Associations Between Restrictive Masculinity and Depression Across Sexual and Gender Identities

JONATHAN K. NOEL, PhD, MPH; ABIGAIL G. NOSAL; KELSEY A. GATELY, OTD, OTR/L; SAMANTHA R. ROSENTHAL, PhD, MPH

ABSTRACT

INTRODUCTION: The current study examined associations between believing in restrictive masculinity norms and depression in a sample of Rhode Island young adults.

METHODS: Data from the 2024 Rhode Island Young Adult Survey (n=1008) was used. Restrictive masculinity was measured using a 12-item questionnaire. Depression symptoms were assessed with the CES-D10. Logistic regression models assessed main effects after stratification by sexual and gender status and adjusting for age, race, ethnicity, and social status.

RESULTS: Overall, 45.5% screened positive for depression. Restrictive masculinity was positively associated with a positive depression screen, but only among cisgender heterosexual males (OR[95%CI]=1.05 [1.01,1.10]).

CONCLUSIONS: Lowering the healthcare burden of depression may require providers to be trained to identify restrictive masculinity norms, particularly among cisgender heterosexual males, and to understand how holding such norms can influence the manifestation of depression symptoms.

KEYWORDS: masculinity; depression; young adults

INTRODUCTION

Restrictive masculinity is characterized by the internalization of rigid traditional masculine norms that dictate male behavior.[1,2] These norms promote emotional suppression, dominance, self-reliance, and avoiding vulnerability, which reinforce gender inequality and shapes how depression symptoms manifest in men. Within this construct, male dominance is promoted in financial, sexual, and societal domains, and strict behavioral expectations are enforced.[1,3-5] Consequently, emotional suppression linked to these norms is idealized and increases psychological distress, reduces help seeking, and increases the risk for untreated depression.[2,6] Conforming to "anti-femininity" ideals – a core component of restrictive masculinity that rejects traits like emotional expressiveness, empathy, and dependence – fosters hostility and suppresses emotional distress, further worsening mental health outcomes.[3,7] Within this framework, these traits are devalued, reinforcing the idea that femininity and masculinity are strictly separate.[8,9] By rejecting femininity, restrictive masculinity not only dictates behavioral expectations for men, but also enforces a system where anything perceived as feminine is stigmatized. This deepens gender inequality and increases psychological distress in men who struggle to meet these narrow expectations.[10,11] Importantly, among cisgender heterosexual men, adherence to restrictive masculinity has been associated with a higher likelihood of depressive symptoms.[4]

Broadly, depression is a prevalent concern among young adults. In Rhode Island; approximately 29.2% of young adults aged 18–25 reported experiencing a mental health condition in 2022,[12] and nationally, depressive symptoms among young adults aged 18–29 were estimated at 21% in 2019, driven by growing societal pressures.[13,14] Large disparities across sexual and gender identities in depression rates have been noted, which may be at least partially explained by social and cultural expectations surrounding gender roles.[8,10] Sexual and gender minorities (SGM) often experience higher rates of depression compared to cisgender heterosexual individuals, and nearly 49% of persons identifying as a sexual minority screened positive for depression, compared to 19.5% of heterosexual individuals.[15] Others have reported that SGM individuals have up to three times the odds of experiencing depressive symptoms compared to cisgender, heterosexual peers.[15,16] SGM populations, generally, face a heightened risk of depression due to discrimination, stigma, and insufficient support systems, and understanding these disparities requires examining how gender norms and social status interact with mental health outcomes.[10,15,16]

Among cisgender heterosexual men, depression is widely underreported due to societal pressures discouraging emotional expression and help-seeking. Nearly 50% of men with depressive symptoms do not seek professional help,[4,7] and restrictive masculinity beliefs strongly correlate with higher depressive symptoms, with men conforming to these norms reporting 25% higher depression scores.[3] Additionally, men adhering to rigid masculine expectations are 2.5 times more likely to experience mental distress.[11] These norms influence how depression manifests, with men often displaying externalizing behaviors like substance abuse, risk-taking, and social withdrawal, perpetuating a cycle where restrictive masculinity both increases vulnerability to depression and prevents treatment-seeking.[2,5]

Across all sexual and gender status (SGS) groups, societal norms shape beliefs in, and impact of, restrictive masculinity, with significant implications for mental health, including differential presentation of depression symptoms. Masculinity norms discourage emotional expression and help-seeking behavior, as men fear being perceived as weak or vulnerable.[4,7] These internalized expectations often lead men to isolate themselves and suppress emotional struggles, further complicating their mental health.[6,17] As a result, depression in cisgender heterosexual males often manifests through externalized behaviors, such as aggression, rather than internalized symptoms like sadness, leading to underdiagnosis and untreated depression.[18] For men who do not identify as heterosexual, societal expectations of masculinity often clash with their sexual identity, increasing isolation and mental health struggles.[17,19] Transgender men face challenges related to masculinity and gender expression, leading to emotional distress as they navigate conflicting gender expectations.[16,20] Similarly, non-binary individuals also encounter societal pressures and discrimination related to gender expectations, leading to social isolation, which contribute to depression.[20]

Existing evidence suggests that restrictive masculinity is a risk factor for depression and shapes the manifestation of depression symptoms. Here, we examine the association of restrictive masculinity and depression across different SGS groups in a sample of Rhode Island young adults. It was hypothesized that belief in restrictive masculinity norms would be associated with depression across all SGS groups.

METHODS

This study used data from the 2024 Rhode Island Young Adult Survey (RIYAS), which was a cross-sectional survey containing mental health and related behaviors administered to young adults in Rhode Island.

Sample

The 2024 RIYAS was implemented by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals and administered between May and August 2024 to individuals who were 18–25 years old and lived in Rhode Island. Participants were recruited through paid social media ads (e.g., Instagram) and Spotify, which was supplemented by recruitment through flyers and emails to students at local colleges and universities. All responses were collected via self-report, and participants received a $10 electronic gift card upon completion. Here, n = 1,008 surveys were completed, and all are included in the present analysis. Informed consent was provided via electronic affirmation, and the study was approved by the Institutional Review Board at a local university.

Measures

Restrictive masculinity was assessed using a 12-item questionnaire whose factor structure has been previously determined,[21] and items measured perceived roles of men in the household, at work, and in society. Responses were collected on a 5-point Likert scale ranging from *strongly disagree* (coded as 1) to *strongly agree* (coded as 5). Item level responses were aggregated by summation (α = 0.76), and higher scores indicated greater agreement with restrictive masculinity norms.

Depression symptoms were assessed using the 10-item Center of Epidemiologic Studies Depression Scale (CES-D10).[22] Items measured past week symptoms related to the development of depression, and responses were collected on a 4-point Likert scale ranging from *rarely or none of the time* (coded as 0) to *most of the time* (coded as 4). Two items were reverse coded. Item level scores were aggregated by summation (α α = 0.78), and participants with scores ≥10 were classified as screening positive to depression (coded as 1).

Several covariates were also assessed, including age, sexual and gender status (SGS), race/ethnicity, and relative social status. SGS included *cisgender heterosexual male, cisgender heterosexual female,* and *sexual and gender minority,* while race and ethnicity were combined into a single item that included *White, non-Hispanic; Black, non-Hispanic; Hispanic, Asian, non-Hispanic;* and *Other/Multiracial, non-Hispanic*. Relative social status was assessed using the MacArthur Scale of Subjective Social Status.[23]

Analysis

The distributions of continuous variables were examined and deemed normally distributed, and descriptive statistics are reported for all variables. Bivariate two-sample t-tests and chi-square tests were used to identify correlations with depression screening status. Then, due to depression screening status being a dichotomous variable, logistic regression models were used to determine the main effect of restrictive masculinity, after adjustment for all covariates. Because of previously identified differences in restrictive masculinity norms across SGS groups,[21] the analysis was stratified by SGS groups to determine if the relationship between restrictive masculinity and depression screening status was consistent across groups. The analysis was conducted using Stata Version 15 (College Station, TX: StataCorp LLC), and statistical significance was determined using 95% confidence intervals (CIs) at α = 0.05.

RESULTS

In the sample, 20.1% identified as cisgender heterosexual males, and 57.4% identified as White, non-Hispanic (**Table 1**). Mean age was 21.3 years old (SE = 0.07), and mean relative social status was 5.7 (SE = 0.06), which is approximately the mid-point of the scale. Mean restrictive masculinity

Table 1. Descriptive statistics and bivariate correlations (N = 1,008)*

	Overall (%)	Positive Depression Screen n = 458 (45.4%)	Negative Depression Screen n = 550 (54.6%)	*p*
Age [Mean (SE)]	21.3 (0.07)	21.1 (0.10)	21.1 (0.09)	0.859**
Sexual and Gender Status				**<0.001*** **
Cisgender Heterosexual Male	203 (20.1)	54 (11.8)	149 (27.1)	
Cisgender Heterosexual Female	363 (36.0)	142 (31.0)	221 (40.2)	
Sexual and Gender Minority	442 (43.9)	262 (57.2)	180 (32.7)	
Race/Ethnicity				0.693***
White, non-Hispanic	579 (57.4)	271 (59.2)	308 (56.0)	
Black, non-Hispanic	77 (7.6)	34 (7.4)	43 (7.8)	
Hispanic	197 (19.5)	89 (19.4)	108 (19.6)	
Asian, non-Hispanic	86 (8.5)	33 (7.2)	53 (9.6)	
Other/Multiracial, non-Hispanic	69 (6.9)	31 (6.8)	38 (6.9)	
Social Status [Mean (SE)]	5.7 (0.06)	5.27 (0.09)	6.06 (0.07)	0.248**
Restrictive Masculinity [Mean(SE)]	27.3 (0.24)	26.7 (0.36)	27.8 (0.31)	**0.023*** **

*bold indicates statistical significance; **two-sample t-test; ***chi-square test

Table 2. Adjusted odds of screening positive for depression after stratification by sexual and gender status*

	Cisgender Heterosexual Males		Cisgender Heterosexual Females		Sexual and Gender Minorities	
	OR	95% CI	OR	95% CI	OR	95% CI
Age	1.04	0.89, 1.20	1.01	0.092, 1.12	1.00	0.92, 1.09
Race/Ethnicity						
White, non-Hispanic	1.00	ref	1.00	ref	1.00	ref
Black, non-Hispanic	2.06	0.78, 5.45	0.93	0.42, 2.06	0.63	0.26, 1.54
Hispanic	1.13	0.49, 2.58	0.95	0.54, 1.67	0.87	0.52, 1.47
Asian, non-Hispanic	0.49	0.13, 1.83	0.88	0.41, 1.91	1.14	0.52, 2.50
Other/Multiracial, non-Hispanic	2.91	0.70, 12.05	0.60	0.24, 1.53	0.78	0.37, 1.64
Social Status	0.89	0.74, 1.06	**0.81**	**0.70, 0.93**	**0.74**	**0.66, 0.83**
Restrictive Masculinity	**1.05**	**1.01, 1.10**	1.01	0.98, 1.04	1.02	0.99, 1.06

*bold indicates statistical significance

score was 27.3 (SE = 0.24), which is slightly below the scale's mid-point.

In the bivariate analysis, sexual and gender status ($p < 0.001$) and restrictive masculinity score ($p = 0.023$) were correlated with screening positive for depression (**Table 1**). After stratification by sexual and gender status, and adjustment for all variables, restrictive masculinity remained associated with screening positive for depression only among cisgender heterosexual males (OR[95%CI] = 1.05 [1.01, 1.10]) (**Table 2**). Additionally, relative social status, which was not associated with depression status in the bivariate analysis ($p = 0.248$) (**Table 1**), was associated with lower odds of screening positive for depression in the stratified adjusted analysis, although only among cisgender heterosexual females (OR[95%CI] = 0.81 [0.70, 0.93]) and persons who identify as a sexual or gender minority (OR[95%CI] = 0.74 [0.66, 0.83]).

DISCUSSION

The present study shows that higher restrictive masculinity scores were associated with increased odds of screening positive for depression in cisgender heterosexual males, which is consistent with previous research,[2,4,9] although no significant effects were detected in other SGS groups. However, higher social status among persons who identify as a cisgender heterosexual female or any sexual or gender minority was negatively associated with screening positive for depression, which is also consistent with previous literature.[2,4,9]

The relationship between restrictive masculinity norms and depression is particularly pronounced among cisgender heterosexual men.[9] Adherence to self-reliance, emotional suppression, and stoicism is linked to higher depressive symptoms,[24] and societal expectations for men to be tough and emotionally restrained contribute to depression and

create barriers to early intervention.[25] Cultural influences shape how masculine norms contribute to depression, and across cultures, masculinity is often linked to dominance, control, and self-sufficiency, reinforcing the belief that seeking psychological support is a sign of weakness.[24,26] These pressures heighten the risk of depressive symptoms and isolate men by preventing access to essential social or medical support.[9,24]

Restrictive masculinity also significantly delays the recognition and treatment of depression, as men are less likely to acknowledge symptoms that contradict societal ideals of strength and independence.[4] This often leads to delayed help-seeking, reinforcing psychological distress and isolation.[26,27] The stigma around emotional vulnerability further discourages men from engaging in mental health services, contributing to underdiagnosis and undertreatment.[3,7] Individuals who identify as cisgender heterosexual females and SGMs often have greater societal permission to express emotions, which serves as a protective factor.[14] While cisgender heterosexual females and some SGM individuals may recognize or accept restrictive masculine norms, they are also less likely to internalize them as strongly as cisgender heterosexual men.[24] Cisgender heterosexual females in particular often experience less psychological distress related to restrictive masculinity because their gender identity is not as directly tied to fulfilling traditional masculine roles.[8,9] For SGM individuals, while gender identity and minority stress complicate outcomes, a greater willingness to seek support buffers against negative effects.[15]

Additionally, higher socioeconomic status protects against depression for cisgender heterosexual females and SGM populations by increasing access to mental health resources.[16] However, this benefit is not seen in cisgender heterosexual men, as the pressure to conform to masculine ideals often overrides the advantages of high social status.[24] In contrast, men's mental health is more closely tied to meeting societal expectations of masculinity than to financial or professional success.[25]

Implications

Healthcare providers must be trained to recognize and address barriers to care created by restrictive masculinity beliefs through integrated clinical assessments, professional training, and public health initiatives. An important step in addressing masculinity-related barriers to mental health care is improving diagnostic practices. Traditional criteria for depression may overlook how restrictive masculinity influences symptom presentation, as men often exhibit externalizing behaviors like irritability and aggression instead of sadness or withdrawal.[2] This can lead to underdiagnosis and undertreatment. Incorporating masculinity-informed assessments into routine screenings and refining tools to align with male-specific symptoms can improve diagnostic accuracy and ensure timely interventions.[1,26]

Improving diagnostic accuracy requires better education and training to foster gender competency in mental health care. Integrating masculinity-related content into medical curricula can enhance clinicians' ability to recognize and address restrictive masculinity in practice.[26] However, professional training on this topic remains underdeveloped and inconsistently implemented.[1,25] Without proper training, clinicians may struggle to recognize and address the ways in which masculine norms affect men's willingness to disclose mental health concerns or seek treatment. Targeted interventions can counteract restrictive masculinity norms by promoting health-supportive conceptions of masculinity. Reframing help-seeking as a sign of strength can encourage men to seek mental health support in ways that align with their identity.[24] Peer-led support initiatives in male-dominated spaces like workplaces, sports teams, and religious organizations have shown promise in normalizing mental health conversations.[11] These approaches leverage familiar social structures, making support more accessible than traditional therapy models.

Clinical interventions should work within the masculine norms framework to encourage mental health engagement. Male-friendly therapeutic models like goal-oriented and action-based interventions have proven effective in engaging men who might resist traditional therapy.[26,28] Structured, solution-focused approaches can improve treatment adherence, while education on emotional expression can challenge beliefs discouraging vulnerability.[25] Additionally, future research should focus on the development of interventions to break down barriers to care among culturally sensitive individuals and the development of novel screening tools that incorporate the impact of restrictive masculinity norms.

Limitations

The current study uses cross-sectional data and causality cannot be inferred. Data is self-reported and subject to recall and social desirability bias. Indeed, it is likely that both restrictive masculinity norms and depression symptoms are underreported. The sample used is not representative of all young adults in Rhode Island as a non-probability sample technique was used and cisgender heterosexual males are underrepresented. Consequently, generalizability of the results to young adults outside Rhode Island may be limited. Additionally, perceptions of masculinity may vary amongst specific SGM subgroups given the diverse intersectional experiences of sex, orientation, gender identity, and expression within this population.

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Authors

Jonathan K. Noel, PhD, MPH, Department of Health Science, College of Health & Wellness, Johnson & Wales University, Providence, RI; Center for Student Research & Interdisciplinary Collaboration (CSRIC), Johnson & Wales University, Providence, RI.

Abigail G. Nosal, Department of Health Science, College of Health & Wellness, Johnson & Wales University, Providence, RI; Center for Student Research & Interdisciplinary Collaboration (CSRIC), Johnson & Wales University, Providence, RI.

Kelsey A. Gately, OTD, OTR/L, Department of Health Science, College of Health & Wellness, Johnson & Wales University, Providence, RI; Center for Student Research & Interdisciplinary Collaboration (CSRIC), Johnson & Wales University, Providence, RI.

Samantha R. Rosenthal, PhD, MPH, Department of Health Science, College of Health and Wellness, Johnson & Wales University, Providence, RI; Center for Student Research & Interdisciplinary Collaboration (CSRIC), Johnson & Wales University, Providence, RI; Department of Epidemiology, Brown School of Public Health, Brown University, Providence, RI.

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Correspondence

Samantha R. Rosenthal, PhD, MPH
Johnson & Wales University
8 Abbott Park Place, Providence, RI, 02903
samantha.rosenthal@jwu.edu