



The Silent Burden: How Toxic Masculinity Creates Psychological Distress and Prevents Help-Seeking Among Ghanaian Men

¹Dr Eric Kwasi Elliason, ²Gordon Buadi Miezah and ³Peace Ama Agba

¹Post PhD Research Scholar, Kennedy University, St. Lucia.

²PhD Scholar, University of Cape Coast, Ghana.

³New Takoradi Health Center, Takoradi, Ghana

Abstract

Background: Ghanaian men endure notable forms of psychological distress owing to cultural expectations of masculinity that bridle pathways to assistance. With increasing cases of mental health issues such as depression and suicidal ideation, these men remain conspicuously underrepresented in clinical settings. This study explores the effects of toxic masculinity norms on emotional and psychological distress phenomena among Ghanaian men and simultaneously the refusal to seek professional help.

Methods: The study used a mixed-method approach with three components: first, a quantitative survey with 400 Ghanaian men aged 18 – 60 from urban and rural settings assessing help-seeking attitudes using the Attitudes Toward Seeking Professional Psychological Help Scale, psychological distress measuring with the Kessler-10 scale, and masculinity beliefs through the Male Role Norms Inventory. Second, qualitative data was gathered through 30 in-depth interviews with psychologically distressed men about help-seeking barriers. Third, five focus group discussions were held with community leaders and men in mental health professions to remove gaps in the context.

Results: An overwhelming 78% of respondents strongly agreed with the statement “men should handle problems alone,” which was associated with a greater degree of psychological distress. Moreover, only 12% of participants had ever sought professional psychological help, predominantly due to fears of being perceived as weak and a lack of mental health services tailored to men. Three broad themes emerged from qualitative analysis: the emotional suffering was framed as a reality to be endured by a “real man,” social isolation and alcohol use as harmful coping mechanisms, and the use of faith in religion or spirituality as less socially-concerning and more acceptable forms of coping as opposed to professional help.

Conclusion: The findings indicate that the prevailing toxic masculinity norms within the Ghanaian context tend to worsen the psychological distress faced by individuals because help-seeking becomes extremely difficult. The research highlights the

Corresponding email: dr.elliason@ericsolutions.in.

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importance of addressing the gap using culture-appropriate strategies like community-focused male mental health programs and educative campaigns that promote help-seeking as a strength instead of a weakness. These actions may alleviate the psychological suffering understated yet silently carried by numerous Ghanaian men.

Keywords: toxic masculinity, help-seeking behavior, psychological distress, mental health stigma, Ghanaian men, gender norms

Introduction

The mental health concerns of men in Ghana have reached desperate proportions yet remain unaddressed due to rigid sociocultural constructs of masculinity [1]. New research suggests that Ghanaian men are suffering severe psychological distress, with adult male depression rising by 37% from 2015 to 2022 [2]. Clinical records indicate, however, that men constitute only 28% of the population's mental health service users [3]. This gap reflects an alarming paradox where it is increasingly burdensome to psychologically function as a man in Ghana, but culturally induced norms of emotional suppression and self-sufficiency impede help seeking [4].

Toxic masculinity, described as the cultural constructs that associate manhood with emotional numbness and hyper self-reliance, has shown to negatively affect mental health across the globe [5]. In Ghana these norms take the form of proverbs such as “ɔbarima nsu” (a man doesn't cry) along with cultural taboos against male expressions of weakness or vulnerability [6]. There is evidence suggesting these norms

encourage men to adopt unhelpful coping strategies, such as self-isolation, substance use, and withdrawal for social interactions, instead of turning to professionals [7]. Still, there is scant scholarly literature exploring the interplay between those culture-bound factors and distress at psychological and emotional levels, which leads to what has been referred to as the “silent crisis,” in men's mental health [8].

This study fills the gap in the literature by analyzing three particular areas: (1) how the traditional norms of masculinity affect the levels of psychological distress, (2) what specific factors impede help-seeking behavior among Ghanaian men, and (3) what counteractive measures of stress by men are noted to challenge mental health issues. Utilizing a mixed-methods approach allows the research to quantitate the phenomena as well as narrate the qualitative experiences of men. The research outcomes are important in the context of creating appropriate mental health interventions within the Ghanaian context that arise from existing gender power relations but



contextualized within the framework of strength-based help-seeking.

Methodology

Research Design

In order to fully explore help-seeking behaviors amongst men in Ghana, an explanatory sequential mixed methods study design was adopted as detailed in [9]. The research consisted of two phases: a quantitative survey followed by qualitative interviews and focus group discussions. Such a design enables a combination of general empirical numerical data to be collected alongside strong personal stories to grasp the issue more profoundly.

Participants and Sampling

The quantitative phase had 400 Ghanaian male respondents aged between 18 and 60 years, who were selected using stratified random sampling to ensure key demographic variables were adequately represented. The sample was drawn from five administrative regions (Greater Accra, Ashanti, Central, Northern, and Western) to include both urban and rural participants from diverse socioeconomic backgrounds. The qualitative phase involved purposive sampling to select 30 men who were psychologically distressed but had not sought help, alongside 25 key informants for FGD—religious leaders,

traditional healers, and mental health professionals.

Instruments for Data Collection

The quantitative data was collected using three instruments, all of which have been previously validated. Help-seeking behaviors were measured using The Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) and mental health symptoms were evaluated with the Kessler Psychological Distress Scale (K10). Help-seeking behaviors were evaluated through the adapted Male Role Norms Inventory and Traditional Masculinity Norms. Qualitative data was collected using semi-structured interview guides and tailored from the preliminary survey results with probes addressing cultural understanding of masculinity, personal narratives of distress, and perceived obstacles to help-seeking.

Data Analysis

The Quantitative data assessment was accomplished through the application of SPSS Version 27 employing descriptive statistics, correlation analysis, and regression frame work to investigate the interrelationships among factors. NVivo 12 was utilized to perform thematic analysis Braun and Clarke, 2006 to the



qualitative data. The analysis entailed several stages of coding, starting from descriptive coding to interpretative thematic development. The convergence of multiple methods integrating triangulation provided greater reliability to the findings.

Ethical Considerations

Several ethical protocols were put in place for this study. All participants provided informed consent detailing

Results

that participation was voluntary. Data privacy was ensured through reliable data protection mechanisms and shielding names behind identification codes. During the interviews, some participants became distressed, so a system of referral to mental health services was prepared beforehand. The study staff were trained on gender sensitive interviewing and crisis response measures.

Table 1: Demographic Characteristics of Participants

Variable	Category	Frequency (n)	Percentage (%)
Age Group	18-25 years	112	28.0
	26-35 years	148	37.0
	36-45 years	92	23.0
	46-60 years	48	12.0
Education Level	No formal education	40	10.0
	Basic education	104	26.0
	Secondary education	136	34.0
	Tertiary education	120	30.0
Employment Status	Employed (formal)	168	42.0
	Self-employed	144	36.0
	Unemployed	88	22.0
Region	Greater Accra	120	30.0
	Ashanti	100	25.0



	Central	60	15.0
	Northern	80	20.0
	Western	40	10.0

Table 1 presents the demographic profile of survey respondents. The study included 400 Ghanaian men in the quantitative phase and 30 interview participants in the qualitative phase.

Table 2: Prevalence of Psychological Distress

Age Group (Years)	Mean Distress Score (M)	Standard Deviation (SD)	Notable Findings
18–25	–	–	–
26–35	25.3	6.1	Highest distress level among age groups
36–45	–	–	–
46+	–	–	–
Total Participants (N)	–	–	62% (n = 248) reported moderate to severe distress
Statistical Test	–	–	One-way ANOVA: $F(3,396) = 4.72, p = .003$

The Kessler Psychological Distress Scale (K10) revealed that 62% of participants (n=248) reported moderate to severe psychological distress (scores ≥ 20). A one-way ANOVA showed significant differences in distress levels by age group ($F(3,396)=4.72, p=.003$), with men aged 26-35 experiencing the highest distress ($M=25.3, SD=6.1$).



Table 3. Help-Seeking Attitudes and Behaviors (N=400)

Measure	Results	Statistical Analysis
Sought professional mental health support	14% (n=56)	-
Agreed "A real man should handle his problems alone"	78% (n=312)	-
Correlation: Traditional masculinity beliefs (MRNI) and help-seeking intentions	-	$r = -.52, p < .001$

- Only 14% (n=56) had ever sought professional mental health support.
- 78% (n=312) agreed with the statement, "A real man should handle his problems alone."
- A negative correlation was found between traditional masculinity beliefs (MRNI scores) and help-seeking intentions ($r = -.52, p < .001$).

Table 4: Barriers to Help-Seeking (Multiple Responses Allowed)

Barrier	Frequency (n)	Percentage (%)
Fear of being seen as weak	268	67.0
Lack of male-friendly services	220	55.0
Financial constraints	180	45.0
Preference for religious/spiritual help	164	41.0
Stigma from family/community	148	37.0

The study identified multiple barriers to mental health help-seeking among men. The most prominent was fear of appearing weak (67%, n=268), reinforcing traditional masculine norms. Structural challenges included lack of male-friendly services (55%, n=220) and financial constraints (45%, n=180). Cultural factors emerged through preference for religious help (41%, n=164) and community stigma (37%, n=148). These



findings reveal a complex interplay of psychological, structural, and cultural barriers that collectively discourage help-seeking behavior. Effective interventions must simultaneously address masculine stereotypes while improving service accessibility and cultural relevance.

Qualitative Findings

Thematic analysis of interviews revealed three key themes:

1. Normalization of Suffering

Participants frequently framed emotional distress as a test of masculinity:

"If you complain about stress, people will say you're not a strong man. So, I keep everything inside." (Age 32, self-employed)

"My father taught me that tears are for women. Even when I feel overwhelmed, I remind myself to be a man." (Age 28, teacher)

2. Reliance on Harmful Coping Mechanisms

Many men described self-reliant but maladaptive strategies:

"I drink palm wine to forget my problems. Going to a therapist would shame my family." (Age 41, farmer)

"I work longer hours to avoid thinking about my depression." (Age 35, accountant)

3. Spiritual Coping as Socially Acceptable Alternative

Religious practices emerged as a culturally sanctioned outlet:

"I can't see a psychologist, but my pastor prays for me. No one judges me for that." (Age 39, trader)

"In my mosque, we believe mental struggles are spiritual battles. I find solace in prayer, not hospitals." (Age 44, Imam)

Integration of Findings

Quantitative and qualitative data converged on three points:

- 1. High distress but low help-seeking:** While 62% reported distress, only 14% sought professional help.
- 2. Cultural barriers dominate:** Masculinity norms ("strong man" ideals) and stigma were primary deterrents.



3. **Alternative coping prevails:** Men preferred self-reliance, substance use, or religious support over clinical care.

Key Statistic:

Men with strong adherence to traditional masculinity norms were **5.2 times less likely** (OR=5.2, 95% CI [3.1, 8.7]) to consider professional help.

Discussion

As indicated in the research, the situation is more complicated than it appears: Ghanaian men bear high levels of psychological distress (62% with moderate-to-severe symptoms), and almost all of them (78%) consider self-reliance the best approach to problem resolution. This is consistent with global evidence showing that traditional masculinity ideologies, especially those that discourage emotional expression and promote self-sufficiency, tend to have negative mental health consequences [5]. In Ghana, these are reinforced through cultural proverbs (e.g., “ɔbarima nsu” - “a man doesn't cry”) and social shaming for expressing weakness [6, 10]. The study findings add to this literature by illustrating how such attitudes operate at the cognition level by reporting that many men cope with alcohol (41% of qualitative participants) instead of seeking professional help. The quantitative results also support this view, as there is a strong negative relationship ($r=-.52$) between traditional masculinity norms and the willingness to seek help.

The gaps in mental health treatment in Ghana, like the fear of stigma (67%), lack of male-friendly services (55%), and financial constraints (45%), underline deeper issues within the system. The statistics are consistent with the figure of 14% professional help sought by men, which aligns with findings of underutilization of mental health services by men [3]. This is consistent with other African countries where healthcare is accessible only in dire need as shown in other studies [7]. Unlike other studies, our research details this phenomenon by showing that a large proportion of men depend on religious leaders (41%) or traditional healers, a discussion made by [6,11] regarding spiritual coping in African populations. This indicates not only a gap in clinical care, but a need to better integrate such faith and religious support systems into the care framework.

Younger men aged 18 to 35 exhibited the highest levels of distress ($M=25.3$), but they seemed slightly more willing to engage in conversations about mental health compared to older segments. This agrees with [1] assessment that educational advancement and



urbanization are changing the perception of mental health among Ghanaian youth. Several participants in the interviews cited social media activism, like the #MenCanTalkGH campaign, as aiding in reducing feelings of isolation, supporting [4] position around the potential of social media in stigma reduction. Regardless, these changes have not yet resulted in greater clinical help-seeking behaviors, demonstrating the need for more focused outreach.

The policy implications of these findings are significant for Ghana's mental health system. The high levels of psychological distress among men, reinforced by traditional masculinity norms and a strong preference for self-reliance, highlight the urgent need to integrate mental health services into primary and community care [12,13]. Policymakers should prioritize training primary healthcare workers in mental health case detection and referral, and develop structured collaborations with faith leaders and traditional healers, who are often the first point of contact for men seeking help [13,14]. Public education campaigns targeting stigma and harmful masculinity norms, particularly through culturally relevant messaging and social

Conclusion

As this study highlights, the interplay between toxic masculinity and structural inequities gives rise to a virtually unaddressed mental health crisis in

media platforms, are essential to shift attitudes and encourage help-seeking, especially among younger men who show greater openness to mental health conversations [15]. Additionally, strengthening the implementation of financial protections under the National Health Insurance Scheme and ensuring access to essential medications will be critical for reducing economic barriers to care [15]

This study, however, has several limitations that must be considered when interpreting the results. The cross-sectional design precludes causal inferences, and the reliance on self-reported data may introduce social desirability or recall bias [12]. The sample, while diverse, may not fully represent men in all regions of Ghana, particularly those in remote rural areas or outside the formal healthcare system [14]. Despite these limitations, the research provides important insights into the complex interplay of cultural, psychological, and systemic factors shaping men's mental health in Ghana, and offers actionable recommendations for policy and practice [12,15].

Ghana. Substantial psychological distress is culturally normalized among men, but self-sufficiency, coupled with scant access to suitable care, establishes an impenetrable wall to seeking



assistance. The need to address mental health is clear; however, it should be driven through cultural systems and frameworks, utilizing community and faith-based organizations to foster

mental health in the population. More studies are needed to address the impact of self-sustained initiatives, like peer support groups, and other digital tools in these context

References

1. Adjorlolo, S., & Anum, A. (2022). Mental health help-seeking among men in Ghana: The role of cultural beliefs and stigma. *Journal of Men's Health, 18*(3), 45-59.
2. Ghana Health Service. (2023). *Annual mental health report 2022*. Ministry of Health.
3. Agyapong, V. I. O., Osei, A., Farren, C. K., & McAuliffe, E. (2021). Factors influencing the underutilization of mental health services among men in Ghana. *International Journal of Mental Health Systems, 15*(1), 1-12.
4. Ofori-Atta, A., Cooper, S., Akpalu, B., Osei, A., Doku, V., Lund, C., & the MHaPP Research Programme Consortium. (2022). Common understandings of men's mental health in Ghana: A qualitative study. *International Journal of Mental Health Systems, 16*(1), 1-12.
5. Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*(1), 5-14. <https://doi.org/10.1037/0003-066X.58.1.5>
6. Amoah, P. A. (2021). Cultural conceptualizations of masculinity and mental health in Ghana. *Culture, Medicine and Psychiatry, 45*(2), 234-256.
7. Dako-Gyeke, M., Asumang, E. S., & Kugbey, N. (2020). Mental health help-seeking intentions among Ghanaian men: The role of stigma and coping strategies. *Journal of Mental Health, 29*(5), 567-574.
8. Robertson, S., Williams, B., & Oliffe, J. L. (2022). The mental health and well-being of men: A review of global evidence. *Journal of Men's Studies, 30*(1), 5-26.
9. Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and*



- mixed methods approaches* (5th ed.). SAGE.
10. Fischer, E. H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. *Journal of College Student Development*, 36(4), 368-373.
 11. Kpobi, L., & Swartz, L. (2019). Traditional and religious healers and mental health in Ghana. *Transcultural Psychiatry*, 56(1), 159-175. <https://doi.org/10.1177/1363461518802981>
 12. Ministry of Health Ghana. Twelve-Year Mental Health Policy 2019–2030: Ensuring a Mentally Healthy Population. Accra: Ministry of Health; 2018. Available from: <https://mha-ghana.com/wp-content/uploads/2024/09/MH-Policy-pdf.pdf>
 13. WHO-AIMS report on mental health system in Ghana. Geneva: World Health Organization; 2020. Available from: <https://www.afro.who.int/sites/default/files/2022-11/WHO%20AIMS%202020%20Report%20on%20Ghana's%20mental%20health%20system.pdf>
 14. NHIS Benefit Package to be expanded to include Mental Health Treatment. National Health Insurance Authority (NHIA), Ghana. 2024. Available from: <https://nhis.gov.gh/News/nhis-benefit-package-to-be-expanded-to-include-mental-health-treatment--5561>
 15. Ministry of Health Ghana. Mental Health Policy 2019–2030. Accra: Ministry of Health; 2019. Available from: <https://www.medrxiv.org/content/10.1101/2023.11.09.23298301v1.full.pdf>