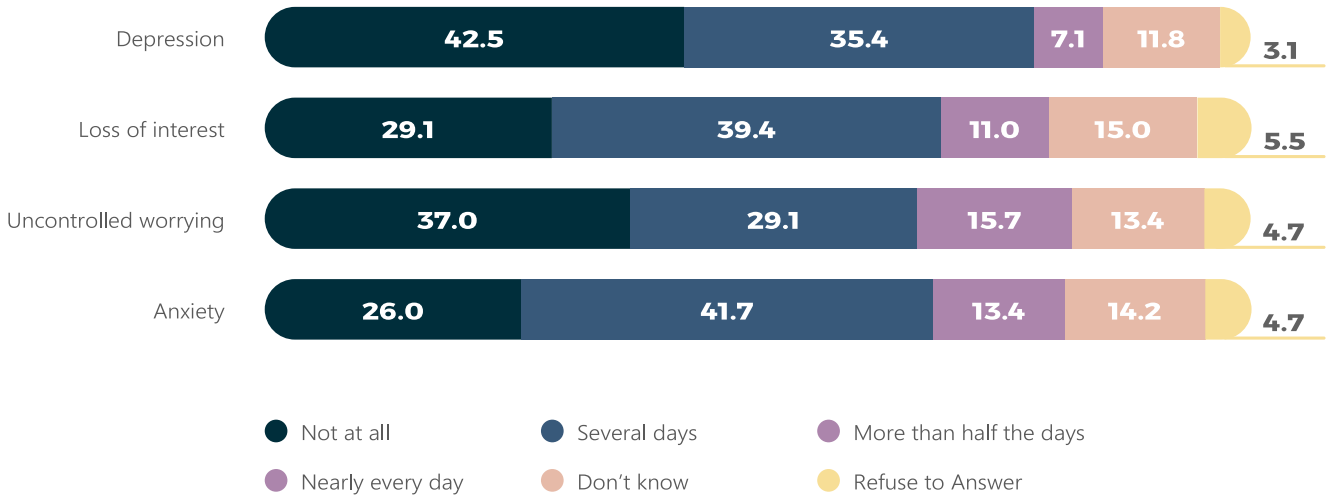
Attitudes toward gender roles remain largely traditional in caregiving, with more than half of respondents stating that this responsibility should fall mostly on women. At the same time, support for equality is strong in decision-making domains: 84.3% of respondents endorsed shared responsibility for reproductive health decisions, and a majority (66.1%) supported joint financial decision-making.

Normative Attitudes and Emotional Well-being

Moldovan respondents show moderate rejection of strict self-reliance norms, with a majority (53.5%) disagreeing that men should solve problems alone. Attitudes toward violence and consent are broadly restrictive, with 93.7% agreeing that "men should never use physical violence in a personal relationship", while views on sexual orientation and male affection show moderate support alongside notable uncertainty. More than half (58.3%) reject the idea that "men who show care or affection toward other men are weak". Similarly, 47.3% support equal respect for men regardless of sexual orientation while 41% disagree and 7.1% report uncertainty.

Emotional expression remains constrained, with most respondents reporting discomfort discussing emotions (52% uncomfortable). As seen in Figure 14, psychological distress is widespread, 69.3% reported experiencing anxiety at least several days in the past two weeks, 58.2% reported difficulty controlling worry, 65.4% reported reduced interest or pleasure, and 54.3% reported feeling down or depressed at least several days.

Figure 14. Experienced anxiety and depressive symptoms (%) N = 127



Help-Seeking Behavior and Barriers

When facing emotional challenges, respondents primarily rely on partners and friends, with reporting comfort talking to a wife or partner (31.8%) and to friends (27.2%). Other family members were also favoured by Moldovan respondents (24.9%).

In contrast, comfort with professional mental health providers remains limited, with fewer than one in ten respondents indicating psychologists or mental health professionals as a preferred source of support (5.5%). Community organizations (0.9%), online platforms (0.9%), and religious leaders (3.2%) are rarely endorsed as sources of support. This pattern is reinforced by responses on least comfortable sources, where community organizations (22.3%), religious leaders (18.1%), and online platforms (18.1%) were most frequently selected, alongside psychologists (8.4%). To the question how to improve access to support systems, respondents most often emphasized the importance of confidentiality and anonymity, better information about available services, and affordable or free support.

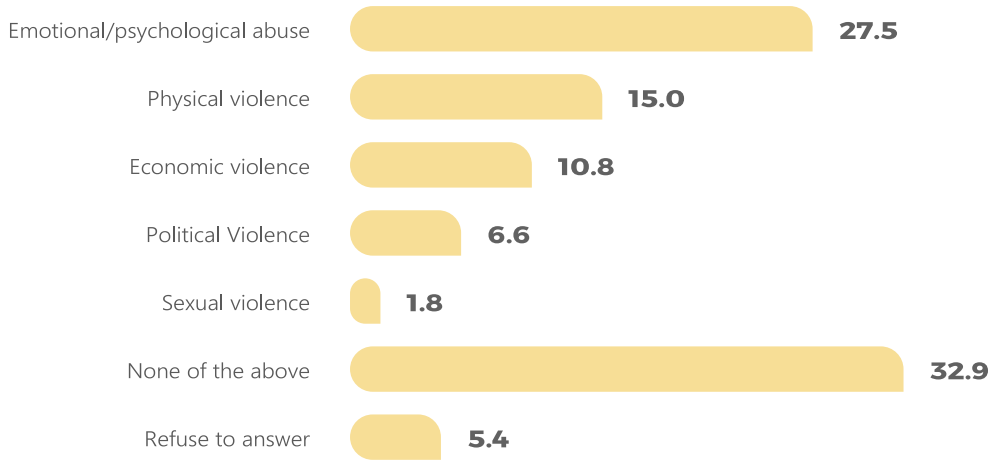
Moldovan respondents show low help-seeking rates: 37.8% of respondents never sought support in the past year, with under half engaging in any help-seeking. Among help-seekers, friends, partners, and family members dominate, with professional services used by smaller proportions.

Barriers to professional help emphasize wanting to keep challenges private and beliefs about handling problems independently as a man, followed by cost and lack of information.

Violence Exposure and Peer Support

In Moldova, more than half of respondents reported some experience of violence, while 32.9% indicated that they had not experienced any of the listed forms. Emotional or psychological violence was the most commonly reported type (27.5%), followed by physical violence (15%) and economic violence (10.8%). Smaller shares reported political violence (6.6%) and sexual violence (1,8%). These patterns point to notable exposure to non-physical forms of violence, while also suggesting possible underreporting of more sensitive experiences (see Figure 15).

Figure 15. Experienced forms of violence (%) N = 167[15]



15. Note: This is a multiple-choice question, with N calculated based on the number of "yes" responses.

When asked how they would respond to a friend seeking support, the majority of respondents (76.4%) said they would listen and try to help or give advice themselves. Only 8.7% reported that they would refer a friend to formal support services.

4.6 Key Takeaways and Next Analytical Steps

The descriptive results presented in this chapter provide a detailed picture of respondent's attitudes, experiences, and help-seeking behaviors across the four study contexts. While patterns vary by country and demographic profile, the findings reveal a set of shared tendencies that point to deeper normative and structural dynamics shaping men's mental health and support-seeking. To move beyond description and comparative reporting, the following chapter synthesizes these results through an analytical lens, examining how masculinity norms, moral expectations, institutional trust, economic conditions, and experiences of insecurity intersect to produce recurring patterns of silence, endurance, and selective openness. Chapter 5 thus translates empirical observations into interpretive insights that inform gender-transformative policy, advocacy, and psychosocial practice.

Chapter 5.

Concluding synthesis

This chapter synthesizes the key analytical insights emerging from the study, situating them within the broader theoretical frameworks of masculinity, intersectionality, and mental health. Drawing together empirical findings from the four country contexts. It examines how the male participants of this research navigate emotional distress, help-seeking, and moral responsibility within post-Soviet socio-cultural conditions.

The discussion goes beyond descriptive results to explore the deeper normative and structural logics shaping men's behavior and self-perception. It analyzes how historical legacies of militarization, institutional distrust, and gendered moral expectations intersect to produce enduring patterns of silence, endurance, and selective openness. The synthesis identifies recurring patterns and tensions, between awareness and normalization, responsibility and vulnerability, solidarity and silence, and draws implications for gender-transformative policy and psychosocial practice (See the details on Core Cross-Country Patterns and Paradoxes in Annex 2 and Analytical Additions in Annex 3).

This methodological reality shapes our analytical approach in several important ways. First, we focus on describing associations and patterns within our target population rather than making population-level claims. Second, we treat country-level differences as contextual variations that may reflect sampling approaches, urban concentration, or unmeasured factors, rather than as definitive national characteristics. Third, we use our findings to generate hypotheses and identify relationships that warrant further investigation through representative research.

5.1 Overview: Masculinity, Mental Health, and Help-Seeking in Post-Soviet Contexts

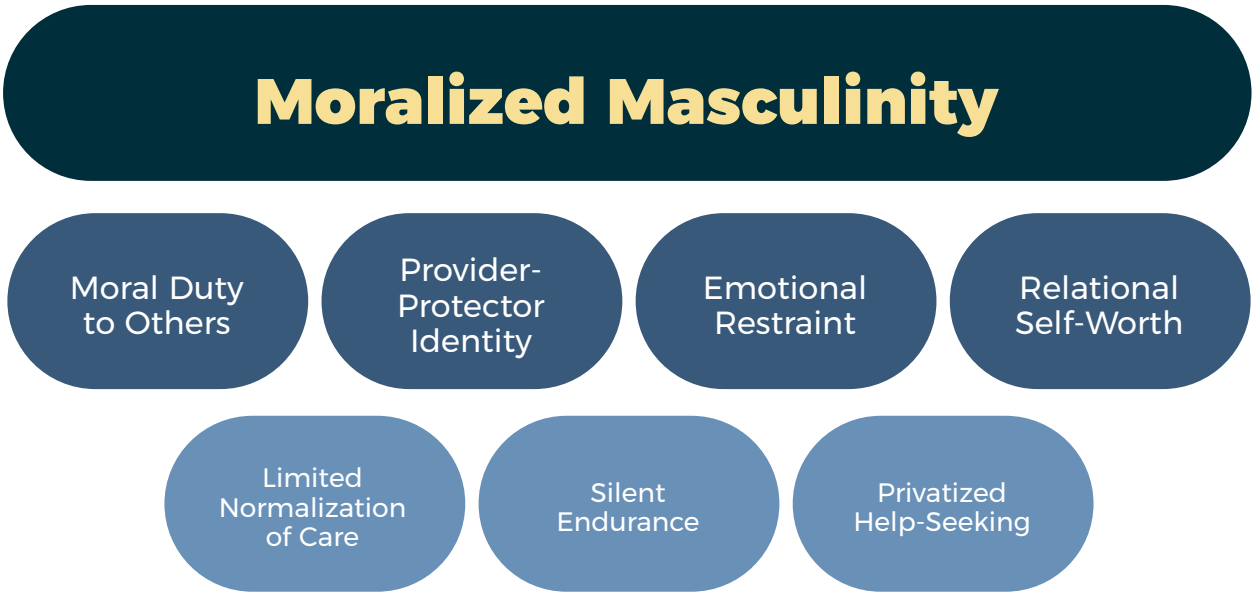
The analysis across the four study contexts reveals a shared regional framework of masculinity grounded in moral duty, emotional restraint, and responsibility for others. Although historical and political settings differ, similar patterns appear in how men interpret strength and respond to distress.

Across the region, masculinity is constructed less through dominance or aggression and more through ethical obligation, to provide, to protect, and to maintain stability within family and society. These identities are relational and collective rather than individualistic, men's self-worth derives from their capacity to care for others and to cope with hardship calmly and responsibly. Yet this ethic of care remains directed outward, focused on family, community, or nation, while self-care is often treated as morally secondary or even inappropriate.

This produces a distinctly moralized self-control, a form of emotional discipline rooted in social responsibility rather than self-expression. While this model of masculinity reflects integrity and duty, it also limits emotional openness and suppresses vulnerability.

Help-seeking, where it occurs, remains largely relational and private, directed toward partners or friends rather than professionals. Awareness of services exists but does not necessarily lead to normalization. Even when the respondents intellectually endorse equality or empathy, behavioral engagement remains limited. Across settings, these patterns suggest an evolving masculinity, transitioning from coercive authority toward moral responsibility, yet still struggling to integrate emotional authenticity (see Figure 16).

Figure 16. Moralized Masculinity as a Shared Regional Framework



However, we must repeat a critical sampling paradox: the men who participated in our online survey about emotions and help-seeking are likely already more open, reflective, and willing to engage with these topics than men who declined participation or lack digital access. This means our findings may capture masculinity in transition, the attitudes of men already questioning traditional norms, rather than those most rigidly adhering to them. The barriers and silences we document among this relatively progressive group may represent the "floor" rather than the "ceiling" of regional challenges. Rural men, older cohorts, those with less education, and those who would never click on a survey about emotional health are more likely to face rigid norms, greater service barriers, and deeper institutional mistrust.

5.2 Masculinity as Moral Responsibility: The Family-Nation Nexus

A defining characteristic of masculinity across these contexts is its moral orientation toward others. Being a "good man" is equated with providing for and protecting one's family and contributing to collective stability. Emotional strength and self-control are viewed as virtues that enable dependability. Vulnerability, in contrast, is often seen as a failure of duty, a loss of control that threatens one's moral and social standing.

While this moralized provider-protector ideal may appear altruistic, it often operates as a subtle mechanism of control. The language of responsibility and care can legitimize hierarchical authority by framing male dominance as moral duty. Men's role as "guardians" of family and nation thus becomes a socially accepted form of power presented as benevolence. This dynamic reflects what feminist theorists describe as benevolent patriarchy, a form of control justified through protection rather than coercion (Kandiyoti, 1988; Connell & Messerschmidt, 2005). It creates a paradox: men's moral authority is affirmed through care, yet that very authority limits relational equality and emotional reciprocity.

5.3 Economic Precarity and the Provider Imperative

This moralized provider identity becomes particularly rigid under conditions of economic insecurity. A substantial minority of the respondents reported experiencing financial strain, ranging from households just managing to cover basic needs to those actively struggling. Yet financial provision remains consistently identified as a dominant male role across all contexts. This creates a double bind: economic instability makes the provider role harder to fulfill, while failure to provide threatens masculine identity and self-worth.

Our data suggest that economic precarity may reinforce emotional stoicism because expressing distress may be interpreted as admitting failure as a provider (see Figure 17). Men may fear that acknowledging mental health struggles could threaten their employment, family respect, or social standing, fears that are economically rational under precarious conditions, not merely cultural

artifacts. Among respondents citing "wanting to handle problems alone" as a help-seeking barrier, many may be protecting their provider identity rather than simply adhering to traditional masculinity norms.

Figure 17. The Provider Imperative under Economic Precarity

Notably, cost was cited as a barrier to help-seeking even among respondents who described their financial situation as comfortable, suggesting that mental health care is perceived as an unaffordable expense regardless of actual resources. This indicates both real economic constraints and a moral hierarchy of spending, in which resources are prioritized for family provision while self-care is deprioritized or viewed as unjustified.

This demonstrates that masculine restraint is reinforced not only by internalized ideals of responsibility, but by external conditions that make help-seeking practically risky, economically burdensome, or socially unsafe. In such contexts, avoiding formal support may represent a rational response to structural insecurity rather than a simple expression of gender conservatism.

This duality, ethical responsibility and embedded hierarchy, reveals how even "moral masculinity" can reproduce unequal power structures while limiting self-care. On one hand, it promotes responsibility, care, and ethical leadership. On the other hand, it neglects personal well-being. Emotional labor is directed outward, respondents invest heavily in caring for family and community but not in their own mental health. The result is a deficit of self-care, where psychological endurance replaces emotional reflection or support.

This pattern aligns with Connell's notion of hegemonic masculinity but reflects a post-Soviet adaptation of it, less about control over others than about self-control for others. Masculinity is thus redefined as moral governance of the self, the ability to stay rational, calm, and reliable in service of collective good. Yet within this moral order, compassion for oneself remains an unrecognized form of care.

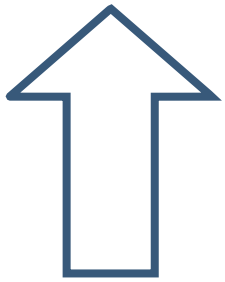
5.4 Selective Progressivism: Redefining Male Roles without Gender Parity

The findings reveal a pattern of selective progressivism, a partial reconfiguration of gender norms characterized by openness to equality in male-coded spheres (leadership, financial decisions) but limited transformation in female-coded domains (caregiving, emotional labor).

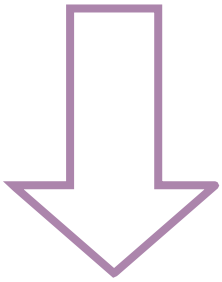
The respondents appear increasingly willing to share decision-making power and view partnership as a moral ideal based on fairness and mutual respect. However, caregiving and domestic work remain feminized, reflecting continuing symbolic boundaries between "rational responsibility" (masculinized) and "emotional care" (feminized).

This selective progressivism suggests that gender equality is often interpreted through the lens of rational fairness rather than emotional or domestic redistribution. Masculinity is evolving toward ethical partnership, yet emotional labor remains structurally undervalued. The ideal of the modern man, fair, responsible, and composed, continues to exclude vulnerability and domestic intimacy as legitimate masculine traits. At the same time, this pattern helps explain a broader paradox observed across the study: social attitudes become more fluid, yet behaviors are slower to follow. Many respondents now reject violence, support equality, and value empathy, yet few translate these views into everyday emotional practice. Emotional openness and help-seeking remain constrained by expectations of control, restraint, and moral self-discipline.

Figure 18. Selective Progressivism in Masculinity Norms



Where change occurs
Decision-making
Financial equality
Rejection violence
Rational fairness
Consent for Sexual Activity



Where it stalls
Caregiving
Emotional labor
Seeking help
Vulnerability
Respect to Sexual Diversity

This paradox of progress without practice reveals a persistent gap between belief and behavior (see Figure 18). Men often understand, at a cognitive level, that vulnerability and emotional care are acceptable or even desirable, yet still experience them as socially risky. Awareness of equality and mental well-being has grown faster than the moral permission to act on that awareness.

In this sense, selective progressivism operates not only across social domains (decision-making versus caregiving) but also between attitudes and actions. Equality is endorsed in principle, but emotional equality, particularly the right to need care, remains unrealized in practice (see Figure 18). The challenge, therefore, is not convincing men that emotions matter, but transforming the social and moral conditions that make emotional expression and help-seeking feel unsafe or inappropriate.

5.5 Generational Dynamics and Masculinity in Flux

Our data hint at possible generational differences, though our sampling approaches and small subsample sizes limit definitive conclusions. The age distribution varied substantially across our country's subsamples. These differences in age composition make direct cross-country comparisons of attitudes challenging, as observed patterns may reflect generational position as much as cultural context.

Where younger respondents appeared more frequently in our samples, we observed patterns suggesting greater uncertainty and fluidity in masculinity norms. Higher rates of "don't know" responses and lower endorsement of rigid self-reliance norms appeared more common among younger cohorts, though we cannot statistically confirm these as age effects given our sampling constraints.

This raises the hypothesis that masculinity norms may be generationally unstable, with younger cohorts exhibiting uncertainty and fluidity rather than fixed adherence to traditional or progressive models. Specifically, the relatively high uncertainty in responses regarding help-seeking acceptability in Armenia, may reflect not universal confusion but rather a generational transition concentrated among younger, urban, educated men, exactly the sample's demographic profile.

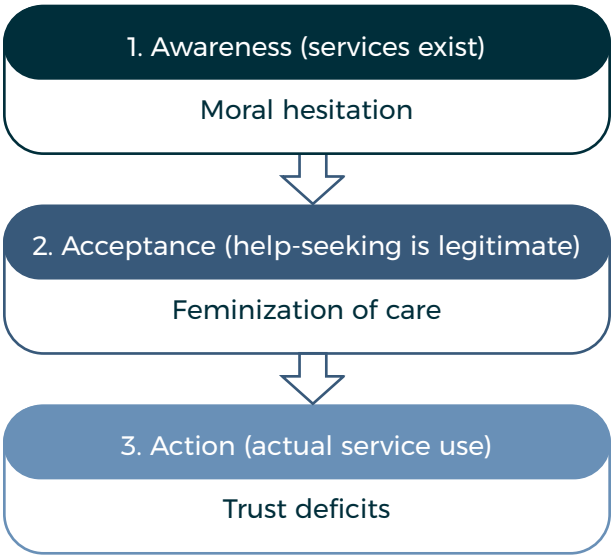
If masculinity norms are indeed in generational flux, this creates both opportunity and risk. Younger men's apparent openness could be leveraged through youth-focused interventions, peer-led programs, and university-based services. However, intergenerational tensions may also arise if older generations perceive younger men's emotional openness as threatening traditional family structures or social stability. Programs that facilitate intergenerational dialogue, rather than imposing youth-oriented norms, may navigate this tension more effectively.

5.6 Awareness, Uncertainty, and the Feminization of Help-Seeking

Our findings challenge the assumption that information deficit is the primary barrier to respondent's help-seeking. Across the sample, a substantial majority of respondents reported that psycho-social support services exist in their communities, with awareness levels varying but generally indicating considerable service visibility, at least among urban, educated populations.

Yet awareness does not translate to access or acceptance. Among respondents who knew services existed, help-seeking rates varied dramatically across contexts, with substantial variation unexplained by service awareness alone. The barriers most frequently cited were not informational ("don't know where to go") but moral and relational: wanting to keep problems private, believing problems should be handled independently, and concerns about confidentiality (see Figure 19).

Figure 19. From Awareness to Action: Where Help-Seeking Breaks Down



This reveals that the core challenge is not making men aware that services exist, but rather:

1. **Moral permission:** Helping men believe that seeking support is compatible with being a "good man," responsible provider, or reliable partner
2. **Institutional trust:** Convincing men that services are confidential, effective, and culturally appropriate
3. **Social normalization:** Shifting community-level norms so help-seeking is viewed as strength rather than weakness

Where gender expectations are clearly defined, particularly evident in the Moldova subsample, services become feminized even when visible. Men know therapy exists; they simply do not believe it is for them. This feminization operates at symbolic and practical levels: services may be staffed by women, marketed toward women, or associated with emotional labor culturally coded as feminine.

The implication for advocacy and policy is profound: awareness campaigns are necessary but may be insufficient. Telling men "services are available" does not address why they feel unable or unwilling to use them. Instead, or rather in addition, interventions must focus on social norm change, trust-building through transparency, reframing help-seeking as masculine responsibility, and providing proof of effectiveness through outcome data and success stories that normalize the process.

5.7 Emotional Distress and Silent Endurance

Across all contexts, emotional distress is widespread but rarely spoken about. Anxiety, worry, and sadness are experienced frequently but seldom named. Respondent's ability to manage hardship calmly continues to serve as a key measure of respectability and reliability.

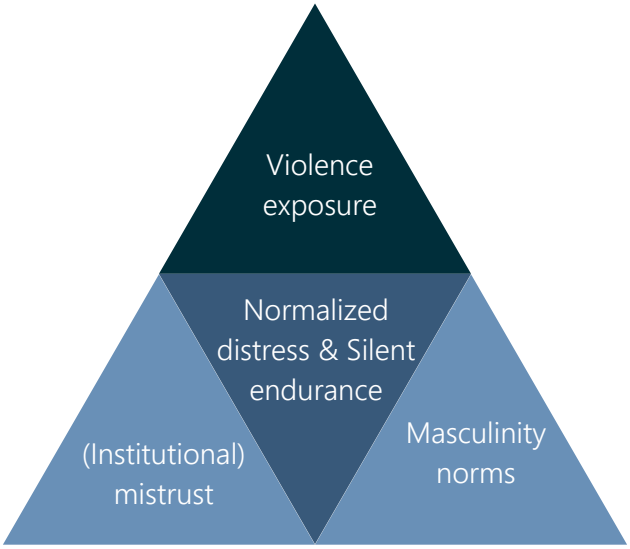
This creates a culture of silent endurance, where suffering becomes proof of strength rather than a signal of need. Such endurance is not only personal but also structural, an adaptation to political instability, conflict, and economic insecurity. Stoicism serves both as a survival strategy and a social expectation, where strength means containing rather than expressing pain.

The cumulative cost of this silence is significant. High levels of distress coexist with limited engagement in professional support systems, showing the hidden cost of moralized masculinity. Emotional suppression preserves dignity but undermines well-being, perpetuating cycles of unacknowledged trauma.

The data reveals high violence exposure across all contexts. The substantial majority of respondents reported experiencing at least one form of violence, with emotional/psychological violence, physical violence, and political violence most commonly reported. This is not an incidental finding but a defining characteristic of our sample, and likely of men's lived experience across post-Soviet contexts.

Yet we observe no clear linear relationship between violence exposure and help-seeking. In some contexts, high violence exposure coexists with relatively higher help-seeking rates; in others, violence survivors appear to remain largely silent. This suggests that violence exposure alone does not determine help-seeking behavior, rather, the interaction between trauma, masculinity norms, institutional trust, and economic conditions shapes whether men seek support or endure silently (see Figure 20).

Figure 20. The Violence–Distress–Silence Nexus



Several patterns warrant attention:

1. **Political violence as unique barrier:** Respondents who experienced political violence may face compounded distrust of formal institutions, fearing that disclosure could invite surveillance or reprisal. In contexts where political violence was notably prevalent, higher informal help-seeking alongside lower formal service use may indicate that men seek support from trusted networks precisely because formal systems feel unsafe.
2. **Masculinity and victim identity:** Men exposed to violence, particularly sexual or emotional abuse, may face additional barriers because acknowledging victimhood contradicts the protector role. Our finding that sexual violence was least frequently reported may reflect not only lower prevalence but also profound underreporting driven by masculine shame and stigma.
3. **Trauma as normalized context:** Widespread violence exposure means distress is often interpreted as normal response to abnormal circumstances rather than as mental health issue requiring support. Men may view their symptoms as "natural" reactions to instability, not as treatable conditions.

5.8 The Private Nature of Support and the Fear of Exposure

Help-seeking among men is deeply relational and rooted in trust. Support is sought mainly within close networks, such as partners, close friends, or family, where confidentiality and loyalty are guaranteed. This reliance on private care reflects both moral logic and structural necessity, as institutional support is distrusted and public disclosure feels unsafe.

Such relational containment sustains a moral economy of privacy. Emotional needs are handled within personal bonds rather than professional spaces. Men prefer to deal with distress within relationships that confirm their reliability. This privatization of care allows men to remain composed in public while acknowledging distress in safe, loyal circles.

However, it also reinforces institutional invisibility, keeping psychological pain private rather than treated as a public concern. Without trustworthy, confidential professional support, family and peer networks become the only acceptable spaces for emotional care, which are both helpful and limiting.

Institutional mistrust is not merely cultural legacy but active political reality, particularly where authoritarian governance persists. Among the Belarus subsample, a small but notable proportion explicitly cited fear of government surveillance as a barrier to seeking formal support, a constraint virtually unique to this context. Yet this figure likely underestimates the true impact, as surveillance fears may shape behavior without being consciously articulated as barriers.

The coexistence of high psychological distress, progressive gender attitudes, and cautiously selective help-seeking among the Belarus respondents suggests a rational adaptation: men seek support from trusted informal networks precisely because formal systems carry political risk. They are not avoiding help altogether but strategically navigating which sources feel safe.

5.9 Violence, Militarized Masculinity, and Emotional Cost

Exposure to political violence, conflict, and repression has strengthened masculine ideals of toughness and sacrifice. The duty to protect one's family and country remains central to the respondent's moral identity. Yet this same ideal encourages emotional suppression, normalizing trauma as the price of loyalty and stability.

Militarized masculinity equates endurance with virtue, turning pain into moral credit. Within this mindset, vulnerability is incompatible with strength, and recovery is seen as endurance rather than healing. The result is a shared legacy of unresolved trauma, both personal and generational, where emotional resilience is expected but emotional safety is lacking.

Our findings reveal a striking gap between men's personal identification with protecting the homeland versus their perception of societal expectations. Across contexts, very few respondents personally prioritized defending the motherland as central to their masculine identity, yet substantially more believed society expected this of them. This gap was most pronounced in the Belarus subsample and least evident in the Georgia subsample.

This pattern suggests important dynamics:

1. **Rejection of state-imposed militarism:** Where authoritarian regimes use compulsory military service and nationalist rhetoric to enforce masculine compliance, men may personally reject militarized identity while recognizing its social imposition.
2. **Genuine post-conflict identification:** Georgia's smaller gap may reflect that men in countries where conflicts are unresolved, integrate defense into personal identity, rather than viewing it as externally imposed.
3. **Help-seeking implications:** Men who reject state-imposed masculine duties may be more open to emotional vulnerability if it feels self-determined.

Beyond visible violence, respondent's also experience widespread emotional, economic, and relational harm, including sexual violence, that often remains unspoken. Many internalize humiliation or deprivation as personal failure rather than structural injustice. This normalization of everyday violence reinforces masculine ideals of endurance and self-blame, preventing acknowledgment of suffering. Because men are often expected to be protectors, identifying as victims contradicts this role, deepening silence and isolation.

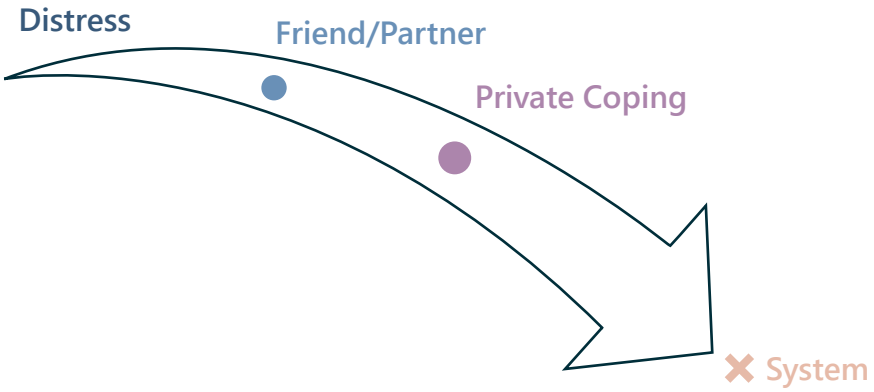
Violence is therefore not just an event but a continuing social condition, rooted in repression, instability, and insecurity. These pressures create ongoing emotional strain that blurs the line between resilience and exhaustion. Addressing men's mental health requires recognizing this as a collective issue that calls for trauma-informed and gender-sensitive responses rather than individual endurance.

5.10 Peer Solidarity and Privatized Compassion

Respondent's close relationships provide important informal support, marked by empathy and loyalty. Many are willing to listen to a friend in distress but hesitate to recommend professional help. This private compassion offers real comfort but reinforces the idea that emotional problems should stay within personal circles.

Our findings reveal a critical bottleneck: the substantial majority of respondents said they would listen and help a distressed friend themselves, yet only a small minority would refer that friend to professional services. This means peer networks function as gatekeepers rather than gateways, they provide comfort and containment but rarely facilitate professional connection.

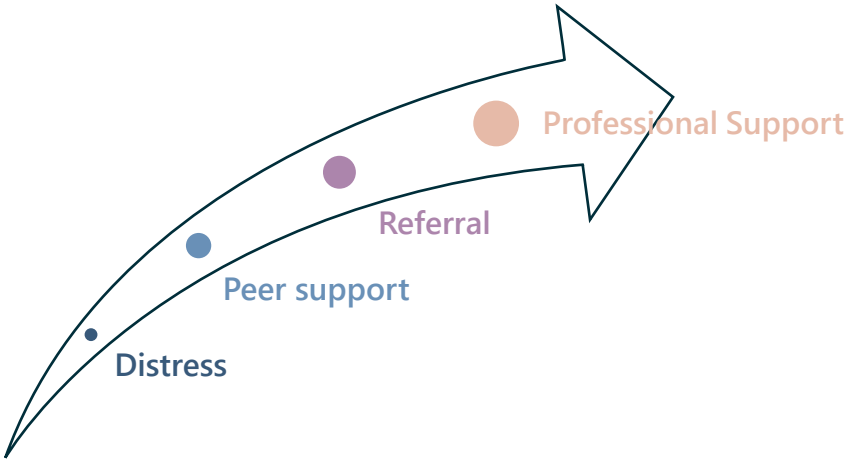
Figure 21. Current Relational Support Practices



This pattern has profound implications. Respondent's actual help-seeking pathways, as shown in the figure left, do not intersect with formal services. The current mental health system assumes men will self-refer when distressed, but our data show that first contact is almost always informal. If that informal contact does not lead to professional care, the pathway most likely ends (see Figure 21).

Peer networks therefore hold both potential and limitation. They reduce isolation but also maintain avoidance of formal systems. Strengthening these networks through peer mentoring, men's groups, or workplace dialogues could help shift norms. When peer support connects to professional help, it redefines help-seeking as a shared and responsible act rather than a private failure (see Figure 22).

Figure 22. Peer Networks as Gatekeepers and Potential Gateways



5.11 From Endurance to Ethical Care

Across the region, masculinity is undergoing moral change. Yet traces of hierarchy remain beneath this moral surface. The idea of protection and provision, while less aggressive, still justifies unequal authority at home and in public life. In this way, the moralization of masculinity does not fully break from patriarchal power but reshapes it into a more acceptable form, what can be described as *ethical dominance*: control expressed through care.

A key limitation of this study is that it captures the experiences of digitally connected, urban, and educated men, those already somewhat open to reflection and change. The men not reached, rural, older, with less education, economically more insecure, or disconnected from digital life, likely face even greater stigma, isolation, and institutional barriers. If this relatively progressive group still reports high distress and low help-seeking, the wider situation is almost certainly more severe.

The ideal of the "good man" is shifting from dominance toward integrity, from control toward care, and from silence toward empathy. Yet this transition remains incomplete. Masculinity is increasingly ethical but still self-denying, demanding service to others while neglecting compassion for the self. As long as strength is defined by endurance alone, men will continue to carry invisible burdens that neither families nor societies can sustain. Improving men's mental health therefore requires a new understanding of strength, one that includes seeking help as part of moral responsibility. True resilience means addressing pain, not concealing it.

The following chapter builds on this foundation, translating these insights into concrete recommendations for policy, advocacy, and practice aimed at reshaping systems of care and support across the region.

Chapter 6.

Recommendations: Research for Advocacy and Policy

The recommendations presented in this chapter translate the analytical insights of the preceding chapters into concrete, actionable directions for policy, advocacy, and practice[16]. Building directly on the patterns and paradoxes identified in Chapter 5, this chapter responds to a central finding of the study: men's (respondent's) mental distress in post-Soviet contexts is not primarily the result of ignorance or resistance, but of moral, structural, and institutional conditions that make help-seeking feel risky, inappropriate, or incompatible with responsible masculinity.

16. ***Note:** The recommendations presented in this chapter are derived from the study's findings and reflect normative best-case scenarios for strengthening men's mental health support systems across the four study contexts. The authors recognize that political, institutional, and resource constraints may affect the feasibility or timing of implementation in specific settings. In particular contexts where civic space, service provision, or institutional trust are constrained, some recommendations should therefore be interpreted as longer-term strategic directions rather than immediately actionable measures. These recommendations have not undergone a formal feasibility assessment and should be considered with appropriate contextual sensitivity.

6.1 General Strategic Recommendations

Accordingly, the recommendations do not focus narrowly on expanding service availability or raising awareness. Instead, they address the deeper conditions shaping men's help-seeking behavior: moralized self-control, economic precarity, institutional distrust, trauma normalization, feminization of care, and the privatization of emotional support. Their overarching aim is to support an ongoing transition in masculinity, from endurance without care toward responsibility that includes care for oneself.

To reflect the multi-layered nature of these challenges, the recommendations operate across three interconnected fields:

- **Policy**, addressing legal, institutional, and economic frameworks;
- **Advocacy**, shaping social norms, narratives, and public meaning-making;
- **Practice**, focusing on service design, professional capacity, and delivery models.

A detailed matrix of issues, actions, actors, and country priorities is provided in Annex 4. The sections below synthesize those recommendations into a coherent strategic narrative.

Normalizing Help-Seeking as Responsible Masculinity

A core implication of the findings is that awareness alone is insufficient. Across all contexts, men largely know that mental health services exist, yet lack moral permission to use them. Help-seeking remains tolerated rather than normalized and is often feminized or associated with personal failure.

Strategic direction

Help-seeking must be reframed not as vulnerability opposed to strength, but as a form of responsibility that sustains men's ability to provide, protect, and relate.

In the short term, policy and advocacy efforts should integrate men's mental health explicitly into health, labor, education, and equality strategies. Emotional literacy should be embedded in secondary and vocational education, and public campaigns should link help-seeking to fatherhood, partnership, reliability, and moral integrity. Practitioners should be equipped with gender-sensitive knowledge to start with, and gender-sensitive communication tools that resonate with men's existing moral frameworks rather than attempting to replace them.

In the longer term, normalization requires institutional anchoring. Cross-ministerial strategies on men's mental health, gender-disaggregated public health indicators, and sustained engagement with media and education systems are necessary to ensure that normative change is durable rather than symbolic.

Reframing Moral Duty: From Self-Denial to Ethical Self-Care

Across the region, masculinity is strongly anchored in moral duty toward others. While this ethic of care promotes responsibility, it also renders self-care morally ambiguous or secondary. Under economic pressure, silent endurance becomes a rational strategy for preserving provider identity.

Strategic direction

Self-care should be reframed as an ethical obligation rather than a personal indulgence.

In the short term, labor and social policies should integrate men's mental well-being through workplace counseling, preventive coverage in insurance schemes, and incentives for paternal caregiving such as *use-it-or-lose-it paternity leave*[17]. Advocacy initiatives should explicitly valorize caregiving, emotional labor, and rest as responsible masculine acts. Practitioners can support this shift by validating stoicism as a survival strategy while gradually expanding men's coping repertoires.

Over the longer term, redefining moral duty requires alignment between/intersectional approaches toward economic, family, and health policies. National work–life standards, time-use data collection, opportunity to receive appropriate professional services within the health insurance system, and sustained cultural narratives that value emotional labor is essential to ensure that responsibility toward others no longer depends on self-neglect

Closing the Attitude-Behavior Gap

A recurring paradox identified in the analysis is the gap between progressive attitudes and limited behavioral change. Many men endorse equality, empathy, and non-violence, yet hesitate to seek help themselves.

Strategic direction

Interventions must move beyond persuasion toward enabling and triggering action.

In the short term, reducing practical and psychological friction is key. Subsidized first counseling sessions, anonymous or low-threshold entry points, and solution-focused short-term counseling can lower the barriers to initial engagement. Advocacy should explicitly acknowledge hesitation, using peer narratives that normalize delayed action and model concrete steps toward seeking support.

In the longer term, help-seeking must become visible and expected rather than exceptional. This includes embedding emotional literacy across educational pathways, institutionalizing referral mechanisms from informal to formal support, and tracking convergence between attitudes and behaviors through national data systems.

17. "Use-it-or-lose-it" paternity leave is a policy, common in Nordic countries and increasingly the EU, that earmarks a specific, non-transferable portion of paid parental leave exclusively for fathers. If not used by the father, this leave is forfeited rather than transferred to the mother, effectively boosting uptake and fostering gender equality (OECD, 2023).

Transforming Peer Networks from Gatekeepers into Gateways

Men's primary support systems remain relational and private. Friends, partners, and family members provide significant emotional care but rarely facilitate professional help-seeking, effectively containing distress within personal networks.

Strategic direction

Peer networks should be recognized and supported as primary gateways into formal care.

In the short term, policy frameworks should recognize peer support as a legitimate entry point, funding pilot peer-mentor and navigator programs. Advocacy can empower peers with simple tools and messages that frame referral as an act of care rather than abandonment. Practitioners should be trained to work with partners and friends as allies through couple- or peer-entry models.

Long-term impact requires embedding peer-professional integration within mental health systems. Certified peer navigators, Mental Health First Aid programs, and hybrid community–psychology models can institutionalize relational care while maintaining professional standards.

Addressing Trauma, Violence, and the Politics of Silence

Exposure to violence is widespread across all contexts, yet distress remains normalized and unspoken. Particularly acute are the intersections between trauma, masculine shame, and institutional distrust, including the profound underreporting of sexual violence against men.

Strategic direction

Mental health systems must assume trauma as a common context rather than an exception.

In the short term, mandatory trauma-informed training, anonymous self-assessment tools, and public campaigns framing recovery as courage are essential. Explicit attention must be given to male survivors of sexual violence, challenging shame and myths that exclude men from victimhood.

Over the longer term, trauma recovery requires time, trust, and collective acknowledgment. Veteran-specific services, survivor-led peer groups, community-based healing initiatives, and, where relevant, links to transitional justice processes are necessary to address both individual and collective trauma.

Rebuilding Trust under Conditions of Surveillance and Distrust

In authoritarian or post-repressive contexts, institutional mistrust is rational rather than cultural. Fear of surveillance, data misuse, or political repercussions undermines formal help-seeking even among men with progressive attitudes.

Strategic direction

Trust must be structurally guaranteed, not rhetorically asserted.

Short-term measures include legal prohibitions on data-sharing with security agencies, compulsory confidentiality training, and donor-funded independent audits leading to visible "safe service" certification. Anonymous and encrypted digital counseling platforms provide immediate low-risk access. Sustained trust requires independent civil-society mental health infrastructure, transparent oversight, and diaspora-accessible services for displaced populations.

Long-term institutionalization of independent, legally protected mental health services with enforceable guarantees of confidentiality and zero data-sharing with security bodies is essential. Trust should be sustained through permanent third-party oversight, formal certification of "safe services", and the development of secure, anonymous, and, specifically relevant for Belarus, diaspora-accessible care infrastructures.

Expanding Access through Community-Based and Digital Innovation

Over-institutionalized systems, geographic inequality, and workforce shortages continue to limit access, particularly for rural and marginalized men.

Strategic direction

Mental health systems must shift toward decentralized, low-threshold, and digitally enabled models.

In the short term, piloting community mental health centers, mobile clinics offering integrated health services, and locally adapted digital tools can rapidly expand access while reducing stigma. Blended care models increase flexibility and continuity. Preferably, the specialists involved should not be locals and be free from possible friendly ties with the local community.

Long-term reform requires redistributing funding from psychiatric hospitals to community-based care, integrating mental health into universal coverage, embedding digital mental health within national eHealth strategies, and investing in workforce development, including male community counselors.

Addressing Service Feminization and Workforce Imbalances

The perception of therapy as feminized continues to undermine engagement, compounded by shortages of male providers and gender-insensitive service design.

Strategic direction

Mental health services must become explicitly male-inclusive without reinforcing harmful stereotypes.

Short-term actions include scholarships and incentives for male trainees, neutral or strength-based service framing, and clinic redesign to prioritize privacy. Over time, balancing gender representation in the workforce and institutionalizing gender-sensitive training will ensure services reflect the diversity of men's experiences.

Long-term, mental health systems should institutionalize balanced gender representation in the workforce and embed gender-sensitive training and service design as standard practice. Sustained normalization of male help-seeking requires structurally inclusive services that reflect men's diversity and position therapy as a legitimate, competent, and non-gendered form of care. Finally, educational programs targeting first: teachers on importance of equal gender norms and behaviours, then targeting students on normalizing gender-norms as essential to avoid continued feminization of help-seeking and therapy.

6.2 Country-Specific Recommendations

While the structural drivers of men's mental health challenges are shared across the four study contexts, the descriptive results highlight distinct national configurations of norms, barriers, and opportunities. The recommendations below therefore tailor the general strategic directions outlined in Section 6.1 to the specific patterns observed in each country, prioritizing interventions most likely to be effective given local conditions.

6.2.1 Armenia: Reducing Normative Uncertainty and Integrating Post-Conflict Care

Armenian respondents stand out for its high levels of uncertainty regarding the acceptability of men's help-seeking and the visibility of psycho-social support services. Combined with a strong provider–protector masculinity shaped by recent armed conflict, this uncertainty produces a context in which distress is widespread but norms for responding to it are poorly articulated.

Policy priorities should focus on clarifying norms and embedding men's mental health within post-war recovery, labor, and family policy. Given the low perceived knowledge on availability of services and high preference for relational based support, investments in community-based mental health infrastructure and clear public mapping of alternative available support are essential. Veteran- and conflict-affected populations require dedicated trauma-informed services that acknowledge military culture and normalize help-seeking as part of responsible reintegration. Integrating psychosocial support into employment services and social protection schemes can further frame mental health as resilience rather than weakness.

Advocacy efforts should address normative ambiguity directly. Campaigns in Armenia should not assume entrenched stigma but instead respond to uncertainty by clearly articulating that help-seeking is acceptable, expected, and compatible with being a "good man." Diaspora engagement is additionally relevant, as transnational Armenian networks can model alternative masculinities without appearing externally imposed. Intergenerational dialogue initiatives can help bridge the gap between younger men's norm fluidity and older generations' endurance-oriented expectations.

Practice-level interventions should leverage Armenia's strong reliance on relational support. Entry points through partners, peers, and family members are critical, particularly given the low comfort with community organizations. Practitioners should be trained to work with men indirectly through these trusted relationships and to frame counseling in terms of restoring stability, responsibility, and family functioning rather than emotional disclosure alone.

6.2.2 Belarus: Guaranteeing Safety and Trust under Conditions of Surveillance

Belarusian respondents present a distinct configuration: relatively progressive gender attitudes and comparatively high help-seeking coexist with extremely high psychological distress and pervasive institutional mistrust driven by political repression. Fear of surveillance and data misuse constitutes a rational barrier rather than a residual stigma.

Policy action in Belarus must therefore prioritize enforceable confidentiality and service

independence. Given the current political environment, formal legal safeguards are unlikely to provide reliable protection. Instead, safety standards are more realistically promoted through voluntary codes of best practice developed and adopted by independent initiatives and professional communities. Discreet, independently operated and diaspora-accessible services can help create credible "safe service" ecosystems. At the same time, it is important to recognize that engagement with certain initiatives may carry risks in Belarus, where even non-material support can lead to legal consequences; therefore, programs should prioritize approaches that minimize visibility and personal exposure.

Advocacy strategies should focus less on persuading men that help-seeking is acceptable and more on demonstrating that it is safe. Messaging should stress that psychological help can be accessed safely and discreetly and will not compromise personal security. Initiatives should clearly signal that seeking support does not require public identification or exposure to institutional risks. Advocacy should avoid relying on political actors as visible champions in order to preserve trust and neutrality. In exile and diaspora communities, trusted peer advocates can play a key role in linking men to support without exposing them to risk.

Practice-level priorities include expanding anonymous, encrypted counseling options and training providers in confidentiality protection, digital security, and trauma-informed care for survivors of political violence. Initiatives should prioritize minimal data practices, collecting only information strictly necessary for providing support and avoiding storage of sensitive personal data whenever possible. Given the high prevalence of violence exposure, services should assume trauma as a baseline rather than an exception, offering low-friction access that does not require public visibility or formal registration.

6.2.3 Georgia: Bridging Acceptance and Action in a Stoic Context

Georgian respondents are characterized by relatively high acceptance of help-seeking in principle but extremely low actual use of professional services. Strong norms of self-reliance, privacy, and dignified endurance continue to shape behavior, particularly among middle-aged men with post-conflict identities.

Policy interventions should focus on reducing the practical and symbolic costs of initial help-seeking. Subsidized first sessions, workplace-based counseling programs, and integration of psychosocial screening into primary care can lower entry barriers. Given moderate service awareness, the emphasis should be less on information provision and more on activation mechanisms that translate acceptance into action.

Advocacy efforts in Georgia should explicitly target the attitude-behavior gap. Messaging that normalizes hesitation, trial use ("try once"), and pragmatic engagement with support is likely to resonate more than emotional appeals. Peer-based narratives, particularly from men who frame help-seeking as a tool for maintaining control, performance, and family responsibility, are especially relevant.

Practice priorities include offering solution-focused, time-limited counseling formats that align with men's preference for problem-solving approaches. Strengthening referral pathways from informal support (friends, partners) to professionals is critical, as peer solidarity is strong but rarely leads to formal care. Community-based men's groups and workplace dialogues can serve as transitional spaces between private endurance and professional support.

6.2.4 Moldova: Countering Feminization among Younger Men and Preventing Silent Endurance

Moldovan respondents present a paradox of high service visibility combined with strong feminization of help-seeking and low professional engagement, particularly among a predominantly young sample. Traditional provider–protector norms persist, even as many respondents are students or at early life stages.

Policy priorities should focus on early intervention and prevention. Integrating mental health into education systems, youth services, and employment preparation programs can help normalize help-seeking before stoic patterns solidify. Investments in affordable or free services and clear confidentiality guarantees are particularly important given concerns about privacy and cost.

Advocacy strategies should directly challenge the feminization of care. Campaigns aimed at young men should frame mental health as relevant to ambition, competence, and future family responsibility rather than vulnerability. Digital platforms, social media, and peer-led initiatives are especially effective given the demographic profile of the sample.

Practice-level actions should emphasize low-threshold, digitally enabled, youth-friendly and, in general, age-targeted services. Blended care models combining online tools with optional in-person support can reduce stigma and increase engagement. Redesigning services to feel neutral, practical, and male-inclusive is essential to prevent reliance on private coping from becoming entrenched as men transition into adulthood.

6.3 Concluding Note: From Findings to Action

These recommendations respond to the study's central insight: men's mental health challenges are not failures of character or awareness, but outcomes of moral expectations, economic pressures, trauma histories, and institutional conditions. Addressing them requires coordinated action across policy, advocacy, and practice, sustained over time and adapted to national realities.

The roadmap outlined in this chapter, and detailed further in Annex 4, provides a foundation for moving from moral endurance toward sustainable care. The findings suggest not only need, but opportunity: masculinity is already changing. The task ahead is to support that transition in ways that are ethical, inclusive, and structurally grounded.

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Appendixes

Annex 1.

Demographic Profile of Respondents (by Country)

Variable	Total (N=591)	Armenia (n=165)	Belarus (n=122)	Georgia (n=177)	Moldova (n=127)
Age Groups					
18–29	40%	27%	34%	24%	87%
30–44	36%	52%	49%	34%	5%
45–59	15%	16%	11%	24%	3%
60+	6%	4%	3%	13%	2%
Type of Settlement					
Capital city	63%	71%	50%	64%	65%
Other city/town	29%	24%	48%	28%	17%
Village	8%	5%	2%	8%	17%
Employment Status					
Employed / self-employed	72%	83%	81%	76%	43%
Student (not employed)	13%	3%	10%	4%	44%
Unemployed (seeking or not)	5%	5%	5%	8%	2%
Retired / disabled	3%	2%	2%	4%	3%
Education					
Completed higher education	66%	81%	76%	74%	23%
Incomplete higher / secondary technical	20%	9%	16%	17%	38%
Secondary or below	10%	8%	1%	5%	30%
Marital Status					
Single	38%	27%	37%	31%	65%
Married / partnered with children	35%	44%	20%	51%	13%
Married / partnered without children	19%	19%	35%	10%	17%
Divorced / widowed	4%	5%	8%	3%	2%
Financial Situation (self-assessed)					
Comfortable or very good	57%	64%	55%	47%	64%
Just getting by	32%	25%	31%	42%	26%
Struggling	7%	8%	13%	6%	4%

Annex 2.

Core Cross-Country Patterns and Paradoxes

Analytical Theme	Observed Regional Pattern	Country Contrasts / Paradoxes	Interpretive Insight
1. Awareness and Gender Framing of Help-Seeking	Help-seeking is broadly gendered, with awareness increasing but acceptability framed as feminine.	**Armenia:** uncertainty ("don't know" crisis). **Moldova:** clear feminization. **Belarus:** clarity but still feminized. **Georgia:** most egalitarian perceptions but lowest behavioral uptake.	Awareness does not equal normalization. Men's understanding of help-seeking is filtered through moral ideas of respectability and gender propriety.
2. Masculinity Ideals	Regionally, masculinity revolves around duty, provision, and moral responsibility rather than dominance.	**Armenia & Moldova:** provider-protector model. **Belarus:** moral-ethical masculinity. **Georgia:** relational masculinity anchored in family.	A shift from coercive to ethical masculinity, yet still bounded by emotional restraint.
3. Self-Reliance and Emotional Expression	Self-reliance and stoicism remain central but weakening in some contexts.	**Belarus & Armenia:** majority reject strict self-reliance. **Georgia:** strong endorsement persists. **Moldova:** ambivalent middle.	Emotional control remains a moral expectation even when men cognitively reject it.
4. Emotional Distress and Internalization	Psychological distress is high across all contexts, especially under repression or economic strain.	**Belarus:** highest distress under repression. **Armenia & Moldova:** silent suffering. **Georgia:** lower reported distress, possibly under-reported.	"Silent endurance" functions as a culturally sanctioned coping mechanism.
5. Attitudes vs. Behavior	Disjunction between stated openness and actual help-seeking.	**Belarus:** high alignment (progressive norms lead to some behavioral engagement). **Armenia & Moldova:** major gap between attitudes and action: men endorse openness but rarely seek support. **Georgia:** egalitarian ideals coexist with minimal behavioral uptake	Normative change alone is insufficient; structural and trust conditions mediate behavior.
6. Institutional Distrust	Deep legacy of Soviet psychiatry, coercive state control, and stigma.	**Belarus:** fear of surveillance. **Armenia & Moldova:** distrust of psychiatry. **Georgia:** reform progress but uneven access.	Institutional fear and historical stigma form structural deterrents independent of masculinity.
7. Violence and Political Contexts	Structural violence (war, repression) heightens trauma and re-militarized masculinity.	**Belarus:** political violence. **Armenia & Georgia:** conflict legacies. **Moldova:** lower exposure but enduring insecurity.	(Geo)Political trauma reproduces stoicism and reinforces emotional silencing.
8. Informal Peer Networks	Men rely on private relational support (partners, friends) across all contexts.	**Belarus & Armenia:** strongest reliance on close family and peers for emotional support. **Georgia & Moldova:** high willingness to support friends but low personal help-seeking, "privatized compassion".	Informal networks sustain "privatized care", offering solidarity but limiting professional help.

Annex 3.

Analytical Additions

Observed Pattern	Interpretation / Theoretical Implication
Men define themselves primarily through family and collective care (provider, protector), not through personal self-care	Masculinity in the region is *other-oriented*: men's sense of worth depends on responsibility for others rather than nurturing themselves. Emotional labor is externalized, care for family, nation, but not internalized as self-care. This aligns with Connell's notion of "hegemonic care duty" and the Soviet ethic of productive sacrifice. However, the moral logic of provision and protection *can also legitimize hierarchical relationships, where care becomes a form of control*. This reflects the persistence of benevolent patriarchy, which sustains authority through moral obligation rather than coercion.
Decision-making roles align with rationality, leadership, and control traits viewed as moral, not oppressive	Rationality and responsibility replace dominance as moral signifiers of manhood. This creates a "moral masculinity" that legitimizes authority through care and competence, but still excludes emotional expressiveness.
Men are more progressive in redefining traditional male roles (e.g., financial decision-making shared equally) than traditional female roles (e.g., caregiving)	This asymmetry suggests *selective progressivism*: men are willing to share power in domains coded as masculine (leadership, finance), but less willing to challenge female-coded domains like caregiving. It reflects partial norm change where equality is conceptualized as rational fairness, not redistribution of emotional or domestic labor.
Help-seeking is relational and private (partners, friends), mirroring family-centered masculine duties	Men enact help-seeking in line with relational ethics: they trust emotional safety only within existing bonds of loyalty (family/friends). Public or professional help-seeking violates the privacy expected of male composure.
High emotional distress and violence exposure coexist with low comfort expressing emotions or seeking help	This "deficit paradox" shows a cycle of silent suffering: emotional burden without social permission for vulnerability. It reveals the embodied cost of moral masculinity endurance as a virtue produces hidden distress.

Annex 4.

Recommendation Matrix

Identified Issue / Analytical Theme	Field	General Recommendation with short (0-2years)- and long-term (3-5 years) actions[18]	Collaboration & Actors	Country Focus
1. Awareness Without Normalization Men know services exist but lack moral permission to use them. Therapy remains feminized and morally ambiguous.	Policy	**Integrate normalization of men's help-seeking into national health and education frameworks** ***Short-term:*** • Include men's help-seeking and stigma reduction measures in national health, labor, and equality strategies where policy engagement is possible; in contexts with limited public data availability (e.g., Belarus), support independent research initiatives and diaspora-based monitoring to generate evidence on men's mental health. • Embed emotional literacy in secondary and vocational curricula. ***Long-term:*** • Establish a "Men's Mental Health and Equality" national strategy with cross-ministerial ownership. • Add male mental health indicators to public health monitoring.	**Primary:** Ministries of Health, Education, Labor. **Supporting:** WHO offices, equality councils, donors, research institutions.	All (Priority: ARM, MDA, GEO)
	Advocacy	**Reframe help-seeking as strength and moral responsibility.** ***Short-term:*** • Launch national "Strong Men Seek Support" campaigns with respected male role models. • Disseminate peer testimonials linking therapy to fatherhood and partnership. • Engage diaspora figures and transnational influencers to discuss help-seeking as modern responsibility without framing it as external or "Western" imposition. ***Long-term:*** • Partner with film/media sectors to normalize emotionally open male characters. • Promote intergenerational dialogues on care and courage.	**Primary:** Gender NGOs, men's networks, media orgs. **Supporting:** Sports federations, cultural bodies, influencers.	All (Priority: ARM, MDA)

18. In the Belarusian context, current political and institutional constraints may limit the feasibility of certain policy-level recommendations in the short term. Where relevant, these recommendations should therefore be interpreted as longer-term strategic directions rather than immediately actionable measures.

	Practitioner	**Equip service providers as male engagement advocates.** ***Short-term:*** • Train clinicians in gender-sensitive knowledge and communication. • Produce accessible outreach tools explaining therapy. ***Long-term:*** • Integrate male engagement modules in professional education. • Encourage practitioners as public voices for mental health normalization.	**Primary:** Psychology associations, Ministries of Health. **Supporting:** Universities, NGOs, training centers.	All
2. Moral Duty Without Self-Care Masculinity centered on providing/ protecting others; self-care seen as indulgent or weak.	Policy	**Embed men's mental well-being into labor and social policy where cooperation with authorities is feasible.** ***Short-term:*** • Require employers to implement workplace counseling programs. • Include preventive mental health in insurance benefits. • Encourage large employers and international companies with Belarusian roots (e.g., diaspora-based technology firms) to offer workplace counseling and mental well-being programs. • Introduce or expand use-it-or-lose-it paternity leave policies to incentivize fathers' caregiving and normalize male involvement in emotional and domestic labor. • Develop guidance for Belarusian diaspora communities on accessing mental health services and navigating host-country labor protections and support systems. ***Long-term:*** • Institutionalize psychosocial risk prevention in labor codes. • Introduce national "Healthy Work-Life" standards. • Integrate gender-disaggregated time-use surveys into national statistics and set policy targets for equitable distribution of caregiving and domestic work. • Provide opportunities to receive appropriate professional services within the health insurance system.	**Primary:** Ministries of Labor, Health, Social Affairs. **Supporting:** Employers' federations, unions, WHO, donors.	All

	Advocacy	**Reframe self-care as a moral and social duty.** ***Short-term:*** • "Strong Providers Care for Themselves" campaigns via workplaces and community networks. • "Real Men Do Care" campaigns showcasing fathers and men engaged in caregiving and emotional labor with the same prestige as provider roles. • Engage role models on self-care as responsibility. ***Long-term:*** • Normalize rest and reflection as responsible acts through national media. • Institutionalize "Responsible Fatherhood" programs linking well-being and duty. • Shift cultural narratives to explicitly value emotional labor and caregiving as masculine strengths essential to family and social well-being.	**Primary:** NGOs, community councils, labor groups. **Supporting:** Employers, media, fatherhood organizations.	All
	Practitioner	**Mainstream self-care through male-oriented practice.** ***Short-term:*** • Introduce "Stress and Strength" workshops for working men. • Train counselors to validate stoicism while expanding coping tools. ***Long-term:*** • Embed preventive self-care components in therapy models. • Develop peer-led workplace wellness systems.	**Primary:** Health services, occupational clinics. **Supporting:** NGOs, HR teams, universities.	All
3. Progress Without Practice Respondents endorse equality and empathy but rarely act: attitude-behavior gap persists.	Policy	**Turn awareness into systemic behavioral change.** ***Short-term:*** • Subsidize initial counseling sessions. • Embed help-seeking triggers in schools, military, workplaces. ***Long-term:*** • Integrate emotional literacy in national curricula. • Track gendered help-seeking rates in national surveys.	**Primary:** Ministries of Health, Labor, Education. **Supporting:** Behavioral scientists, NGOs.	All (Priority: GEO)

	Advocacy	**Bridge belief and behavior.** ***Short-term:*** • "From Belief to Action" media campaigns using real men's stories. • Peer endorsement of therapy as courage. ***Long-term:*** • Institutionalize help-seeking visibility in sport and media. • Publicize annual progress to sustain cultural shift.	**Primary:** Advocacy NGOs, digital media partners. **Supporting:** Peer groups, influencers.	All
	Practitioner	**Simplify access and reinforce behavioral uptake.** ***Short-term:*** • Provide free or anonymous first sessions. • Offer practical, solution-focused short-term counseling. ***Long-term:*** • Integrate referral pathways from informal to professional help. • Publish anonymized data to model change.	**Primary:** Mental health providers, employers. **Supporting:** Universities, associations.	All
4. Peer Networks as Gatekeepers Men rely on peers and partners for support but rarely connect to professionals.	Policy	**Institutionalize peer-professional integration models.** ***Short-term:*** • Recognize peer support as a valid entry point to care. • Provide funding for pilot peer-mentor programs. ***Long-term:*** • Embed peer support infrastructure in national mental health systems. • Certify trained peer navigators as adjunct service providers.	**Primary:** Ministries of Health, NGOs. **Supporting:** Peer orgs, universities, WHO.	All
	Advocacy	**"Be the Bridge" campaigns for supportive peers.** ***Short-term:*** • Develop simple peer toolkits for helping a friend. • Public messaging: "You can help him find help". ***Long-term:*** • Normalize peer-facilitated referrals as social responsibility. • Showcase peer success stories nationally.	**Primary:** NGOs, youth groups, digital campaigns. **Supporting:** Sports clubs, workplaces.	All

	Practitioner	**Create bridges between informal and formal care.** ***Short-term:*** • Train professionals to work with partners/friends as allies. • Pilot "couple or peer entry" sessions. ***Long-term:*** • Scale Mental Health First Aid programs. • Develop hybrid community-psychology models.	**Primary:** Mental health services, peer orgs. **Supporting:** Workplaces, local governments.	All
5. Generational Flux and Uncertainty Younger men show norm fluidity; older generations retain stoicism.	Policy	**Integrate intergenerational masculinity dialogue in education.** ***Short-term:*** • Support youth programs exploring "What it means to be a man today". • Include gender empathy in civic curricula. ***Long-term:*** • Institutionalize mentorship between older and younger men. • Add emotional literacy modules to national education standards.	**Primary:** Ministries of Education, Youth Affairs. **Supporting:** Universities, NGOs, cultural centers.	ARM, MDA
	Advocacy	**Leverage youth openness and respect elders.** ***Short-term:*** • Youth campaigns via TikTok/Instagram featuring humor and relatability. • "Respectful Masculinity Evolution" dialogues in communities. ***Long-term:*** • National intergenerational programs linking resilience to emotional healing.	**Primary:** Youth orgs, social media partners. **Supporting:** Veteran & elder orgs, universities.	MDA (youth-heavy), ARM
	Practitioner	**Design age-sensitive engagement.** ***Short-term:*** • Youth-oriented counseling styles; digital access. • Older-men outreach via community centers. ***Long-term:*** • Train age-diverse counselors. • Develop men's groups bridging age cohorts.	**Primary:** Health institutions, NGOs. **Supporting:** Universities, local councils.	ARM, MDA

6. Economic Precarity and Provider Trap Financial insecurity reinforces stoicism and limits help-seeking.	Policy	**Address economic roots of provider anxiety.** ***Short-term:*** • Subsidize mental health services for low-income men. • Partner with Belarusian charities, diaspora organizations, and crowdfunding initiatives to subsidize access to mental health services for financially vulnerable men. • Tax incentives for employers offering counseling. ***Long-term:*** • Establish paid mental health leave and anti-discrimination laws. • Link welfare programs to psychosocial support.	**Primary:** Ministries of Finance, Labor, Health. **Supporting:** Donors, employers, unions.	BLR, ARM, MDA
	Advocacy	**Link well-being to productivity.** ***Short-term:*** • Campaigns: "Healthy mind = strong provider." • Publicize the economic cost of untreated distress. ***Long-term:*** • Integrate men's well-being into economic development agendas.	**Primary:** NGOs, media, employers. **Supporting:** Economic think tanks, unions.	All
	Practitioner	**Integrate financial counseling and stress management.** ***Short-term:*** • Screen for economic distress during intake. • Offer financial resilience workshops (including targeted support for exiled Belarusians, former political prisoners, and economically displaced men). ***Long-term:*** • Collaborate with employment centers to link economic aid and therapy.	**Primary:** Health providers, employment agencies. **Supporting:** NGOs, donor programs.	All

7. Violence–Distress–Silence Nexus High exposure to violence; trauma unspoken or normalized, including likelihood of underreporting of sexual violence against men due to masculine shame	Policy	**Institutionalize trauma-informed service architecture.** ***Short-term:*** • Mandatory trauma training for providers. • Anonymous trauma self-assessment tools online. ***Long-term:*** • Develop national trauma-response frameworks. • Link mental health policy with transitional justice. • Establish veteran-specific mental health services staffed by professionals trained in military culture and combat-related trauma. • Integrate community-based trauma healing and reconciliation mechanisms where appropriate, addressing collective and intergenerational trauma.	**Primary:** Ministries of Health, Justice. **Supporting:** NGOs, trauma experts, OHCHR.	All
	Advocacy	**Normalize trauma recovery as courage.** ***Short-term:*** • "Healing Is Strength" campaigns. • Create survivor-led storytelling platforms. • Develop carefully designed awareness campaigns addressing sexual violence against men, explicitly challenging shame and stigma (e.g. "Being victimized does not make you less of a man"). ***Long-term:*** • Support programs helping veterans and conscripts redefine post-service identity beyond militarized masculinity, integrating care, civic engagement, and emotional well-being. • Challenge rape myths through sustained public education, explicitly acknowledging that men can be victims of sexual violence and deserve support and justice.	**Primary:** Survivor-led NGOs, human rights orgs. **Supporting:** Media, CSOs.	All, specific focus on ARM, GEO, and BLR
	Practitioner	**Adopt universal trauma-informed practice.** ***Short-term:*** • Train all counselors in safety, trust-building, and shame reduction. • Create safe male spaces for disclosure. • Provide specialized training for mental health professionals on working with male survivors of (sexual) violence, with explicit focus on shame, masculinity threat, and fear of disclosure.	**Primary:** Mental health institutions, trauma networks. **Supporting:** Academic centers, CSOs.	All

		Long-term: • Establish male trauma recovery groups and peer-led programs. • Support peer-led veteran and survivor groups where shared experience reduces stigma and builds trust. • Establish male-only survivor support groups and develop clinical protocols specifically addressing (sexual) violence against men within a gender-sensitive, trauma-informed framework.		
8. Political Surveillance and Rational Distrust Authoritarian repression undermines trust in formal help.	Policy	**Guarantee service independence and confidentiality.** ***Short-term:*** • Adopt or amend mental health confidentiality legislation explicitly prohibiting data-sharing between mental health services and state security agencies, except in narrowly defined emergency cases subject to judicial oversight. • Mandate compulsory confidentiality training for all mental health workers, aligned with medical privacy standards. • Establish donor-funded, independent confidentiality audits for state and NGO services, leading to publicly visible "Safe Service" or "Confidential Care" certification. ***Long-term:*** • Institutionalize independent civil-society mental health networks. • Publicize certified "safe services" with clear messaging on zero data-sharing and anonymity guarantees.	**Primary:** Parliament, Ministries of Justice/ Health. **Supporting:** Civil society, human rights bodies.	BLR, ARM, GEO
	Advocacy	**Build trust through transparency.** ***Short-term:*** • Require mental health platforms and service providers to clearly communicate confidentiality standards, limits of information sharing, and user safety protocols directly to users. • Ensure all platforms prominently explain confidentiality practices and data protection measures to users before engagement. ***Long-term:*** • Third-party audits of data safety and independence.	**Primary:** NGOs, rights orgs. **Supporting:** Donors, exile networks.	BLR, ARM, GEO

	Practitioner	**Ensure genuine safety in practice.** ***Short-term:*** • Train providers in anonymity, data ethics, and encrypted communication. • Expand anonymous chat-based and text-based counseling platforms that allow men to seek support without face-to-face exposure or formal registration. ***Long-term:*** • Establish (diaspora-accessible,) encrypted online therapy networks.	**Primary:** Service providers, IT experts. **Supporting:** NGOs, tech firms.	BLR
9. Service Infrastructure Gaps Over-institutionalized systems, rural inequality, workforce shortage.	Policy	**Shift from hospital to community-based models.** ***Short-term:*** • Pilot community mental health centers. • Train GPs in psychosocial screening. • Fund development of digital mental health tools (apps, online screening, anonymous chat-based counseling) in local languages, prioritizing confidentiality and low-threshold access. ***Long-term:*** • Support legislative and budgetary reforms to shift funding from psychiatric hospitals to community-based services. • Integrate mental health into universal coverage. • Integrate digital mental health services into national eHealth and public health strategies, ensuring sustainable funding, regulation, and quality standards.	**Primary:** Ministries of Health. **Supporting:** WHO, EU programs, NGOs.	All
	Advocacy	**Promote equity and decentralization.** ***Short-term:*** • Mobilize rural leaders for service advocacy. • Mobilize community actors and diaspora networks for service advocacy while ensuring services remain nonpartisan and not affiliated with political movements. • Use evidence on unmet needs. ***Long-term:*** • Campaign for community-centered funding priorities.	**Primary:** NGOs, community orgs. **Supporting:** Local governments, donors.	All

	Practitioner	**Develop mobile and local access (mental) health models.** ***Short-term:*** • Deploy mobile clinics offering general health check-ups with integrated psychosocial support to reduce stigma and facilitate discreet access in rural areas. • Establish low-threshold walk-in centers. • Offer blended care models combining in-person counseling with app-based support and secure messaging between sessions. ***Long-term***: • Train, promote, and deploy male community counselors. • Train mental health professionals in digital therapeutic tools and online service delivery to reach rural, mobility-limited, and politically constrained populations.	**Primary:** Health ministries, local CSOs. **Supporting:** Universities, NGOs.	All
10. Service Feminization and Provider Gaps Men perceive therapy as feminized; lack of male providers and gender alignment.	Policy	**Foster male inclusion and diversity in the mental health workforce.** ***Short-term:*** • Scholarship programs for male psychology students. • Incentives for male practitioners in rural areas. • Pilot educational programs targeting both educators and students on normalization of gender norms and egalitarian gender roles ***Long-term:*** • Balance gender ratios in mental health professions. • Support inclusive service design through policy mandates. • Develop targeted educators programs to normalize gender roles, educate on psycho-social support. • Develop targeted student educational programs, specifically targeting boys and male students, on gender-roles and help-seeking normalization and educate on psycho-social support.	**Primary:** Ministries of Education, Health. **Supporting:** Universities, professional associations.	MDA, ARM

	Advocacy	**De-feminize the public image of therapy.** ***Short-term:*** • Campaigns featuring men in therapy as competent and composed. • Highlight diversity in mental health careers. ***Long-term:*** • Collaborate with male advocates to normalize emotional openness.	**Primary:** NGOs, media orgs. **Supporting:** Influencers, sports icons.	MDA, ARM
	Practitioner	**Develop male-inclusive therapeutic environments.** ***Short-term:*** • Redesign clinics for privacy and neutrality, emphasize low-threshold access. • Offer "performance optimization" framing. ***Long-term:*** • Institutionalize gender-sensitive, youth-friendly, age-appropriate therapy training and participatory design.	**Primary:** Service providers, design experts. **Supporting:** Professional schools, NGOs.	All

Annex 5.

Full questionnaire

Understanding How Men Seek Psycho-Social Support: Research for Action and Advocacy

QQ for CAWI SURVEY

Yerevan, October 17, 2025

Introduction and agreement

Hello!

Through this survey, we'd like to hear from you about an important topic: how men like you take care of their well-being. By sharing your experience, you'll help shape a better understanding of how to make support more accessible and helpful for men.

It will only take about 15 minutes. Your answers are completely confidential, and you can skip any question you're not comfortable answering.

The survey is conducted by **CRRC-Armenia Foundation**, an independent non-partisan research institute based in Armenia, with support from **MÄN**, a Swedish civil society organization working for men's health and gender balance.

Thank you for taking part - your voice truly matters!

If you are a man aged 18 or above who resides in, or originates from, Armenia, Georgia, Belarus, or Moldova, we kindly invite you to answer the following questions.

Language. Please, select the language in which you would prefer to take part in the survey:

Armenian	1
Georgian	2
Russian	3
Romanian	4
English	5

Agreement. Do you agree to participate?

Yes	1
No	2 [FINISH]

Section E: Eligibility

Q1. I confirm that I am male and/or identify as male, and that I am 18 years old or older.

Yes	1
No [Finish]	2
Refuse to Answer [Finish]	-99

Q2. Which of the following countries have you been mainly living in at least during the last 1 year or more?

Armenia	1
Georgia	2
Moldova	3
Belarus	4
Other (Please, specify)	999
Refuse to Answer	-99

Q3. Where are you originally from?

[Ask if Q2 = 999]

Armenia	1
Georgia	2
Moldova	3
Belarus	4
Other [Finish]	999
Refuse to Answer [Finish]	-99

BQ4. What is your age? Please enter "0" if you don't want to answer.

Q5. What kind of settlement do you live in?

In the capital city	1
In another city/town	2
In a village	3
Refuse to Answer	-99

Section A. Country-specific & Contextual Differences

A1. For whom is it generally more acceptable to seek help for emotional or mental health problems in your community?

More for men	1
More for women	2
Equally for both	3
For none of them	4
Don't Know	-98
Refuse to Answer	-99

A2. Are formal emotional or psychological support services (e.g., psychologists, mental health professionals, or medical institutions) available in your community?

Yes	1
No	2
Don't Know	-98
Refuse to Answer	-99

Section B: Masculinity & Social Roles

B1. What do you consider to be the most important things for you to do, specifically as a man? Please, select up to **three** roles.

[Technical instruction: Randomize the options]

Provide financially for my family	1
Express my emotions openly	2
Be a father	3
Protect the motherland	4
Show affection to loved ones	5
Make important decisions and take the lead	6
Spend quality time with family	7
Keep my family safe	8
Care for people around me	9
Be actively involved in my community or society	10
Other (Please, specify)	999
Don't Know	-98
Refuse to Answer	-99

B2. What do you think society expects men to do? Please, select up to **three** roles.

[Technical instruction: Randomize the option]

Provide financially for my family	1
Express my emotions openly	2
Be a father	3
Protect the motherland	4
Show affection to loved ones	5
Make important decisions and take the lead	6
Spend quality time with my family, partner, or children	7
Keep my family safe	8
Care for people around me	9
Be actively involved in my community or society	10
Other (Please, specify)	999
Don't Know	-98
Refuse to Answer	-99

B3. According to you, which of the following traits should a "real man" have? Please, select up to **three** traits.

[Technical instruction: Randomize the options]

Trait	Code
Strength and resilience	1
Emotional control and anger management	2
Leadership and decision-making	3
Courage to act	4
Rational thinking	5
Honesty and integrity	6
Responsibility	7
Dominance	8
Independence	9
Empathy	10
Don't know	-98
Refuse to answer	-99

B4. In your opinion, who should be the primary responsible for the following tasks?

		Mostly women	Mostly men	Both equally	Don't know	Refuse to answer
a	Caregiving and domestic tasks (e.g., cooking, cleaning, childcare)	1	2	3	-98	-99
b	Reproductive health decisions (e.g., family planning, contraception)	1	2	3	-98	-99
c	Financial Decisions for Households	1	2	3	-98	-99

B5. Please indicate how much you agree or disagree with following statements:

[Technical instruction: Randomize the options]

	Statements	Strongly agree	Agree	Disagree	Strongly disagree	Don't Know	Refuse to Answer
a	Men should solve their own problems without seeking help	1	2	3	4	-98	-99
b	Men should never use physical violence in a personal relationship	1	2	3	4	-98	-99
c	A man has to be monogamous	1	2	3	4	-98	-99
d	Men should always ask for consent before sexual activity, even if you are in a committed relationship	1	2	3	4	-98	-99
e	Men who show care or affection toward other men are weak	1	2	3	4	-98	-99
f	All men should be treated with equal respect regardless of their sexual orientation	1	2	3	4	-98	-99

Section C. Awareness & Attitudes Toward Psycho-social Support

C1. In general, how comfortable are you to talk about your emotions or personal difficulties with other people?

Very uncomfortable	1
Somewhat uncomfortable	2
Neutral	3
Somewhat comfortable	4
Very comfortable	5
Don't know	-98
Refuse to Answer	-99

C2. Over the last two weeks, how often have you been bothered by the following problems?

		Not at all	Several days	More than half the days	Nearly every day	Don't know	Refuse to Answer
a	Feeling nervous, anxious, or on edge	1	2	3	4	-98	-99
b	Not being able to stop or control worrying	1	2	3	4	-98	-99
c	Little interest or pleasure in doing things	1	2	3	4	-98	-99
d	Feeling down, depressed, or hopeless	1	2	3	4	-98	-99

C3. When you face personal or emotional challenges, which of the following sources of support would you feel **most comfortable** talking to? Please select up to **two** options.

Friends	1
Wife/partner	2
Other family member(s)	3
Religious leaders	4
Psychologists/mental health professionals	5
Community organizations	6
Online platforms	7
Other (Please, specify)	999
Don't Know	-98
Refuse to Answer	-99

C4. When you face personal or emotional challenges, which of the following sources of support would you feel **least comfortable** talking to? Please select up to **two** options.

[Technical instruction: Remove options selected in C4]

Friends	1
Wife/partner	2
Other family member(s)	3
Religious leaders	4
Psychologists/mental health professionals	5
Community organizations	6
Online platforms	7
Other (Please, specify)	999
Don't Know	-98
Refuse to Answer	-99

C5. According to you, what could make psycho-social support more accessible for men who experience emotional, psychological, or mental health issues? Please select up to three options.

[Technical instruction: Randomize the options]

More information about available services and how they can help	1
Affordable or free services	2
Confidential and anonymized services	3
Receiving support family and friends to men's decision to apply for services	4
Support programs which provide resources, services, and opportunities to individuals and families in their own communities	5
Receiving support from male professionals only	6
Receiving support from female professionals only	7
Receiving support with other men together (men group support)	8
Other (Please, specify)	999
Don't Know	-98
Refuse to Answer	-99

Section BE: Behaviour / Experience

BE1. In the past 12 months, how often have you sought personal or professional support when facing emotional, psychological or mental health challenges or difficulties?

Once	1
More than once	2
Never	3
Don't Know	-98
Refuse to Answer	-99

BE2. From whom have you sought support before? Please, select **all** that apply.

[Ask if BE1 = 1, 2]

Friends	1
Wife/Partner	2
Other family member(s)	3
Religious leaders	4

Psychologists	5
Other mental health professionals	6
Doctors	7
Community organizations	8
Online platforms or forums	9
No one, but I would have wanted to	10
No one, and I would never want to	11
Other (Please, specify)	999
Don't Know	-98
Refuse to Answer	-99

BE3. Think of a time when you felt you needed professional help for your emotional or mental health challenges but decided not to seek support. What was/were the reason(s) for your decision? Please, select **all** that apply.

[Technical instruction: Randomize the options]

What other people might think of me if they would find out	1
Wanting to keep my challenges private	2
I should handle problems on my own as a man	3
Services were too far away	4
Feeling that the professionals would be unwelcoming to me, because of my ethnicity, religion, gender, language, etc.	5
Concern about government or authorities finding out	6
Services were very / too expensive	7
I did not know where to seek support	8
Other (please specify)	999
Don't Know	-98
Refuse to Answer	-99

Note:
Now we want to ask a question which might be sensitive for you. If you don't feel comfortable with this question, please select Refuse to answer.

BE4. Have you ever personally experienced any of the following forms of violence or abuse? Please, select **all** that apply.

Physical violence	1
Emotional/psychological abuse	2
Sexual violence	3
Economic violence	4
Political Violence	5
None of the above	6
Refuse to answer	-99

BE5. If a male friend came to you for emotional or mental support, what would be the first thing you would do?

[Technical instruction: Select only one option]

[Technical instruction: Randomize the options]

I would refer him to formal support services (e.g., psychologists, mental health professionals, or medical institutions)	1
I would refer him to informal support services (e.g., friends, family members)	2
I would listen and try to help him myself and try to give advice	3
I would listen and move forward	4
I wouldn't know what to say or to do	5
Other (please, specify)	999
Don't know	-98
Refuse to answer	-99

Section SE: Socio-Economic status

SE0. There are a number of ethnic groups living in your country. Which ethnic group do you consider yourself a part of?

Armenian	1
Georgian	2
Moldovian	3
Belarussian	4
Other (Please specify)	999

SE1. Which of this best describes your current employment status?

Retired and not employed	1
Student and not employed	2
Not employed and not looking for a job	3
Not employed but looking for a job	4
Employed, working either part-time or full time (even if you are retired or a student), including seasonal work	5
Self-employed (even if you are retired or a student), including seasonal work	6
Disabled and unable to work	7
Other (please, specify)	999
Don't know	-98
Refuse to answer	-99

SE2. What is your highest level of education?

No primary education	1
Primary education (either complete or incomplete)	2
Incomplete secondary education	3
Completed secondary education	4
Secondary technical education	5
Incomplete higher education	6
Completed higher education (BA, MA, or Specialist degree)	7
Don't know	-98
Refuse to answer	-99

SE3. What is your marital status?

Single	1
Married/partnered, with kids	2
Married/partnered, without kids	3
Divorced/separated, with kids	4
Divorced/separated, without kids	5
Widowed, with kids	6
Widowed, without kids	7
Refuse to Answer	-99

SE4. How would you describe your financial situation?

Very good	1
Comfortable	2
Just getting by	3
Struggling	4
Don’t Know	-98
Refuse to Answer	-99

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