ЭКСПЕРИМЕНТАЛЬНЫЕ И ЭМПИРИЧЕСКИЕ ИССЛЕДОВАНИЯ

“Boys don’t cry”: Demographic inequalities in the use of mental health and well-being support services and resources in Russia

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Demographic differences in the use of mental health services have not been studied in Russia, a country with one of the largest gender gaps in life expectancy in the world. In the present study, we used an online panel sample (N = 2000) to examine patterns and demographic predictors of the use of mental health support services and resources. Latent class analysis of a set of 21 items reflecting culturally sensitive ways of coping with mental health issues revealed five groups of individuals: those who use no mental health support resources (20.3%), those who rely on prayer and somatic health specialists (35.5%), those using popular self-help media (35.9%), those who engage in religious coping (12.2%), and, finally, those who turn to mental health professionals, such as psychologists, psychiatrists or counsellors (6.2%). Apart from the surprisingly small percentage of the latter group, we discovered strong evidence of gender, education, and income gaps in the use of mental health services. The findings suggest the necessity of improving the accessibility of mental health services for men, older adults, as well as those with lower levels of education and income.

Keywords: mental health, self-support, inequality, gender gap

Introduction

The Strategies to Support Mental Health and Well-Being

Life in modern societies involves increasing levels of daily stress that threaten people's well-being and challenge their mental health. World Happiness Report data demonstrate a significant upward trend in negative affect that began in 2010 and has been accompanied by a weaker decrease in satisfaction with life [Helliwell et al., 2019]. Numerous studies have documented increases in the frequency and duration of mental health disorders over the past two decades [Mojtabaj, Jorm, 2015; Holland et al., 2021]. These data suggest that the need for accessible mental health services and interventions aimed to help people support their well-being and build resilience resources is steadily growing.

Complementing the medical model, positive psychology emerged in 1999 as a movement initiated by a group of researchers who aimed to promote the scientific study of the processes and conditions contributing to well-being of individuals and groups [Gable, Haidt, 2005]. The exponential growth of studies on flow, mindfulness, meaning, and other diverse phenomena of positive functioning has made it possible to formulate scientific recommendations and to develop evidence-based interventions that can improve well-being.

Although initially positive psychology was envisioned as a way toward flourishing for people in absence of mental illness [Seligman, 2000], the more recent complete state theory of well-being [Keyes, 2003; 2014] suggests that positive mental health (flourishing) and its absence (languishing) form a dimension that can be viewed as largely independent of mental illness (or its absence). It follows from this model that attainment of higher levels of positive mental health and well-being is possible for individuals from both non-clinical and clinical populations. Empirical findings indicate that interventions aimed at promoting well-being and preventing its decline may also prevent individuals from developing mental illness in the future [Keyes, 2014]. A whole range of positive interventions have been adapted for use in clinical practice, supplementing and complementing the strategies amed by the medical model [Wood, Tarrier, 2010].

An important advantage of positive psychology interventions lies in their diversity, which allows them to be tailored to the levels of positive and negative mental health of individuals, as well as to the specific life challenges they face [Sin et al., 2011]. Structured protocols and focus on health rather than on symptoms allow to implement many of the mental health promotion strategies offered by positive psychology in various formats that are not limited to the classical face-to-face setting of individual therapy or coaching. These strategies can be taught by means of public lectures and positive education courses. Their self-administration and tailoring to individual differences can be facilitated by various informational technology means, including but not limited to smartphone applications, dedicated websites, and chatbots.

Differences in the Access to Mental Health and Well-Being Services

Large-scale survey data indicate that the use of mental health and well-being services varies substantially across demographic groups. A study by Wang and colleagues [2007] found that the share of respondents who have used any mental health services over the 12 months was much lower in developing countries than in developed ones, and was associated with the countries' share of GDP allocated to healthcare. In developing countries, only a minority of patients with severe disorders received any care, in contrast to a majority in developed countries. The authors also found lower mental health service use among the respondents who were male, married, had lower levels of education or were at the extremes of age or income ranges.

Positive psychology has proposed to complement the medical model of mental health defined in terms of absence of symptoms or suffering with a positive approach to defining mental health in terms of symptoms of optimal functioning and development [Seligman, Csikszentmihalyi, 2000]. Although initially those two paradigms were seen as mutually exclusive or complementary, recent models in positive psychology have proposed that flourishing and mental illness are not opposite poles of one dimension but, rather, orthogonal dimensions [Keyes, 2003], and that ways to improving life can be found even in challenging life circumstances [Wong, 2011]. This approach was labelled meliorism [Pawelski, 2018] and has paved the way for positive clinical psychology [Seligman, Peterson, 2003], which aims to complement traditional therapy in improving the patients' quality of life [Wood, Tarrier, 2010].

The well-being support interventions offered by traditional medical services and by positive psychology differ widely in their accessibility for the public. Medical interventions typically involve drug treatment, require face-to-face visits and in-

person communication, entail higher fees, and are associated with stigmatization [Javed et al., 2021]. In contrast, positive psychological interventions focused on changing the patterns of thinking and activity can be readily available in the form of mobile phone applications, books, educational courses, or other materials that have lower access barriers and allow for higher perceived anonymity. It is therefore plausible that these interventions are more frequently chosen by individuals with specific socio-economic and demographic characteristics. In the present study, we aimed to explore the patterns of using various mental health supporting strategies and resources in the Russian population.

The Russian Context

Russia offers an interesting and potentially unique case for several reasons. Historically, the attitudes toward well-being have been ambivalent; individual happiness (as opposed to universal) was viewed as an unworthy goal, whereas suffering was perceived as a normal and even a positive phenomenon [Leontiev et al., 2022]. Due to the recent history of psychiatry being abused for political means as part of the state repressive machine [Adler, Gluzman, 1993; Van Voren, 2010; Schacht, 2022], the stigma associated with psychiatric diagnosis remains extremely strong. This, in combination with limited spending of public funds on mental health services, greatly reduces the accessibility of professional mental health and psychological support services in most post-Soviet societies [Petrea, 2012; Doblyte, 2020].

At the same time, epidemiological data indicate that neuropsychiatric disorders together with substance abuse and self-harm are among the most important contributors to disability-adjusted life years (DALYs) in Russia, contributing 14.65% in 2019 [IHME, 2024]. There are important differences between men and women, with psychiatric and neurological disorders being responsible for 3.17% and 2.71% of DALY for men, but 5.02% and 6.24% for women, respectively. At the same time, substance abuse and self-harm comprised 4.97% and 4.09% for men and only 1.94% and 0.93% for women, respectively. These data suggest that Russian women might be approximately twice as likely to turn to a psychiatrist or a neurologist, whereas Russian men are several times more likely to use substances or to remain without treatment.

According to World Health Organization [2025] data, suicide rate in Russia was 43.6 per 100,000 for men and only 9.11 for women, and the gap in life expectancy between the sexes comprised nearly 10 years. Among Russians aged below 85, in women the suicide rate tended to increase nearly monotonously across age groups, whereas among men young adults (35-44) showed a comparable rate to older adults.

This gender gap in epidemiology and life expectancy can be explained by the hegemonic masculinity and strong gender stereotypes that characterize Russian society [Hinote, Webber, 2012; Zdravomyslova, Temkina, 2013; Shmelev, Pochebut, 2015]. The asymmetry of the distribution of power between men and women is also associated with higher social expectations applied to men. The recent trends indicate a rise of a politicized form of macho masculinity [Randall, 2020]. Although alcohol consumption has been steadily going out of fashion as an important marker of male identity, it is being replaced by physical strength and wealth with their external attributes [Hinote, Webber, 2012; Zdravomyslova,

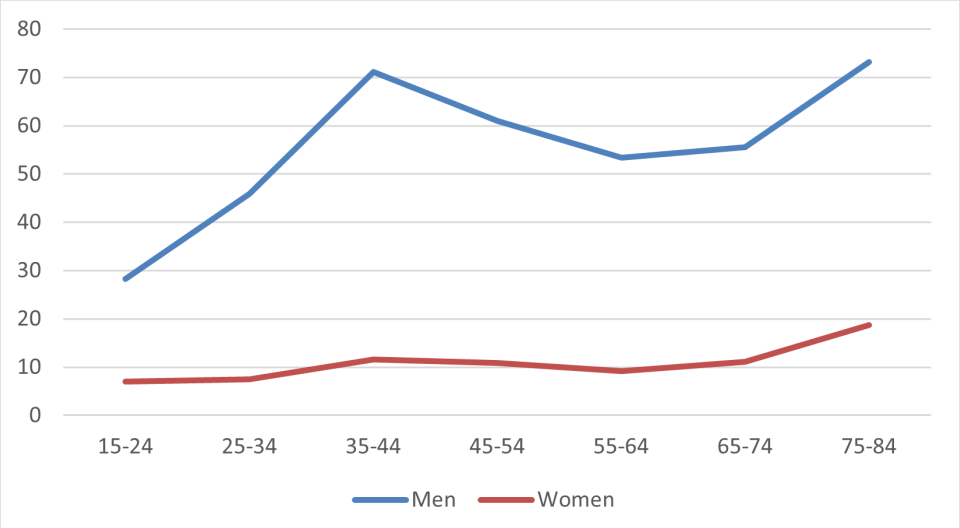

Figure 1. *Suicide rate per 100,000 population by sex in Russia in 2019 (World Health Organization, 2025)*

Temkina, 2013]. Combined with growing persecution of individuals who fail to conform to the binary gender stereotypes imposed by the state-dominated public discourse [Novitskaya, 2017; Gulevich, Krivoshchekov, 2024], this creates for Russian men additional pressure to conform to their prescribed roles leading to fear of not being a "real" man or guilt due to being unable to perform as a breadwinner for the family.

The social and economic challenges of the current decade have clearly exacerbated the situation in the country, both in terms of gender gap in social expectations, health, and longevity, as well as in terms of general mental health of the population. Although the most recent data epidemiological data are not available yet, the sales of antidepressant medications in terms of quantity have grown by 58% in 2022, 86% in 2023, and 99% in 2024 against the pre-Covid 2019 baseline, despite raising prices [Doguzova, 2024; Kolganova, 2025]. Despite the increasing demand and a growing readiness of Russians to seek professional mental health support, public spending on healthcare remains limited [Klepach, Luk'yanenko, 2023]: after peaking to 4.8% of GDP in 2020 during the Covid pandemic, it has returned to the 2019 level of 3.5% [Ulumbekova, 2024]. It is not surprising that individuals facing economic challenges might turn to traditional or alternative mental health support strategies.

The present study therefore aimed to examine patterns of the use of mental health support resources in Russia and to identify demographic differences in these patterns among urban residents with access to relevant infrastructure and digital technologies.

Methods

Participants and Procedure

The study was conducted using an online panel service, Anketolog.ru. The participants (N = 2,000) were anonymous volunteers who agreed to complete a survey on mental health and well-being in exchange for a small monetary reward. The inclusion criteria were being an employed adult aged between 18 and 60 (M = 38.78, SD = 9.25). We recruited an equal number of male (N = 1,000) and female (N = 1,000) participants living in capital cities (Moscow and Saint Petersburg, N = 932) and in large cities (with over 250,000 residents) of other regions (N = 1,068).

Table 1

Sample composition

	Men (N = 1,000)	**Women (N = 1,000)**
Age, M (SD)	41.1 (9.50)	36.4 (8.37)
Place of residence		
Moscow or Saint-Petersburg	52.7%	54.1%
Other regions	47.3%	45.9%
Education		
Secondary school or lower	6.0%	3.2%
Professional school	22.6%	14.2%
Some university	8.6%	4.2%
University degree	54.1%	67.9%
Two or more degrees	8.7%	9.5%
Subjective income		
Cannot afford food	0.5%	0.7%
Cannot afford clothes	4.7%	4.7%
Cannot afford furniture/appliances	21.8%	22.2%
Cannot afford a car	45.5%	40.6%
Cannot afford an apartment/house	22.1%	20.5%
Can afford an apartment/house	2.9%	5.1%
Can afford anything	2.5%	6.2%
Relationship status		
Not in a relationship	25.1%	25.9%
Partnered	74.9%	75.1%
Children		
No children	28.8%	26.3%
Have children	71.2%	73.7%

The data were collected during the first three days of December 2022. Most participants had completed higher education or a professional degree. In terms of income, most participants reported being able to afford furniture or household appliances, but not a car, which can be considered above-average income for Russia as a whole, yet typical for urban settings. The detailed composition of the sample is given in Table 1.

Instruments

Mental health support resources and strategies. The questionnaire included a list of 21 resources and strategies (listed in Table 3 below) that participants could use to manage their mental health and maintain their well-being. The instructions went as follows: "Please read carefully the list below and mark all the service options that you have used over the past year."

Anxiety was assessed using a Russian version of the Generalized Anxiety Disorder (GAD-7) [Spitzer et al., 2006; Zolotareva, 2023a], a seven-item screening measure. The participants were asked to indicate how often they were bothered by each of the problems (ex. "Inability to relax") during the past 2 weeks using a 4-point Likert scale from 0 = "Not at all" to 4 = "Nearly every day". The model has supported a unidimensional structure (MLM: $\chi^2(14) = 116.75$, $p < .001$; CFI = .985; RMSEA = .061 [.051, .071]; SRMR = .019; factor loadings in the .68-.86 range) and the scale was reliable (ω = .92).

Depressive symptoms were assessed using a Russian version of the Patient Health Questionnaire (PHQ-9) [Kroenke et al., 2001; Zolotareva, 2023b], a nine-item screening measure for symptoms of major depression (ex. "Thoughts of dying or hurting myself") with the same 4-point Likert response scale as above. The theoretical unidimensional model showed acceptable fit (MLM: $\chi^2(27) = 508.71$, $p < .001$; CFI = .926; RMSEA = .094 [.087, .102]; SRMR = .046; factor loadings in the .58-.81 range) and the scale demonstrated good reliability (ω = .89).

Self-control was measured using a Russian version of the Brief Self-Control Scale [Tangney et al., 2004; Gordeeva et al., 2016], which includes 13 items rated on a 5-point Likert scale (ex. "I am lazy"). The theoretical bifactor model, consisting of one substantive factor and two method factors corresponding to the item wording direction, demonstrated good fit (MLM: $\chi^2(52) = 311.52$, $p < .001$; CFI = .930; RMSEA = .050 [.045, .055]; SRMR = .037). General factor loadings ranged from .22 to .60 and the scale demonstrated acceptable reliability ($\omega_H = .77$).

Self-reflection was measured using the Systemic Reflection scale from the DTR questionnaire [Leontiev, Osin, 2014]. The scale consists of 12 items (e.g., "Understanding oneself helps to understand others", "To understand the situation, one needs to relate one's feelings to what has caused them") rated on a 4-point scale ranging from 1 = Disagree to 4 = Agree. A unidimensional model demonstrated acceptable fit (MLM: $\chi^2(54) = 580.07$, $p < .001$; CFI = .918; RMSEA = .070 [.065, .075]; SRMR = .043) with factor loadings ranging from.59 to .72. The scale demonstrated high reliability (ω = .90).

Proactive coping was measured using a brief Russian version of the Proactive Coping Inventory [Greenglass, 2002; Belinskaya et al., 2018] consisting of 27 items rated on a 4-point scale (1 = Disagree completely to 4 = Agree completely). The items form 6 subscales: Proactive coping (6 items, ω = .82), Reflexive coping (5 items, ω = .88), Strategic planning (3 items, ω = .79), Preventive coping (5 items, ω = .84), Seeking instrumental support (4 items, ω = .81), and Seeking emotional support (4 items, ω = .83). The theoretical 6-factor structure demonstrated excellent fit (MLM: $\chi^2(309) = 1333.48$, $p < .001$; CFI = .950; RMSEA = .041 [.038, .043]; SRMR = .041) with factor loadings ranging from.51 to .82. The fit of a bifactor model with a single proactive coping factor (ω = .93) was also acceptable (MLM: $\chi^2(297) = 1852.49$, $p < .001$; CFI = .924; RMSEA = .051 [.049, .053]; SRMR = .070). All the items loaded significantly on the general factor (λ = .29-.78) and all but one loaded significantly on their respective group factors (λ = .21-.75).

Attitudes toward uncertainty were assessed using a set of 30 items developed by the third author [Kornilova, Chumakova, 2014]. Exploratory analyses identified four groups of items interpreted as preference for uncertainty (10 items, ω = .83, sample item: "I like finding myself in new and unusual places and situations"), uncertainty anxiety (8 items, ω = .80, ex. "I am scared by the unpredictability of events in the world"), uncertainty avoidance (7 items, ω = .76, ex. "Relationships that have no defined 'rules of the game' at the outset are doomed to fail"), and preference for certainty (5 items, ω = .82, ex. "I would like to always know what I can expect from the world"). The fit of a bifactor ESEM model with a single factor reflecting the attitude to uncertainty (ω = .86) was good (MLM: $\chi^2(295) = 1237.25$, $p < .001$; CFI = .929; RMSEA = .040 [.039, .042]; SRMR = .025). All items loaded significantly on the general factor (λ =.22-.61).

The demographic questionnaire included questions about place of residence, age, education, marital status

(coded as having or not having a partner), having children, and subjective income (seven categories).

Data Analysis

First, to investigate the typical patterns of use of mental health support resources, we performed latent class analysis (LCA) in Mplus 8.8. Latent class analysis is a robust and flexible classification method that can be used to detect unobserved homogeneous subgroups of individuals in a population by defining a categorical latent variable based on a set of categorical indicators [Collins, Lanza, 2010]. In contrast to cluster analysis, latent class analysis allows researchers to ensure that the optimal solution is found by using a large number of optimizations with random starting parameters and to evaluate the quality of the resulting classification using a range of statistics. Because these statistics tend to perform unequally under different conditions, they need to be interpreted in combination and the choice of the best model is not always straightforward [Sorgente et al., 2025].

We entered our binary indicator variables as categorical and carried out a latent class analysis using the robust maximum likelihood (MLR) estimator with 10000 random starts and 2000 second-stage optimizations. We compared models with 2 to 7 latent classes. After finding a solution for each model, we repeated the analysis with the number of random starts and second-stage optimizations increased by a factor of 2.5 to ensure that the solution with the best log-likelihood value would be replicated. Finally, for each model we carried out the Vuong-Lo-Mendell-Rubin Likelihood Ratio Test (VLMRT), Lo-Mendell-Rubin Adjusted Likelihood Ratio Test (LMRT), and bootstrapped likelihood ratio test (BLRT) (we set LRTSTARTS to 0 0 500 100 and K-1STARTS to 500 100).

The characteristics of the latent class analysis models are given in Table 2. Although models with six and seven classes showed the best fit based on information criteria (AIC, BIC, and SABIC), these models showed increased non-convergence (17-19%) and resulted in small sizes of the smallest classes (N = 52 or 2.6% of the total sample size for the six-class model and N = 12, or 0.6%, for the seven-class one), below the conventional 5% criterion [Sorgente et al., 2025]. The VLMRT and the LMRT indicated that the 6-class model was not superior to the one with 5 classes. As a result, based on a combination of statistical criteria, interpretability, and model parsimony, we chose the model with five latent classes.

After identifying and describing the latent classes based on item response probabilities, we examined the demographic predictors of class membership using the R3Step approach in Mplus [Asparouhov, Muthén, 2013]. Next, we used the BCH approach in Mplus [Bakk, Vermunt, 2015; Asparouhov, Muthén, 2021] to test the equality of means of psychological variables across latent classes. These approaches allow latent class membership to be modeled as an unobserved variable while accounting for classification uncertainty, thereby providing unbiased estimates of the associations between latent classes and external variables. Finally, as an additional follow-up analysis, we examined the demographic predictors of the use of each mental health support resource separately for men and women using multigroup logistic regression in Mplus with WLSMV estimator.

Results

Latent Class Analysis

The probabilities of using each of the mental health support resources among members of the five classes are given in Table 3. Overall, Russian participants were most likely to engage in prayer (36%), consult a neurologist (29%), to watch media on self-improvement (28%), or to read popular psychology literature (27%) or professional literature (23%). Only 20% reported ever using psychological counselling, and 20% of the participants have not used any of those strategies.

Table 2.
Parameters of the latent class models

N classes (parameters)	Loglikelihood value	Entropy	AIC	BIC	SABIC	VLMRT	LMRT	BLRT
2 (43)	-14880.14	1.000	29846.29	30087.13	29950.51	p<.001	p<.001	p<.001
3 (65)	-14220.70	0.921	28571.41	28935.46	28728.96	p<.001	p<.001	p<.001
4 (87)	-14040.40	0.812	28254.80	28742.08	28465.68	p<.001	p<.001	p<.001
5 (109)	-13921.44	0.791	28060.88	28671.38	28325.08	p=.016	p=.017	p<.001
6 (131)	-13832.26	0.772	27926.52	28660.24	28244.05	p=.281	p=.283	p<.001
7 (153)	-13756.28	0.783	27817.56	28675.50	28189.41	p=.059	p=.059	p<.001

Table 3.
The mental health resource use probabilities by the members of each latent class

	Class 1 (6.3%)	Class 2 (12.0%)	Class 3 (35.8%)	Class 4 (26.0%)	Class 5 (19.9%)	Overall sample
Online or in-person counseling with a psychologist or psychotherapist	0.78	0.26	0.24	0.12	0.00	0.20
Psychiatric consultations	0.26	0.11	0.05	0.08	0.00	0.07
Neurological consultations	0.57	0.36	0.27	0.44	0.00	0.29
Medication treatment in connection with a psychological request	0.31	0.11	0.08	0.06	0.00	0.08
Support groups (online groups in social networks and messengers, face-to-face meetings)	0.60	0.20	0.14	0.02	0.00	0.12
Contacting a psychological support hotline	0.36	0.08	0.05	0.02	0.00	0.05
Prayer	0.70	1.00	0.21	0.45	0.00	0.36
Conversation with a priest / mullah / rabbi / lama / monk, etc.	0.46	0.43	0.04	0.09	0.00	0.12
Other group formats of group psychological help (online sessions of psychological practice, seminars, workshops, etc.).	0.49	0.11	0.09	0.00	0.00	0.08
Online products of automated or semi-automated psychological help (chatbots of psychological support, online courses to improve general psychological competence, etc. products without personal communication)	0.52	0.05	0.12	0.00	0.00	0.08
Reading psychological literature (e.g., books by Irvin Yalom and other psychological authors)	0.72	0.44	0.46	0.03	0.00	0.27
Reading theological literature	0.31	0.49	0.02	0.04	0.00	0.10
Reading esoteric literature (books on self-discovery, spiritual practices, etc.)	0.55	0.24	0.23	0.06	0.00	0.16
Using mindfulness or anxiety reduction apps or using other automated meditation products	0.51	0.07	0.14	0.01	0.00	0.09
Audio podcasts and videos on self-development and mindfulness	0.76	0.25	0.50	0.08	0.00	0.28
Professional literature on improving efficiency, self-efficacy, work organization, and time management	0.60	0.23	0.34	0.15	0.00	0.23
Coaching in online or in-person format	0.52	0.06	0.13	0.03	0.00	0.10
Group trainings aimed at developing self-regulation skills and increasing psychological resilience (e.g., resilience)	0.59	0.01	0.10	0.02	0.00	0.08
Practices to explore one's sexuality	0.45	0.09	0.13	0.05	0.00	0.10
Substance use	0.13	0.05	0.04	0.06	0.00	0.05
None of the above	0.00	0.00	0.00	0.00	1.00	0.20

The class profiles revealed substantial diversity of strategy use patterns. Members of the first, smallest class (N = 126) used a wide range of strategies, first of all, psychological counselling, followed by self-improvement media, popular psychological literature, and prayer. They were also most likely to turn to mental health specialists, such as psychiatrists. We labelled this group as psychologically aware participants. The second class (N = 241) was characterized by a reliance on prayer in combination with reading theological and psychological literature and talking to priests. We labelled this group as religious participants. The participants belonging to the third, largest class (N = 716), were likely to rely on self-help media, psychological and professional literature, yet somewhat less likely to rely on religious sources, compared to the sample average. We labelled this group as media consumers. The fourth class, also numerous (N = 519), was characterized by the use of chiefly two strategies, prayer and consultations with a neurologist with a lower probability of turning to a psychologist than the three previous groups. We labelled this group as self-reliant participants. Finally, the fifth class included participants (N = 398) who did not use any of the strategies listed.

To compare the diversity of mental health support strategies across classes, we used Welch's ANOVA to compare the number of strategies used between the first four classes (for simplicity, in this analysis we treated class as an observed variable, assigning each participant to their most probable or modal class). The differences were strong and significant ($F(3; 407.88) = 656.01$, $p < .001$, $\eta^2 = .66$) and all the classes differed from one another according to Games-Howell post hoc test. Class 1 participants resorted to a substantially larger number of strategies (M = 10.44, SD = 2.95), compared to Class 2 (M = 4.81, SD = 1.70), Class 3 (M = 3.44, SD = 1.65), and Class 4 (M = 1.70, SD = 0.92).

Demographic Predictors of Latent Classes

The findings regarding the demographic predictors of latent classes obtained using the R3STEP procedure are given in Table 4. Class 5, whose members reported using none of the strategies, was set as a reference group. The strongest differences across groups were observed for gender, age, education, and income. Compared with non-users, representatives of the remaining groups were more likely to be female (marginally significant for Class 4: $p = .052$) and to have higher levels of education. Psychologically-aware participants (Class 1) and media consumers (Class 3) were also likely to be younger and to have higher levels of income. Media consumers (Class 3) were also less likely to have a partner, whereas self-reliant participants (Class 4) were more likely to have children, although these effects were weaker.

Psychological Differences across Latent Classes

The descriptive statistics for classes based on modal class assignment are given in Table 5. Below we present and interpret the results of chi-square tests obtained using latent class membership variable based on the BCH approach to testing the mean differences across latent classes on continuous outcomes.

The mean differences in anxiety were significant ($\chi^2(4) = 134.41$, $p < .001$) with psychologically-aware participants showing higher scores, compared to the other four classes. Classes 2 (religious) and 3 (media consumers) did not differ, but both had significantly higher scores, compared to classes 4 (self-reliant) and 5 (not using any strategies). The latter group showed significantly lower scores, compared to the other four classes. The same picture was observed for depression ($\chi^2(4) = 136.76$, $p < .001$), where Class 1 scored significantly higher than the other four classes,

Table 4.

Multinomial logistic regression coefficients for predictors of latent class membership

	Class 1 (6.3%)	Class 2 (12.0%)	Class 3 (35.8%)	Class 4 (26.0%)
Sex (0-Male/1-Female)	1.05***	0.48*	1.02***	0.33^{x}
Age (years)	-0.08***	-0.01	-0.06***	0.00
Region (0-Capital cities/1-Other)	0.44	0.29	0.16	-0.09
Education (0-5)	0.45***	0.41***	0.41***	0.17*
Income (0-7)	0.43***	0.19	0.20**	0.01
Partnered (0-1)	0.15	-0.42	-0.38*	0.13
Children (0=None, 1=Has children)	0.33	0.52	0.08	0.43*

*Note: *** $p < .001$, ** $p < .01$, * $p < .05$, ^{x} $p = .052$. Class 5 whose members used none of the strategies listed was used as the reference group.*

Classes 2 and 3 again had comparable scores but scored higher than the Classes 4 and 5, and Class 5 scored the lowest.

With respect to personality resources, the differences were weaker. In terms of Self-control ($\chi2(4) = 25.05$, $p < .001$), Classes 1, 2, and 3 with the lowest scores did not differ from one another, and neither did Classes 4 and 5 with the highest scores. Classes 1 (psychologically-aware) and 3 (media consumers) had lower scores than Class 4 (self-reliant), and Classes 1-3 had lower scores than Class 5 (no strategies at all). For systemic reflection the differences were stronger ($\chi2(4) = 97.09$, $p < .001$), yet similar: Classes 1, 2, and 3 did not differ from one another and all three had significantly higher scores than Classes 4 and 5 that did not differ from one another.

Proactive coping ($\chi2(4) = 30.42$, $p < .001$) was significantly higher in Class 1 (psychologically aware), compared to the other four groups; Class 5 also scored lower than Classes 2 and 3. Active coping ($\chi2(4) = 24.41$, $p < .001$) was equally more pronounced in Classes 1, 2, and 3, compared to 4 and 5. There were no significant differences in reflexive coping ($\chi2(4) = 1.98$, $p = .74$) or prevention coping ($\chi2(4) = 9.45$, $p = .051$). Strategic planning ($\chi2(4) = 13.39$, $p = .010$) was more pronounced in Classes 1 and 3 compared to 4 and 5. Instrumental support seeking ($\chi2(4) = 39.87$, $p < .001$) was more pronounced in Class 1 compared to all the other classes, and in Classes 2 and 3, compared to Class 5. Emotional support seeking ($\chi2(4) = 54.67$, $p < .001$) was significantly higher in Class 1 and significantly lower in Class 5, compared to all the other groups.

Finally, the differences in the overall attitude to uncertainty were significant ($\chi2(4) = 34.33$, $p < .001$), indicating a more positive attitude in each of the four classes, compared to Class 5. The liking of uncertainty ($\chi2(4) = 42.79$, $p < .001$) was significantly higher for psychologically-aware participants, compared to the other classes, higher in readers, compared to self-reliant participants, and lower in Class 5, compared to all classes but 4. Uncertainty anxiety ($\chi2(4) = 25.54$, $p < .001$) was significantly lower in Class 5, compared to each of the other groups. Uncertainty avoidance ($\chi2(4) = 13.93$, $p = .008$) showed higher scores in self-reliant and religious participants, compared to Class 5. The differences in preference for certainty were not significant ($\chi2(4) = 6.12$, $p = .19$).

Predictors of the Use of Individual Mental Health Support Strategies

The results of this additional multiple regression analysis are given in Supplementary materials, Table SI.1. Firstly, despite lower use of most resources by men, demographic predictors generally tended to explain a larger proportion of individual differences in the use of each strategy for men than for women. Generally, all the effects went in the same direction, suggesting that younger respondents with higher education and higher income are more likely to use various mental health support resources.

Discussion

The challenge of mental health problems is growing worldwide and is particularly salient in countries undergoing major social changes, such as Russia. Nevertheless, the stigma associated with seeking help from mental health professionals takes a long time to disappear. As our data indicate, younger respondents, as well as those with higher levels of education and income are more likely to make use of mental health support resources, whereas older participants, men, and those with lower levels of education and income are more likely not to use any mental health support resources or strategies at all.

Our data indicate that the proportion of individuals who have turned to a mental health specialist (a psychologist, a psychiatrist or a neurologist) was 35.0% for men and 49.2% for women; however, excluding neurologists, the corresponding figures constitute 18.0% and 29.0%. This is comparable to other middle-income countries [Wang et al., 2007]. However, in contrast to the findings from other countries, in Russia the percentage of individuals who had consulted a psychologist or a psychiatrist steadily decreased across age groups from 35.7% in the 18-24 group to 8.6% in the 55 and over, with similar trends observed for both men and women. In terms of income, the association was also nearly monotonous, with the highest percentage of those who used help of either of these mental health specialists in the two richest strata (40.0-40.2%), as opposed to the three poorest ones (16.7-25.5%). The differences in terms of education were smaller: 25.8% of the individuals with university degrees had turned to a psychologist or a psychiatrist over the past year, as opposed to 17.9% of those without higher education.

These results indicate important gaps in the accessibility of mental health services, which are related to income, age, education, and gender. Firstly, despite medical services being officially free, getting quality state-funded psychological or psychiatric help is a fairly challenging task even in the capital, hence the income gap. Secondly, turning to state mental health services is associated with a fear of losing social

Table 5.

Descriptive statistics across classes based on modal class assignment

	Overall sample	Class 1 Psycho-logically-aware (6.3%)	Class 2 Religious (12.0%)	Class 3 Media consumers (35.8%)	Class 4 Self-reliant (26.0%)	Class 5 None at all (19.9%)	Significance of the omnibus differences	Effect size r
Demographic variables							χ^2 (4)	
Gender: Female, %	50.0	66.7_{a}	48.5_{b}	61.0_{a}	45.1_{b}	32.2_{c}	104.69***	.23
Age, M (SD)	38.8 (9.25)	$35.0\ (8.58)_{a}$	$40.0\ (8.88)_{b}$	$36.7\ (8.69)_{a}$	$40.2\ (9.40)_{b}$	$41.2\ (9.33)_{b}$	105.76***	.23
Region: capital cities, %	53.4	44.4_{a}	49.0_{a}	51.7_{a}	57.2_{a}	57.0_{a}	11.98*	.08
Education, M (SD)	4.54 (1.08)	$4.79\ (0.87)_{a}$	$4.70\ (1.00)_{a}$	$4.70\ (0.98)_{a}$	$4.47\ (1.10)_{b}$	$4.15\ (1.21)_{c}$	76.53***	.20
Income, M (SD)	3.09 (1.10)	$3.57\ (1.25)_{a}$	$3.17\ (1.17)_{bc}$	$3.18\ (1.10)_{b}$	$2.99\ (1.02)_{bcd}$	$2.87\ (1.08)_{d}$	53.30***	.16
Partnered, %	74.5	81.7_{a}	73.4_{a}	71.1_{a}	78.2_{a}	74.1_{a}	11.83*	.08
Has children, %	72.5	75.4_{ab}	77.2_{ab}	68.0_{b}	77.5_{a}	70.1_{ab}	17.91**	.09
Psychological variables	M (SD)	Mean z score by class					F(4; 1995)	
Anxiety	8.36 (5.78)	0.50_{a}	0.17_{b}	0.10_{b}	-0.02_{b}	-0.42_{c}	30.35***	.24
Depression	9.80 (6.51)	0.53_{a}	0.17_{b}	0.10_{b}	-0.03_{b}	-0.42_{c}	32.26***	.25
Self-control	39.90 (7.34)	-0.21_{a}	-0.07_{ab}	-0.07_{ab}	0.04_{bc}	0.18_{c}	6.02***	.11
Systemic reflection	36.68 (6.63)	0.27_{a}	0.10_{a}	0.21_{a}	-0.13_{b}	-0.35_{c}	26.13***	.22
Proactive coping total	73.75 (14.27)	0.33_{a}	0.04_{ab}	0.06_{bc}	-0.04_{cd}	-0.18_{d}	7.70***	.12
Active coping	16.61 (3.73)	0.24_{a}	0.05_{abc}	0.08_{ab}	-0.08_{bc}	-0.14_{c}	5.95***	.11
Reflexive coping	14.79 (3.42)	0.11_{a}	-0.01_{a}	0.00_{a}	-0.02_{a}	-0.01_{a}	0.43 (n.s.)	.03
Strategic planning	8.14 (2.29)	0.18_{a}	0.05_{ab}	0.05_{ab}	-0.06_{ab}	-0.11_{b}	3.34**	.08
Preventive coping	14.42 (3.42)	0.14_{a}	0.09_{a}	0.02_{a}	-0.02_{a}	-0.11_{a}	2.44*	.07
Instrumental support	10.10 (2.89)	0.40_{a}	0.00_{b}	0.03_{b}	0.03_{b}	-0.22_{c}	10.37***	.14
Emotional support	9.70 (3.18)	0.45_{a}	-0.01_{b}	0.07_{b}	-0.01_{b}	-0.24_{c}	13.16***	.16
Attitude to uncertainty	101.68 (15.01)	0.21_{a}	0.02_{a}	0.05_{a}	0.05_{a}	-0.24_{b}	8.00***	.13
Liking uncertainty	31.07 (6.79)	0.34_{a}	0.03_{ab}	0.09_{ab}	-0.06_{bc}	-0.21_{c}	9.96***	.14
Uncertainty anxiety	28.80 (5.70)	0.07_{a}	0.00_{ab}	0.06_{a}	0.07_{a}	-0.21_{b}	5.97***	.11
Uncertainty avoidance	23.03 (4.85)	0.03_{ab}	0.08_{ab}	-0.02_{ab}	0.09_{a}	-0.14_{b}	3.48**	.08
Preference for certainty	18.78 (3.87)	0.06_{a}	-0.06_{a}	0.00_{a}	0.07_{a}	-0.07_{a}	1.55 (n.s.)	.05

*Note: *** p < .001, ** p < .01, * p < .05. For demographic variables, comparisons were based on Kruskal-Wallis' ANOVA with Dwass-Steel-Critchlow-Fligner post hoc test to mark homogeneous subsets; for psychological variables, regular ANOVA with Tukey post hoc test was performed. Means that share the same alphabetic index are not significantly different from one another.*

rights, which is partly due to the history of psychiatry being used as a means of political oppression used to silence dissenters in the USSR, hence the age gap. Thirdly, there is an enduring stigma of mental illness and a low level of mental health literacy: in 2022, 64% of Russians believed that individuals with mental health issues were dangerous for the society [Zardaryan, 2022]. Due to this stigma patients who fear being declared "mentally ill" or "abnormal" are more likely to turn to neurologists than to psychologists or psychiatrists.

This stigma is more prevalent among older individuals and those with lower education levels. Our data suggest that more educated participants are more likely to recognize mental health problems and to seek help from mental health professionals, whereas individuals with lower levels of education tend to rely more on religious coping, self-help resources, or consultations with somatic health specialists (neurologists). This pattern is also consistent with findings from other countries, such as Canada [Steele et al., 2007; Bartram, 2019]. Although the situation appears to be gradually improving, the pace of change remains slow: the percentage of Russians reporting that they have never sought help from a mental health specialist decreased only slightly, from 92% in 2009 to 86% in 2024 [WCIOM, 2025].

The most important gap, however, seems to be related to gender. The most recent national public opinion poll data [WCIOM, 2025] indicate that 91% of men and only 81% of women have never turned to a mental health specialist. Our data corroborate these findings: although the level of mental health service use is higher among our online panel participants, compared to representative samples, 82% of men and only 71% of women had not turned to a psychologist or a psychiatrist in the past year.

Moreover, in our sample, men constitute two-thirds of participants who reported not using any mental health support strategies or resources, whereas about two-thirds of those who use the widest range of such resources ("psychologically aware" participants) are women. In contrast to the other groups, the non-users have reported lower anxiety and depression, higher self-control, lower tendency to reflect, as well as lower use of proactive coping and a generally less positive attitude to uncertainty, despite denying anxiety. Men are also more prevalent among those who rely on religion and those who tend to consult neurologists but not psychiatrists or psychologists (the "religious" and "self-reliant" groups).

This gender gap may be explained by the dominant discourse of hegemonic masculinity which dictates that a "real" man should be strong, able to stand by his word, self-sufficient, and devoid of "feminine" traits, such as emotionality or weakness [Riabov, Riabova, 2014; Yusupova, 2015]. Given this, it is hardly surprising that the predominantly male individuals who have not used any of the mental health resources, even those freely available online, deny having experienced any anxiety or depression and ascribe to themselves the highest level of self-control. As Bell Hooks put it, "patriarchy demands of all males that they engage in acts of psychic self-mutilation, that they kill off the emotional parts of themselves" [Hooks, 2004, 66].

Importantly, this gender gap in the use of mental health services is not unique to Russia: it has been documented in other countries [Pattyn et al., 2015; Bilsker et al., 2018], where it was also explained by the content of traditional masculine identity [Seidler et al., 2018] which emphasizes self-sufficiency and tolerance for pain and suffering as attributes of a "real" man. Given that such stereotypes tend to be more prevalent among older cohorts, it is not surprising that younger and more educated men appear more willing to acknowledge emotional difficulties and to seek professional mental health support.

The present findings suggest different pathways towards addressing the problem. First, in the absence of state resources that could help bridge these gaps and provide mental health services to those who need them most, information technology tools, such as websites, blogs, podcasts, and smartphone applications, could improve the accessibility of mental health services for residents with lower socioeconomic status. Secondly, the discussion of mental health issues in popular mass media and in compulsory educational programs could improve mental health literacy and reduce the stigma associated with emotional troubles. Finally, the society needs to recognize and address the negative implications of patriarchal gender stereotypes obliging men to avoid recognizing and expressing their emotional distress: the difference in life expectancy between Russian men and women could be in some part explained by the psychological burden of this traditional masculinity.

Naturally, the present study has several important limitations. The use of an online panel sample does not allow for adequate representation of older individuals and members of socially disadvantaged groups. On the other hand, this setting provides more anonymity compared to a face-to-face interview and is more conducive to expressing unpopular opinions [Rickwood, Coleman-Rose, 2023], which may partly

explain the lower levels of mental health service use reported in interviewer-based surveys. The present study did not address the differences across regions, which should be important and could be addressed in future studies. Finally, qualitative studies are needed to better understand how Russian men and women differ in their approaches to recognizing emotional problems and coping with them.

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Supplementary Materials

Table SI.1.

Demographic predictors of individual well-being support resource use by gender

	Men (N = 1000)								Women (N = 1000)							
	Used %	R^2	Reg	Age	Edu	Inc	Par	Chi	Used %	R^2	Reg	Age	Edu	Inc	Par	Chi
Counseling with a psychologist/therapist	13.5	0,13***	0,09	**-0,29*** **	**0, 11***	**0,15****	-0,05	0,09	26.2	0,12***	**0,14****	**-0,25*** **	0,08	**0,12****	**-0,12****	0,09
Psychiatric consultations	8.0	0,05*	0,07	**-0,19****	0,05	0,09	-0,08	0,10	5.6	0,03	**0,13***	-0,09	-0,04	0,05	-0,01	-0,02
Neurological consultations	25.4	0,06**	0,00	-0,07	0,07	**0,15****	0,03	**0,13***	32.3	0,03*	-0,02	0,00	0,05	-0,02	**0,12***	0,08
Medication treatment	6.4	0,08*	0,02	-0,13	**0,21****	0,06	-0,10	-0,02	9.1	0,01	0,04	0,02	0,04	-0,05	-0,04	-0,01
Support groups	8.7	0,07**	0,10	-0,08	0,02	**0,19****	0,06	0,06	15.6	**0,04***	**0,12***	-0,03	0,06	0,08	0,06	-0,04
Psychological support hotline	5.4	0,07*	0,03	-0,07	0,05	**0,20****	0,05	0,04	5.5	0,04	-0,01	-0,08	0,09	0,11	-0,03	0,11
Prayer	31.4	0,03*	0,00	0,01	**0,13****	0,01	**-0,04**	**0,13***	40.9	0,02	-0,05	0,07	0,04	0,00	0,03	0,08
Conversation with a religious leader	11.7	0,05*	0,03	-0,02	**0,19****	0,03	-0,10	0,12	13.0	0,03	-0,03	-0,07	0,09	0,08	0,02	0,04
Group psychological help	5.2	0,08*	-0,08	**-0,24****	0,06	0,07	0,10	0,09	10.0	0,09*	-0,01	-0,08	**0,19****	**0,19****	-0,08	0,05
Online automated psychological help	6.4	0,09*	0,05	**-0,24*** **	0,11	0,05	0,10	-0,03	10.1	0,07**	0,09	**-0,14***	0,08	**0,12***	0,05	0,06
Psychological literature	18.4	**0,07****	0,10*	**-0,12***	**0,16****	0,08	0,07	-0,03	36.4	0,07**	0,02	**-0,13****	**0,19*** **	0,00	**-0,10***	-0,04
Theological literature	11.6	0,04	0,04	0,04	**0,17****	0,02	-0,07	0,04	8.1	0,01	0,04	0,03	0,07	0,02	-0,03	0,04
Esoteric literature	12.4	0,04	0,03	-0,02	0,09	**0,13***	-0,07	0,05	20.2	0,04*	0,01	0,01	**0,11***	**0,14****	-0,08	0,03
Mindfulness apps	5.8	0,05*	-0,02	**-0,13***	0,03	**0,18****	-0,03	0,01	12.7	0,04*	0,06	**-0,17****	0,04	-0,01	0,02	-0,06
Podcasts and videos on self-improvement	21.1	0,09**	-0,01	**-0,22*** **	**0,16****	0,07	0,08	-0,01	35.0	0,04*	-0,01	**-0,13****	**0,12****	0,07	-0,02	-0,06
Professional literature on self-improv't	20.9	0,09**	-0,06	-0,06	**0,23*** **	**0,12***	-0,01	0,06	24.6	0,06**	0,02	**-0,11***	**0,18*** **	0,09	-0,01	-0,02
Coaching online or in-person	6.1	0,14**	0,05	**-0,21****	**0,21****	**0,15***	-0,09	0,18	12.9	0,06*	0,06	**-0,16****	0,05	**0,11***	0,01	0,06
Group trainings	6.0	0,05	0,01	**-0,18****	0,08	0,07	0,01	0,15	9.9	0,09**	0,07	-0,03	0,10	**0,23*** **	-0,03	0,09
Practices to explore one's sexuality	9.0	0,05*	-0,05	-0,02	-0,03	0,15**	0,05	0,13	11.1	0,09**	0,03	**-0,27*** **	0,03	0,06	0,06	0,02
Substance use	5.5	0,05	0,05	-0,20*	0,03	0,08	-0,06	0,08	3.6	0,02	-0,02	0,08	-0,10	0,01	0,05	-0,01
None of the above	27.5	0,09***	-0,01	**0,13****	**-0,23*** **	-0,08	0,01	-0,07	13.1	0,05**	-0,05	**0,17****	**-0,12***	-0,07	0,08	-0,05

*Note: Reg – Region (0 – Capital cities, 1 – Other regions), Edu – Education, Inc – Income, Par – Partnered, Chi – Having children; *** $p < .001$, ** $p < .01$, * $p < .05$.*

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Conflict of Interest

The authors declare no conflict of interest.

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«Парни не плачут»: демографические различия в использовании ресурсов и служб поддержки психического здоровья и благополучия в России

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Демографические различия в использовании ресурсов и сервисов для поддержания психического здоровья до сих пор не изучались в России, стране с одним из самых больших в мире гендерных разрывов в ожидаемой продолжительности жизни. В настоящем исследовании мы использовали онлайн-панельную выборку (N = 2000) для изучения закономерностей и демографических предикторов использования услуг и ресурсов поддержки психического здоровья. Анализ латентных классов на наборе из 21 утверждения, отражающего культурно-специфические способы разрешения психологических проблем, выявил пять групп респондентов: те, кто вообще не использует ресурсы для поддержки психического здоровья (20,3%), те, кто полагается на молитвы и специалистов по соматическому здоровью (35,5%), те, кто использует популярные медиа для самопомощи (35,9%), те, кто практикует религиозное совладание (12,2%) и, наконец, те, кто обращается к специалистам в области психического здоровья, таким как психологи, психиатры или консультанты (6,2%). Помимо удивительно небольшого процента последней группы, мы обнаружили убедительные доказательства демографических различий в использовании услуг по охране психического здоровья; эти различия связаны с гендером, образованием и уровнем дохода. Результаты говорят о том, что необходимы меры по повышению доступности психологической помощи для мужчин, людей старшего возраста, а также людей с низким уровнем дохода и образования.

Ключевые слова: психическое здоровье, самоподдержка, неравенство, гендерные различия

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