SSM - Qualitative Research in Health 8 (2025) 100596

Contents lists available at ScienceDirect

SSM - Qualitative Research in Health

journal homepage: www.journals.elsevier.com/ssm-qualitative-research-in-health

# Men's mental health service engagement amidst the masculinity crisis: towards a reconstruction of traditional masculinity

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A B S T R A C T

Mental health service underutilisation amongst men is common in the developed world, and Hong Kong is no exception. Some have attributed the phenomenon to conformity to traditional masculinity. Global and local feminist movements and social processes/reforms leading to female advancement across arenas, however, are forcing men to rethink and adapt to new gender roles by "doing", "re-doing" and "undoing" gender. In the current study, masculinity is considered not an entirely toxic or fixed concept but one that can be redefined or reconfigured to become a powerful approach by which service providers can engage and retain male service users. Guided by the health belief model (HBM), we conducted 21 semi-structured in-depth interviews with Hong Kong men aged 18-55. Most of the interviewees had a history of mental distress and suicide and/or self-harm ideation, and some of illicit drug addiction. These men commonly expressed feeling a sense of inadequacy when they encountered mental health problems and tended to utilise alternative coping approaches (e.g. substance use or self-harm) to avoid recognising their problems that required timely and appropriate professional intervention. They largely persisted in cultivating a sense of competency or agency through their ability to provide their families with both tangible and non-tangible support. The study results suggest the efficacy of taking men's unique masculine traits into account and formulating service design and engagement around three elements: (1) engaging potential male service users with purposes that go beyond their emotions/feelings alone; (2) articulating a programme with pragmatic steps and clear, observable and measurable/quantifiable outcomes; and (3) embracing, re-narrating and transforming negative masculinity narratives/beliefs into meaningful ones.

## 1. Introduction

There are consistently low levels of mental health service utilisation amongst adult men in Hong Kong (Shi et al., 2020), a phenomenon also seen in Australia (Harris et al., 2016), the United Kingdom (Galdas et al., 2005) and other developed countries (Dezetter et al., 2013; Gagne et al., 2014). It has been argued that many adverse consequences, such as drug misuse, self-harm and suicide, could be averted with timely intervention (Shi et al., 2022). In Hong Kong, the male-to-female suicide ratio was about 2.28 (males: 19.2 per 100,000; females: 8.4 per 100,000) in 2019 (Centre for Suicide Research and Prevention, 2022). By comparison, the World Health Organization (2019) reports a ratio of 2.33 (males: 12.6 per 100,000; females: 5.4 per 100,000) for the same year. In many countries, suicide rates are between three and five times higher among men than women (Jordan and Chandler, 2019) and yet, men are diagnosed with depression and mood disorders at a far lower rate; this is known as the "gender paradox" (Shelef, 2021, p. 22). This paradox suggests that men may be experiencing distress that is not being adequately identified and addressed by mental health services.

At the same time, it has been observed that men who experience suicidal ideation are less likely than women to use mental health services (Hom et al., 2015), which reduces opportunities for timely intervention. Conversely, such service use hesitance or avoidance is not commonly observed in their female counterparts, who tend to seek treatment more quickly after substance use initiation and upon the onset of a disorder such as drug or alcohol addiction (e.g. Alvanzo et al., 2014; Lewis & Nixon, 2014). Structural factors, including a lack of male-centric mental health resources and the gendered assumptions within mental health service delivery, can limit men's engagement with care. As emphasised in Whitley (2021), addressing men's mental health requires a systemic response that goes beyond individual behaviour to encompass mental health and social services systems' readiness to meet men's needs effectively.

### 1.1. Traditional masculinity

Conformity to traditional masculinity may be a contributor to men's hesitance to engage with mental health services. From a sociological perspective, masculinity is the norms, standards or models to which men in a culture are expected to conform if they wish to interact

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https://doi.org/10.1016/j.ssmqr.2025.100596
Received 15 October 2024; Received in revised form 20 June 2025; Accepted 26 June 2025
Available online 4 July 2025

appropriately and be accepted in the community (Song, 2004). Ongoing research since the 1990s has repeatedly corroborated that conforming to socially approved masculine norms is deleterious to men's overall well-being, with the development of depression not uncommon (Iwamoto et al., 2018). Men are often socialised to suppress and bottle up their emotions, demonstrate toughness, assert independence, and avoid perceived weakness or appearing feminine, all of which has conditioned men to adopt avoidant approaches when it comes to coping with their emotions to prove their manhood (Iwamoto et al., 2018; Rice et al., 2011; Tam & Kwan, 2024). This observation is supported by quantitative studies demonstrating that men who score higher on measures of traditional masculine ideology embrace more negative attitudes towards help-seeking for mental illness (e.g. Berger et al., 2005). In a similar vein, building on Connell's (1995) work on hegemonic masculinity (i.e. social pressure for men to be self-reliant and strong), Best et al. (2016) detailed the ways in which men are socially conditioned to avoid, or even prohibited from, disclosing mental ill-health to others, which in turn exerts a negative impact on service engagement initiation amongst men more broadly. From the social constructionist perspective, the perceived incongruence between help-seeking behaviours and conformity to traditional masculinity may result in a reluctance to seek professional care owing to the fear of stigmatisation (Pattyn et al., 2015).

### 1.2. Rise of the masculinity crisis

Hong Kong represents a unique cultural landscape shaped by a dynamic interplay of Eastern and Western influences, where traditional Chinese masculinity continues to evolve under the impact of both globalised Western masculinities and "Pan East-Asian" soft masculinities (Yu & Sui, 2023). Commonly described as a place where "East meets West," Hong Kong's identity reflects a fusion of its Chinese heritage and its colonial history under British rule (Rochelle, 2015). In contemporary Chinese society, enduring cultural values, such as the emphasis on group harmony and filial piety (Liu & Iwamoto, 2007), continue to hold significance, alongside the importance of occupying a central role within the family and adherence to traditional gender expectations over personal desires or individual preferences (Marshall, 2008; Rochelle, 2015). Tam and Kwan (2024) highlight key themes that characterise Hong Kong Chinese masculinity, including the breadwinner role, the centrality of work, commitment to family values, social respectability, and an increasing focus on romanticism and emotional sensitivity. Their analysis also underscores the shaping influence of social, economic, and political conditions on these masculine ideals and how masculinity is closely tied to men's well-being. Challenges to men's mental health extend beyond conformity to masculine norms and are embedded in broader socio-economic transformations, including changes in labour markets and family dynamics, which have contributed to feelings of marginalisation and created tensions for some Hong Kong men as they navigate shifting gender roles (Leung & Chan, 2014; Yeung, 2013). It is crucial to recognise that masculinity is not merely a psychological trait but a structural construct (Creighton & Oliffe, 2010), and as such, no single model of masculinity is universally applicable. Rather, masculinity is fluid and continually reshaped in response to broader cultural shifts (Song, 2004), reflecting the ongoing evolution of gender norms.

In the wake of successive waves of the feminist movement, both globally and locally, along with social processes and reforms leading to female advancement across arenas—including greater educational attainment and more workplace opportunities—women's societal role has become more prominent than ever before (Leung & Chan, 2014). In Hong Kong, for example, the gender gap in the population aged 15 and above with a post-secondary education is narrowing, and the gross numbers decreased from 1,432,000 in 1996 to 1,002,000 in 2015 (Li & Kam, 2019). In the 2022/23 academic year, the gender ratio of students enrolled in the public-funded higher education programmes was 1.07 (F = 53,080 vs. M = 49,442), with more female than male students seen at all levels of educational attainment in recent years (Census and Statistics Department, 2023). To a certain extent, these ongoing trends may have served to "co-regulate" the societal role of men, resulting in a so-called "men's crisis" or "crisis of masculinity" (Leung & Chan, 2014, p. 216). The term "men's crisis" is placed in quotation marks to indicate that it is not a crisis in an objective or universal sense but rather refers to the precarious nature of hegemonic masculinity. Hegemonic masculinity can be understood as "an identity whose boundaries are clearly drawn and heavily policed, and thus an identity that is easily lost and must constantly be protected" (Mize & Manago, 2018, p. 306). In this view, the notion of "crisis" emerges only when masculinity is perceived as a rigid, fixed identity, one that requires constant vigilance to maintain and safeguard. This, in turn, generates stress, tensions, and power negotiations when responding to the broader, significant shifts in gender identities, setting "the stage for contesting and reinventing established concepts of masculinity and femininity" (Choi & Peng, 2016, p. 149). "Masculinity panics" have been documented in various locations and points in time over the past four centuries (e.g., Kimmel, 2011; Whitehead, 2002). Examples cited in such panics include men no longer claiming to be the sole breadwinners in their families and the growing instability of men's employment (Leung et al., 2019; Lewis, 2001). Alongside these developments, women have started to find their voice and power, with their sense of achievement or fulfilment no longer satisfied merely by being wives and mothers (Kimmel, 2011), whereas the lives of many men have remained the same or even worsened (Reeves, 2022). It is useful here to borrow the concepts of "re-doing gender" (West and Zimmerman, 1987) and "undoing gender" (Bjork, 2015; Risman, 2009) in this study. The former is used to "signify when gendered norms change, producing new forms of masculinities and femininities", whereas the latter is used to "capture situations where gender is of less relevance or importance" (Bjork, 2015, p. 22). There may also be situations in which some aspects of gender are undone while others are still done or re-done (Bjork, 2015; Risman, 2009). In other words, "**doing gender"** refers to the ongoing process of enacting masculinity and femininity through social practices, like being the financial support of the family, and how individuals are held accountable to societal expectations tied to gender roles. "**Re-doing" gender** signifies a shift or change in the established norms of masculinity and femininity, where gendered behaviours or practices are modified to reflect new understandings of what it means to be a man or a woman. "U**ndoing gender**" refers to situations where gender distinctions are minimized or made less relevant. The concepts of "doing gender," "redoing gender," and "undoing gender" (Bjork, 2015; Risman, 2009; West & Zimmerman, 1987) might be useful in reframing hegemonic masculinity traits and turning that into valuable opportunities for engaging male users in the mental health space. To put these concepts into context, many Hong Kong men are currently "doing" (i.e. adhering to traditional masculinity ideology), "redoing" (i.e. renegotiating the boundaries of masculinity and femininity, thereby generating new masculinities and power relations) or "undoing" gender (i.e. making no distinction between masculinity and femininity) (Bjork, 2015; Leung et al., 2019, p. 768). These evolving gender dynamics should be considered when examining men's mental health, as they shape the ways men understand themselves and their mental health needs in the context of a changing social landscape. It is acknowledged that the "masculinities model is arguably the best way forward as it provides a contemporary, theoretical framework for addressing the diversity inherent in men's mental health needs" (Seidler et al., 2018, p. 93).

### 1.3. Research gap

With this masculinity "crisis" as the contextual backdrop, we recognise that the broader societal shifts in power and gender relations may be shaping men's responses to various life setbacks/stressors, including their decisions about whether to engage with mental support services. Male-specific services in Hong Kong remain largely

underdeveloped, despite the increasing recognition of men's unique mental health needs (Leung & Chan, 2014). Fung et al. (2021) found working Hong Kong men with a tertiary level of education to have relatively low scores on knowledge of overall mental health symptoms, with such scores associated with a greater reluctance to seek professional help. However, it is crucial to note that the low engagement with mental health services cannot be attributed solely to men's lack of awareness or knowledge. While improving men's understanding of mental health symptoms and the importance of seeking help is important, it is not sufficient on its own. The broader issue is the lack of male-specific services that are tailored to the unique experiences and needs of men. Inadequate or poorly designed services continue to be a significant barrier for men who may need support but are less likely to engage with the existing offerings. It is well documented that men are not particularly interested in mental health-related initiatives/services and psychosocial interventions, as reflected in their low service utilisation rate (Sagar-Ouriaghli et al., 2019). Research shows the key barriers to mental health help-seeking amongst Chinese men to include "[a] preference [for] self-reliance, seeking help from alternative sources, low perceived need [for] help-seeking, a lack of affordability, [and a] negative attitude toward, or poor experiences with[,] help-seeking" (Shi et al., 2020, p. 8). Similar findings have been reported in other developed economies. For example, Eisenberg et al. (2012) found that 70 % of male college students do not seek counselling services for their mental health issues. Men are also reported to experience greater barriers to accessing care than women (Rochlen et al., 2010), and are also less likely to receive a diagnosis of depression (Johnson et al., 2012; Nadeau et al., 2016). Researchers have repeatedly called for the development of gender-sensitive services that address the unique challenges men face in accessing mental health care. It is essential to focus on not only educating men about mental health but also on developing and enhancing services that are specifically designed to meet their needs, taking into account the social, cultural, and gendered factors that influence their help-seeking behaviors. Without this dual focus on both service development and education, efforts to improve mental health care utilisation among men may remain ineffective (Evans & Wallace, 2008; Inckle, 2014).

### 1.4. Research aim

In a recent study conducted in Hong Kong, a number of male university participants stated that they "do not consider that expressing emotion is unmasculine, and they think that nowadays men are less reticent than previous generations about expressing their emotions in public" (Chan & Cheung, 2021, p. 55). This highlights that shifts in broader societal structures and public consciousness have led to changes in men's views on emotional expression and, potentially, on seeking help for mental health issues. The differentiation in mental health achievement between men and women may therefore be open to challenge, as societal transformations "undo" traditional notions of masculinity and influence men's understanding of their mental health needs.

Our aim in the study reported herein was to explore men's concerns with respect to addressing their mental health issues, as well as their thought processes and coping strategies that do not compromise their perceived locus of control or sense of competence. A central focus of this research is to recognise that the challenge of improving men's mental health service utilisation goes beyond encouraging men to seek help; it also involves ensuring that the services themselves are responsive to the evolving needs of men.

The study's objectives were to identify and elucidate: (1) men's reasons for engaging (or failing to engage) in mental health interventions, and how these behaviors reflect the "doing" and "undoing" of traditional masculinity; (2) the characteristics of men's help-seeking behaviors/patterns, including the ways in which men may "redo" masculinity in their approaches to mental health; and (3) the implications of service design for men, particularly how the "redoing" of masculinity can inform the creation of male-friendly, gender-sensitive services that encourage men to engage with mental health care. Our goal was to generate a theory of change that not only encourages adult men to seek services for their mental health issues but also informs the development of services that are better equipped to meet men's evolving needs in a contemporary context.

## 2. Methodology

### 2.1. Guided theoretical framework: health belief model

We adopted the health belief model (HBM) as a theoretical framework to guide us in designing the interview questions and analysing the data. The HBM was developed in the 1950s based on the assumption that health risks are preventable when people see benefits in mitigating potential health risks by taking certain actions (Green et al., 2020). It can also be used to understand why an individual may or may not engage in preventive health measures (Rosenstock, 2005; Luquis & Kensinger, 2019). The model identifies and organises interventions around the constructs of perceived illness severity and susceptibility, the benefits of and barriers to treatment, cues to action, and self-efficacy (Luquis & Kensinger, 2019; Green et al., 2020). The HBM is conceptualised around the cost-benefit logic, which assumes that people make rational decisions when dealing with health problems. It is apparent that individuals' knowledge of and ability to recognise mental health problems and awareness of the availability of appropriate treatment options are of crucial influence. The HBM is highly relevant, as early identification and intervention can reduce negative health-related illness behaviour, e.g. self-harm/drug addiction/suicide. To explore the perceived barriers to care, unmet service needs and/or service gaps encountered by Hong Kong males at risk of self-harm and/or addictive behaviours, including substance abuse, internet addiction and social withdrawal, an exploratory deductive approach was adopted in this study with the guidance of the HBM. It is hoped that the findings can inform us in formulating practices for more effective intervention and decreasing treatment gaps or delays in the target group.

Green et al. (2020, p. 212) provide concise elucidations for each constructive construct in the HBM. It is helpful to integrate the concepts of hegemonic masculinity traits into HBM because these traits not only influence men's identity and well-being but also shape how they engage with health services, including seeking mental health support.

1. **Perceived susceptibility**: Hegemonic masculinity may lead men to underestimate their vulnerability to mental health issues, viewing emotional struggles as weakness.
2. **Perceived severity**: Men adhering to hegemonic norms may downplay the seriousness of mental health issues, avoiding recognition of their impact to their well-being.
3. **Perceived barriers**: Traditional masculinity presents barriers to seeking help, as mental health services may be seen as feminine or a sign of weakness.
4. **Perceived benefits**: Men may fail to see the benefits of seeking help, believing that it contradicts ideals of strength and independence.
5. **Cues to action**: Social cues to seek help may be ignored, as hegemonic masculinity discourages vulnerability and reliance on others for support.
6. **Self-efficacy**: Hegemonic masculinity encompasses an ingrained belief that self-reliance is the only way to maintain control.

Carpenter (2010) found perceived severity to be a weak predictor of behaviour, with perceived barriers and perceived benefits consistently the strongest such predictors. Similarly, Gulliver et al. (2010) found perceived barriers to deter young adults with poor mental health from seeking help. Although the HBM is primarily used and discussed in the arenas of suicide and drug use, we deemed it useful for exploring Hong Kong men's decision-making process pertaining to the utilisation of

mental health services. Hom et al. (2015) reviewed past studies and attempted to establish the associations between help-seeking and mental health service utilisation using the HBM framework. They revealed that individuals at elevated risk of suicide perceive no need for help, and thus see treatments as unnecessary. The group of interest was also found to prefer self-management and to believe that treatment might not be helpful or effective. Other structural factors, including geographical convenience and availability of care, were also identified as barriers to service use. Law (2020) reported that people who have nearly died of suicide do not find mental health services relevant or helpful; they thus prefer self-reliance over receiving help from others. Sileo and Kershaw (2020) found masculine toughness to be associated with more substance use. The current study focused on exploring the perceived barriers to and benefits of mental health service use amongst men. To increase men's utilisation of services and enhance their motivation for service engagement, we also explored the barriers to taking action from their perspective. By identifying and filling the lacunae in existing services and finding ways to cater to men's needs more effectively, it is hoped that we will see a behavioural change in men's service utilisation.

### 2.2. Research methods

This study constitutes qualitative research that focuses on and captures "the meanings, views, perspectives, experiences and/or practices expressed in the data … because participants' interpretations are prioritised, accepted, and focused on, rather than being used as a basis for analysing something else" (Clarke and Braun, 2013, p. 21). We second Braun and Clarke's (2021) notion that the deductive/inductive analytic process must be viewed as a continuum rather than a dichotomy. In this respect, although we utilised the HBM as a conceptual framework, we paid attention to and retained insights and experiences that fell outside the model's scope. Our aim was to formulate a theory of change in gender-specific mental service engagement for men at risk of social withdrawal, self-harm and addictive behaviours.

Drawing upon the HBM model, we (i.e., two female authors) conducted in-depth semi-structured interviews that consisted primarily of two parts: (1) collecting basic demographic and socioeconomic background information and (2) exploring the interviewees' mental health issues and personal experiences of service use/non-use (see Table 1). A qualitative approach was adopted to explore the diverse experiences of men from different backgrounds and their perceptions and narrations of their subjective experiences. Prior research conducted in Hong Kong suggests that most Chinese men in Hong Kong are not used to expressing their views and feelings (Leung et al., 2019). Hence, we opted for in-depth interviews to afford more space to develop a trusting relationship and explore the complexity of gender-role conflicts and the formation of masculinity. Encouraging the interview participants to narrate their experiences in their own words and at their own pace enabled us to identify the dominant discourses underpinning their perceptions. All of the interviews were audio-recorded and transcribed verbatim for data analysis. Both authors participated in the interview process. All interviews were conducted in Cantonese and lasted for 45-60 min each.

**Table 1**
Formulation of interview questions based on the Health Belief Model

| Health Belief Model Constructs | Interview Question formulation based on HBM constructs |
|---|---|
| **Perceived susceptibility & severity** | Awareness of the signs and severity of mental health problems, e.g. risk of self-harm behaviour/illicit drug use, etc. What makes you susceptible to mental distress?<br>Awareness of the severity of the given illness behaviour and its adverse impacts on one's health, family, and occupational and social functioning? |
| **Perceived barriers to taking action** | What barriers do men face in initiating or maintaining participation in treatment programmes? E.g. cost, time, embarrassment, inconvenience, stigma? |
| **Perceived benefits of behavioural change**<br>**Cues to action** | What are the perceived benefits of joining the programme amongst men? E.g. How likely is their risk of mental distress to be reduced?<br>What are/were the catalysts for men who are/were determined to make a change? |
| **Self-efficacy** | What factors can boost men's confidence in sustaining the new behaviour in question? What are the key components of services that men find helpful? |

Participants were recruited via the purposive sampling method with the help of qualified social workers from the community-based drug counselling services and youth outreach services of eight non-governmental organisations[1] in Hong Kong. These services are mainly government-subvented and aim to provide adults at risk of mental health and/or addiction problems with psychosocial support services. There were several features we looked for when recruiting participants, including variety in the severity of drug use history and self-harm/suicidal ideation, potential triggers of (re)lapses and service use patterns. All potential participants who met the basic inclusion criterion, i.e. being a man between the ages of 18 and 55, were invited to participate in an individual face-to-face interview. Our emphasis on participants' perceptions and interactions with contextual influences allowed us to explore the influential factors attributable to the variation in how they faced their mental health issues and what activated their motivation to seek help. All participants were informed of the nature of the study and the possible risk(s) involved and asked to give consent by signing an informed consent form.

### 2.3. Ethics statement

The study was approved by the Human Research Ethics Committee of the University of Hong Kong (Reference number: EA1904029). The authors provided participants with a physical copy of the consent form and went through each section with them to ensure comprehension and provide opportunities for questions. Written consent was obtained. During the consenting process, it was emphasised that study participation was entirely voluntary, that all data would be kept completely confidential and stored securely, and that their decision to participate would have no impact on the services they received. Finally, participants were assured that, unless special consent was given, no data would be shared with their social workers/service organisations.

### 2.4. Data analysis

To make meaning of the data collected, we employed reflexive thematic analysis. Utilising an existing framework (i.e. the HBM) as the lens through which the authors came up with a list of questions and constructed a semi-structured interview guide. To analyse and interpret the data, the authors adopted the latest version of Braun and Clarke's (2021, p. 331) six-phase guide to perform reflexive thematic analysis. The six phases are 1) data familiarisation with written notes; 2) systematic data coding; 3) generating initial themes from coded and collated data; 4) developing and reviewing themes; 5) refining, defining and naming themes; and 6) writing the report whereby some of these phases can be blended together to a certain degree. Themes then emerged and identified organically.

All of the verbal data were first transcribed verbatim by a group of student helpers. The two authors then read through each transcript to familiarise themselves with and obtain a thorough understanding of the

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data. Coding was conducted manually and was primarily theory-driven for this study, with the authors approaching the data with specific questions to code around (i.e. the six HBM constructs). A coding frame guided by the HBM was drafted by the first author, with relevant details categorised under the six constructs. For example, life stressors/triggers and problem-solving strategies were coded under "perceived susceptibility/severity", reasons for not seeking help under "HBM-perceived barriers", and reasons for taking action/making changes and the features of an ideal programme under "HBM-perceived benefits"/"HBM-perceived cue to action".

Both authors were involved in the data analytic process "to develop a richer, more nuanced reading of the data, rather than seeking a consensus on meaning" (Braun and Clarke, 2021, p. 594). During the process, we got together to discuss the coded texts and our interpretations thereof (e.g. adopting various coping mechanisms, such as excessive drinking, drug use, engaging in self-harm or "walking it off", to numb/suppress emotions) and to collate codes addressing the same area of inquiry in search of themes (e.g. negative problem-solving/coping strategies). This process resulted in the set of candidate themes reported below in the Results section. For data triangulation, we asked the qualified social workers referring cases to the research team to confirm participants' history of drug addiction and self-harm and service use records at the time of referral.

## 3. Results

We conducted 21 semi-structured, face-to-face, in-depth interviews with men aged 18-55 for this study. All of the men were recruited in Hong Kong between June and August 2019 after being referred by the aforementioned local non-governmental agencies offering psychosocial counselling services for drug abuse or self-harm ideation/behaviour. Many of the participants had been receiving services for more than 6 months at the time of the interviews. All identified as Hong Kong Chinese. Most of the participants had mental health problems and/or were experiencing mental distress that required professional help, including suicidal or self-harm ideation or a suicide/self-harm history. Some also had a history/experience of illicit drug addiction. Participants' drug-use patterns (e.g. type, duration, frequency, stage of drug withdrawal) and severity of self-harm (e.g. frequency and duration of suicidal ideation, self-harm with/without suicidal ideation) were captured and analysed against their decision in engaging in mental health services. The sociodemographic characteristics of the participants are presented in Table 2. Three inductive themes were uncovered and are detailed below.

**Table 2**
Sociodemographic characteristics of 21 participants

| Sociodemographic characteristics of participants (N = 21 males) | | | |
|---|---|---|---|
| Number | | | % |
| Age | 18-35 | 11 | 52.3 |
| | 36-45 | 7 | 33.3 |
| | 46 or above | 3 | 14.3 |
| Marital status | Married | 5 | 23.8 |
| | Never married/Single | 11 | 52.4 |
| | Remarried or divorced | 2 | 9.5 |
| | Unknown | 3 | 14.3 |
| Educational attainment | Primary or below | 6 | 26.6 |
| | Secondary level | 8 | 38 |
| | Tertiary level | 3 | 14.3 |
| | Unknown | 4 | 19 |
| Employment status | Full-time employment | 14 | 66.7 |
| | Part-time employment | 1 | 4.7 |
| | Unemployed | 2 | 9.5 |
| | Unknown | 4 | 19 |
| Mental health problems | History of suicidal ideation/suicide attempts and/or self-harm behaviours | 5 | 23.8 |
| | Substance abuse only | 9 | 42.9 |
| | Both | 7 | 33.3 |

### 3.1. Perceived susceptibility & severity – mental health needs distorted by incompetence

The participants' personal accounts of their mental health issues revealed that most were aware of the sources of their stressors or negative emotions but seldom recognised the gravity of their problems. Some trivialised and downplayed their symptoms, which they justified using the societal role of caring for their family or to meet career-related expectations, which is also found in earlier research (e.g., Leung & Chan, 2014; Stagier et al., 2020). Their main life stressors, which derived primarily from perceived incompetence or inability to meet others' expectations, included pressure stemming from failing to provide for their families financially, a craving for recognition, authority or status in the workplace, and feeling incompetent in taking care of themselves, as illustrated in the following interview extracts.

> "Stress was a reason. I did not want my family to have a hard life. I also wanted to show people that I was capable, because my elder brother was very good at school, and I seemed to be the inferior one. I wanted to make more money and prove myself. That was where my stress came from."

> "I have to protect women and do my best not to harm them. I have to be responsible and committed. The responsibility is the promise I made before and after getting married. It is important to me."

> "My greatest responsibility right now is to take care of my family and make money for them. I would feel myself to be incompetent if I could not even fulfil my number one responsibility as a man – taking care of my family."

The participants saw their stressors or strains as resulting primarily from power struggles fuelled by such external factors as workplace structures, competition and societal norms. The participant quoted below exhibited a tendency to hold himself to a strict standard, with an aspiration to overachieve. The resulting strain arising from the discrepancy between aspiration and reality can exacerbate an already poor mental condition, as illustrated by this participant's distress at failing to attain power and control in the workplace:

> "I have very high standards in terms of work. I hate it when workers are unfairly treated and are suppressed without the power to [speak] out. When there is no satisfaction at work, I can not be motivated. I […] want to change the system to empower myself. Salary is not my greatest concern. I seek power more than salary."

Interestingly, however, none of the participants had considered their mental strain to be sufficiently severe to require medical attention, not even when experiencing suicidal ideation, as reflected in the quote below. Instead, when their sense of failure became profound, they would resort to self-blame and feel hopeless about achieving any improvement in their situation.

> "I felt that there was no solution. I was blaming myself, and at the same time I felt hopeless about solving my problems. I felt like I had let down many people, so it would be better to die."

To ameliorate their mental strain, the participants often deployed avoidant coping mechanisms instead of getting professional help. Some had a proclivity to numb or bottle up their emotions by adopting an avoidant coping strategy such as the use of illicit drugs.

> "I felt unsuccessful at work. When I drank cough syrup, I felt like I had escaped from something, so I drank more and more. But after that, I felt my life was decadent, and it upset me. What could I do when I was upset? I drank more and felt upset again, so it became a cycle."

> "Things started to get much more difficult without a leg. So I started to take drugs when I was upset."

"I would say drugs are a way out, as they can sort out my thinking or feelings at the moment."

Nonetheless, the gravity of the distress became obvious when it affected participants' families. It appeared that many of the men tended to perceive their susceptibility to and the severity of their mental health problems based on their fulfilment of their familial role rather than genuinely facing up to their emotions.

"After becoming a disabled person owing to a car accident, I felt isolated and marginalised by society. I do not have a competitive educational background, so I relied on my physical ability to work and made ends meet. I was a very hard-working person, and I could work in the kitchen for 5-6 hours without sitting down. In contrast, I cannot even take care of myself now, and I have depression. I get emotional and grumpy all the time in front of my family members."

### *3.2. Perceived barrier to taking action – help-seeking compromised by self-reliance and shame*

In addition to the usual barriers to utilising health services, such as cost and accessibility, there are several self-perceived reasons considered major barriers to men seeking help. The most prominent is a desire not to be seen as weak or "small". Self-stigmatisation can be a potential barrier to actively choosing to use mental health services. Men often treasure a self-reliant life and want to hide their problems when they feel inadequate, as illustrated in the following quotes.

"I am afraid that people will know. I am kind of an introvert, so I keep things secret and solve problems myself."

"When I come across problems, I rarely ask for help and would rather deal with them myself."

"Men tend to appear to be strong and competent. I think that is the way men are. It may be easier for women to talk about their problems, but it is difficult for men. That is why men usually hide their problems."

Another potential barrier is the fear of losing one's autonomy during the helping process. Whilst the participants demonstrated a fondness for being self-reliant, they also felt that it was shameful to be seen as incompetent or powerless by others.

"I don't like to be forced, disrespected or belittled. Service providers sometimes use verbally punishing tactics to ask me to quit drugs, which is something that I experienced in the previous service …."

"Accepting a social service is a display of weakness. I would be afraid of how people would look at me and see my weaknesses …. That is, I would not tell the whole truth, like about my sadness, in the programme. I would usually divert the topic. Even though there were some trustworthy people, I was not sure whether they wanted to listen to my problems/stories.

Perceived benefits of behavioural change and cues to action – valuable family member first.

The participants expressed hope about becoming a better self or having an ideal self that they wanted to transform into. Service providers can leverage these aspirations and turn that into one's cues to action. Participants displayed a desire for a stronger sense of self-competence and for expanding their capability to live a self-reliant life, especially those who wanted to become a reliable and functional family member, both as a spouse and a parent. As defined by the participants, being a valuable family member means being loyal in relationships, being a stable financial provider for children, and being a good parent.

"I feel bad when I get blamed. There is no excuse because it is really my fault. I want to solve [the situation], so I find ways to do better and avoid making mistakes again. It has been three years, and I have not committed again because of my family. I do not want to go back in again, worry them and make them visit me. It is a motivation for me."

"I hope I can reconcile with my family members in the future, especially my wife."

"I have to be a good father who is able to financially support and provide a comfortable environment for my children."

"I could not face myself when I had a mistress and could not be loyal to my wife."

The main cue for reaching out for help amongst the participants was family, which is congruent with the meta-analysis of Wong et al. (2017) showing that men who strive for success in work and family life are at lower risk of depression and more likely to seek psychological support.

"I had never sought help until the birth of my daughter. I saw an advertisement on Facebook, and I remembered that I had scolded my daughter without a reason. Then I realised that my parental strategy was problematic. I sought help for my daughter while I sought services to help myself out."

"Some people who have a family are withdrawing from drugs; some users have lost … control and consciousness, and some have even committed suicide …. The idea of quitting drugs has grown on me."

### *3.3. Perceived self-efficacy – goal- and outcome-oriented and skills-based learning*

The interviews suggested that participants expected to achieve several key results when they reached out for help. They hoped that despite their problems they would be respected by the professionals concerned and that the services offered would be results-oriented and combined with practical skills-based learning. Pragmatic steps with clear, observable and measurable/quantifiable outcomes, particularly in terms of capacity-building and self-empowerment, are deemed pivotal in programme design for male users. Some of the participants had learnt ways of communicating with their loved ones, as well as how to stay away from fellow drug users and to build a sense of self-worth, as indicated below.

"During the programme, I felt that a drug user was not seen as a useless person but was treated with respect. I don't have a feeling of uselessness anymore. I felt encouraged, and I came into contact with many people that I wouldn't have been able to meet before. I did cooking, drawing and arts classes. I enjoyed these activities. The more time you spent in the programme, the less time you spent on drug use."

"My social worker analysed all my problems with me. So, I realised I didn't want to live like that anymore …. I wanted to make changes and be more productive."

"I learnt how to accept myself, and I am now a lot happier. I know how to communicate with my daughter and be more mindful of my anger and emotions. I found my self-worth in the programme."

"I've reduced the frequency of … contact with my drug-user friends. Social workers talk to and hang out with me every week so as to bring me out of the drug cycle."

"The service helped me to withdraw from both cough syrup and cigarettes because the staff assisted me in planning the withdrawal by clear stages, which was a lot easier."

"I want to believe in myself that I can start all over again. Therefore, I have requested that the staff … do a urine test on me every week."

"I wanted to learn something to help me … find a job."

"I want to find a full-time job as soon as possible."

The interviewees showed awareness of the differences between men and women, including differences in their societal roles, openness towards emotions and communication styles. Services that take such differences into account may be able to create a more comfortable and welcoming environment for male users who are reticent in engaging.

"Communication styles in men and women are different. Men are more straightforward and blunter, while women are softer and more empathetic. Also, having woman in a mal[e] group [would] make participants more restricted in their wording and in the conversation as a whole because women are sensitive about words, and they get hurt easily."

"[When it comes to emotions], men tend to cover up and suppress them. We don't allow ourselves to cry. Even when we meet friends, we don't talk about personal problems/issues; we tend to talk about workplace gossip and some joyous events instead."

"Men do not know much about mental health services. Women find it easier to be in contact with a social worker because of all the education and propaganda teaching them to speak up when they encounter gender inequality or domestic violence. As time goes by, this solution may become rooted in them and facilitate their help-seeking behaviour."

It has been observed that men in the interviews have a proclivity towards enjoying physical and group activities. Including such activities could thus be a fruitful strategy for promoting services to potential male users and engaging them by catering to their interests, as suggested by the following interviewee comments.

"Having more physical activity and training sessions would be attractive to potential men service users."

"Men like interactive focus groups in which a big group of men can sit down, play games and chat. It is like a social net for us."

"I like outdoor activities. They would be an attractive service feature for me …."

## 4. Discussion

All 21 participants were referred for interviews by local non-governmental agencies that offer psychosocial counselling services for drug abuse or self-harm behaviours. Many of them had been receiving such services for more than six months. Nonetheless, these men saw having mental health problems as a failure to meet the expectations of family and work. They expressed a sense of inadequacy at experiencing such problems and tended not to recognise them as illnesses that required timely and appropriate medical and psychosocial help. Their perceptions of their susceptibility to mental ill-health and the severity of their illness seemed to be distorted. Despite the social changes seen in recent years, many men appear to persist in cultivating a sense of competency or agency through holding up to their expected role and duty in a family (Staiger et al., 2020), which aligns with the concept of "doing gender" whereby men remain adherent to the ideology of traditional masculinity (Bjork, 2015) despite its detrimental effects.

HBM can be closely connected to traditional masculinity in mental health service utilisation by aligning the perceived benefits of seeking help with values such as strength, resilience, and responsibility. By focusing on how mental health care can improve men's ability to support their loved ones and meet perceived societal expectations, HBM can help shift attitudes derived from hegemonic masculinities to "plural masculinities" (Seidler et al., 2018, p. 93). A conceptual model emerged from our interviews with male service users that may hold promise for increasing mental health service enrolment and retention among Hong Kong men. The study findings suggest that effective mental health services for men should (1) connect with their sense of duty and responsibility, focusing not just on emotions or feelings, but on helping them fulfill their role as providers and protectors for their loved ones, alongside addressing mental health needs; (2) present a program with practical, actionable steps and clear, measurable outcomes that align with a man's need for tangible results; and (3) challenge and reshape negative stereotypes of masculinity, transforming these into empowering narratives that highlight strength, resilience, and the importance of self-care within the framework of traditional male identity.

### 4.1. Engage potential male service users with purposes that go beyond their emotions/feelings alone

It is noted that the common driving force behind seeking help for men is a satisfying familial relationship. The results of this study suggest that the masculinity crisis may pose more opportunities than threats to men's mental well-being because men seem to focus on the well-being of those they care about rather than rigidly abiding by hegemonic masculinity. "Undoing gender" does not mean that men have to give up traditional masculinity entirely and embrace femininity; instead, they can abandon hegemonic/toxic masculinity and nurture more meaningful forms of masculinity by "redoing gender" (Leung et al., 2019). The positive masculinity model suggests tailoring treatment to men's strengths can muster their innate desire for self-development and elicit gains in their mental health (Seidler et al., 2018). Our results supported such direction and suggested that effective interventions that men find helpful (and that achieve better engagement and treatment effects) are those that align with men's longing for competence in different ways. Our interviews underscore the importance of competence and family relationships as much as career or work success. The self-perception of competence is a psychological variable that reflects people's judgement of their ability to mobilise resources in order to achieve a particular goal (Nobre & Valentini, 2019). When men fall behind in such ability, they experience a strong sense of shame and guilt at having let their family members down. Our participants commonly expressed a sense of powerlessness when experiencing mental strain and refused to recognise it as a signal of their need for timely and appropriate medical and psychosocial help. Despite the increase in the availability of information on and conversations around mental health in recent years, many men appear to persist in cultivating a sense of competency or agency through their ability to hold a functional family together and fulfil their expected role. Staiger et al. (2020) highlighted the significance of familial context in the help-seeking process, noting that perceived expectations associated with paternal roles were particularly influential for some participants in their study. This aligns with our findings, where the motivation to engage with services, or the "cue to action," was often rooted in a desire to have a functional family (e.g., "reconcile with my family members … especially my wife") and to fulfill the role of a "good father." For instance, one participant reflected, "I had never sought help until the birth of my daughter … I sought help for my daughter while I sought services to help myself out," while another participant stressed that he did not want "to worry them and make them visit me. It is a motivation for me." Men continue to weigh "competency" heavily when defining their role in relation to others (Leung & Chan, 2014). Seeing help-seeking behaviours as agentic could thus incentivise them to engage in and continue with mental health services. Encouraging male service users to be valuable family members and make it their top priority seems a strategic and promising direction.

### 4.2. The downward spiral of avoidant coping that led to a diminished sense of competence

To alleviate men's psychological distress, the participants often resorted to avoidant coping mechanisms rather than seeking help. This finding echoes Addis's (2008) description of the "masked depression" framework for men, whereby men tend to suppress their emotions

through various affect regulations such as substance use or abuse. The participants in our study exhibited awareness of their negative emotions but selectively avoided acknowledging the severity of the adverse impacts of their coping mechanisms. One participant, for example, observed the following vicious "cycle," which resonates with the downward spiral illustrated in Figure 1. The spiral was developed abductively to develop our explanatory framework. Initially, we inductively identified patterns in men's narratives, specifically their tendency to use avoidant coping for mental health issues rather than seeking help. Then, we used a deductive approach to check the patterns against the masked depression framework (Addis, 2008) using the qualitative data from the interviews. The identified themes from participants' lived experiences and narratives allowed us to construct the observations inductively, as shown in Figure 1, which illustrates a common trajectory observed among Hong Kong men and depicts a potential pathway for men who experienced emotional distress and adopted compromised or alternative coping strategies without effective interventions. Typically, individuals begin at a baseline level of self-perceived competence. When faced with adverse life events or stressors, they often experience emotional distress. In the absence of adequate support or intervention, some may resort to maladaptive coping strategies to manage this distress. Over time, these may escalate into more severe behaviours such as self-medication, substance use, self-harm, or even suicide attempts. As these individuals struggle to return to their emotional baseline but perceive themselves as failing, they develop a new, diminished sense of self-perceived competence. This decline is particularly evident when they feel unable to meet traditional gender role expectations, such as maintaining employment, fulfilling familial responsibilities, or being a good father or husband. These patterns are deductively hypothesized to repeat as cumulative life stressors persist, and further negative coping mechanisms are adopted. With each iteration, perceived self-competence is theorised to decline further, reinforcing the downward spiral, unless there is timely and effective intervention to disrupt the pattern and provide support (see Figure 1).

### 4.3. *Articulate a programme with pragmatic steps with clear, observable and measurable/quantifiable outcomes*

It is clear that the men in this study wanted to build self-capacity and skills and favoured clear goals, pragmatic strategies and concrete results. Helping men to recognise where their sense of competency lies and working around this key element thus seems a promising strategy (see Figure 2). We therefore propose a competency-based theory of change for the design of mental health services for men. Our assumption is that a health-oriented, competency-based approach will be seen as appealing by men who desire to be a responsible and healthy member of their family. We found that the participants in this study did not usually employ preventive strategies to enhance their mental well-being but were relatively more treatment-focused, particularly in the face of symptoms/repercussions that could no longer be ignored or silenced. Help-seeking was perceived as acceptable only when they had maximised their capacity in trying out self-help coping strategies. Men who display increased conformity to masculine norms may hold the perspective that seeking help is a form of weakness that undermines societal expectations around male strength, independence, and self-reliance (Milner et al., 2019). To undo and re-do gender in this context, external help-seeking can be re-narrated and considered a strength-based action that does not remove one's locus of control. An autonomous, self-subscribed, outcome-driven, activities-based, effective problem-solving package could benefit the target population in the current study by allowing them to deal with their problems through empowerment, helping them to obtain self-acquired capabilities through a regulated, evidence-informed package. Nonetheless, it should be stressed that any such package should be well-structured and clearly articulated, with specific, observable outcomes that can be achieved and measured in a feasible timeframe. The underlying drive includes but is

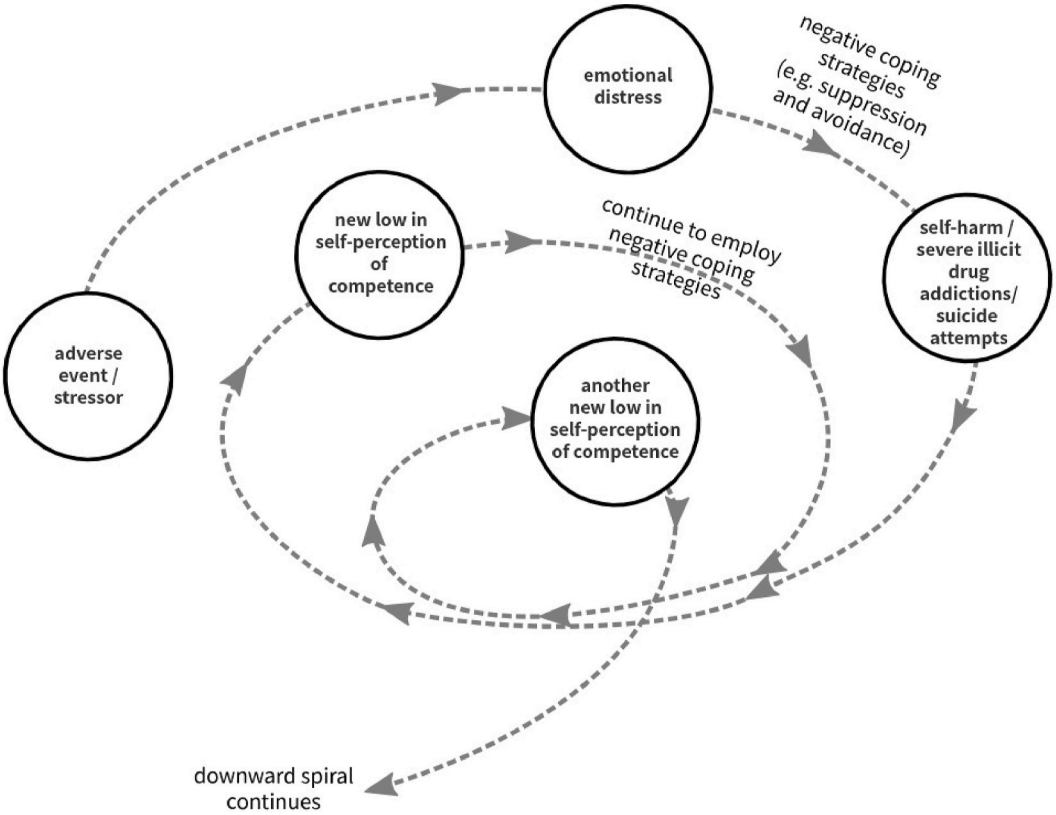


**Fig. 1.** A diagram theorising the role of avoidance coping in diminishing self-competence among men.

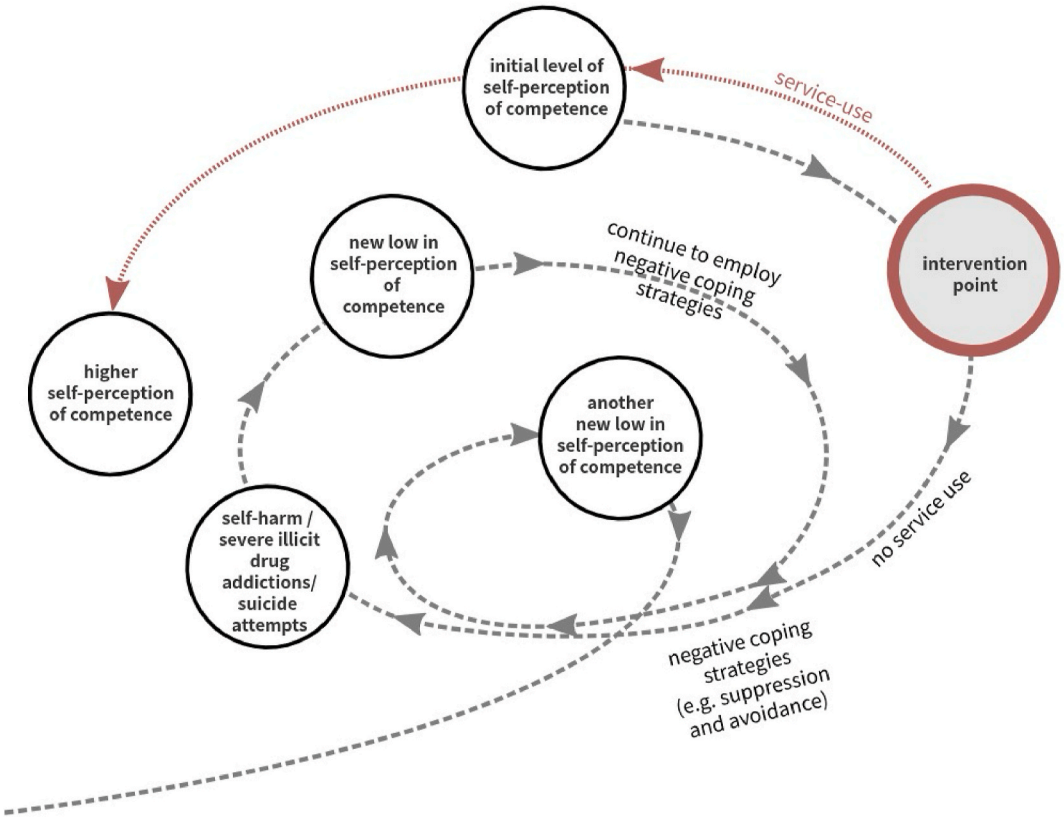


**Fig. 2.** A diagram theorising potential service-use effects on restoring self-competence among men.

not limited to strengthening users' self-image and sense of competence and helping them become a better/more capable person for someone they care about. In return, their desire to be in control will be rewarded with trustful, meaningful, more intimate interpersonal relationships. A package with various capabilities should prove desirable and appealing to many target users.

### *4.4. Embrace, re-narrate and transform negative masculinity narratives/ beliefs into meaningful ones*

In concurrence with previous research, the major barriers to help-seeking in this study were found to be such masculine traits as self-reliance, strength and fear of societal stigmatisation (Busiol, 2016; Mahalik & Di Bianca, 2021). The participants were found to be in a vulnerable state if they perceived their traditional masculine identity or beliefs to be threatened, including their sense of being a strong protector and provider for the family and a man who has "figured it all out" in life. The outcomes of their untreated mental strain while "doing" gender included indulging in illicit drug use and engaging in suicide attempts or self-harm behaviours. Such alternative coping strategies exacerbated their mental condition and intensified their yearning for competence, and, yet, without proper help from professionals, they found themselves in a downward spiral. Alternative self-coping mechanisms have become a compromised strategy for dealing with mental health problems amongst men who value self-reliance and responsibility for their family. There is no simple right or wrong healthcare decision but, in this study, a dilemma emerged and was observed in men undergoing an evolvement of the masculinity crisis. Figure 1 demonstrates the potential pathway of our targeted men, who experienced emotional distress and adopted compromised or alternative coping strategies, which can potentially be attributed to the perceived unavailability of suitable or meaningful services.

To dive deeper, when it comes to the association between masculinity and suicide in men, researchers' views can be crudely divided into conservative or progressive crisis narratives (Jordan & Chandler, 2019). The former narrative postulates that the ongoing threats to traditional gender roles and norms have contributed to the high suicide rate amongst men, and hence that the threats should be removed, whereas the latter stresses the deleterious effects of existing gender norms and advocates for alterations (Jordan & Chandler, 2019). This paper does not intend to contribute to the zero-sum approach to masculinity but to take the position that the positive aspects of masculinity beliefs and traits should be celebrated instead of altered or removed. In other words, we encourage the negative aspects of masculinity to be re-narrated (i.e. undoing gender) and transformed with new meaning (i.e. redoing gender). This is aligned with Kong (2021) who argued that men who are excluded from traditional forms of power often navigate their relationship to hegemonic masculinity by identifying with it, conforming to or rejecting it, redefining its boundaries, or actively resisting it. Services should be discouraged from intending or aiming to change a person's identity and reality or expecting service users to compromise or give up their beliefs and narratives. Jordan and Chandler's (2019) work mentions Powell (2016), who pointed out that it is unhelpful to merely state that "real men should be strong, silent and in control". Such sentiments, he continued, have proved a huge barrier to men seeking help (i.e. doing gender), and "just telling men to get help doesn't in itself take us very far". We second the notion suggested by Struszczyk, et al. (2019) that masculinity should not be considered an entirely toxic or fixed concept. Instead allowing its fluidity to be redefined or reconfigured depending on the situation could be a promising and powerful approach adopted by service providers. Drawing on this notion, we can take a step back by focusing on men's subjectivity in understanding their needs and wants, and be in control of the services they select while facing up to their mental health problems. Against the backdrop of the masculinity crisis, competency-based self-help ideas are being challenged by service design that is more psychosocial- and

therapeutic-driven. As a result, it is hoped that the meaning of and conversations around mental health and masculinities can be renegotiated by "redoing" gender through an increase in men's mental health service utilisation, potentially shaping masculinity norms at a broader societal level.

Some of our participants discussed prior negative experiences with help-seeking, noting that their feelings had been undermined or brushed off by professionals, leaving them feeling belittled or disrespected. To redress such issues, we suggest that services for men be mindful of language use, e.g. replacing "seeking help" with "service use" down the line. Doing so could mitigate the underlying power differences between service providers and service users. The latter should be seen as consumers instead of as vulnerable people who require help from others.

### 4.5. Limitations

Several limitations to this study must be acknowledged. First, the diversity and number of participants were limited. Not least, all of the participants were Hong Kong residents. Hence, the findings may not be applicable in other contexts and should be used in a culturally sensitive manner if adopted. To illustrate, the role of masculine beliefs and their manifestations may vary considerably by background. For example, men of differing socioeconomic statuses and ethnicities face varying degrees of health inequality (Galdas et al., 2005). Consequently, to gain a greater understanding of the findings, a larger and more heterogeneous sample is required. Second, most of the men in this study are already service users, hence, this is a study of participants who are already open to using mental health services despite the challenges they encountered. Lastly, we also acknowledge that we did not explicitly consider women's role in either exacerbating or ameliorating the traditional masculinity traits in society (see Pattyn et al., 2015).

## 5. Conclusion

The evidence suggesting that men as a whole report less mental health service use than women is inconclusive because factors other than gender, such as occupational and socioeconomic status, may also be explanatory variables for the difference between the two (Galdas et al., 2005). We also must be careful not to go overboard and view men, boys and masculinity as inherently toxic/negative (Brookes & Chalupnik, 2023). Instead, we advocate for a middle ground: mental health services should not aim to change male users' identity but should instead focus on and celebrate the positive aspects of men and masculinity, aspects that should ultimately be the outcome of various social processes and movements, and assist them in navigating this challenging transitional era. Transforming toxic masculinity narratives into ones conducive to mental health will ideally increase men's mental service utilisation and ensure that they receive meaningful professional responses and assistance. We argue that service providers should endeavour to recognise the ambivalence of men in today's "masculinity crisis" as an opportunity to engage them for better well-being, as men seem readier than ever before to move forward during the present transitional era. Doing so would also help service providers to better design and structure programmes tailored to meeting men's mental health needs.

It is not our intention to downplay women's mental health needs. However, the norms of traditional masculinity are so pervasive that men report experiencing intense pressure to perform their identity in accordance with such norms even when doing so conflicts with their inner feelings, experiences and beliefs (Evans & Wallace, 2008; Williams, 2009). Consequently, our aim in this study was to explore the constraining effects on men who strictly abide by traditional masculinity and further examine practical ways to boost prevention efforts.

In conclusion, mental health programmes incorporating a competency-based theory of change may be more appealing to men. Gender-specific interventions may benefit men by better understanding their needs and wants amidst the masculinity crisis.

## CRediT authorship contribution statement

**Rita Hui Ting Lok:** Writing – review & editing, Writing – original draft, Visualization, Validation, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Yik Wa Law:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

## Declaration of competing interest

The authors declare no financial interests/personal relationships which may be considered as potential competing interests.

## Acknowledgement

This research project was supported by the Research Grant Council of the University Grants Committee, HKSAR (Grant number: GRF 17618921).

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